

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF NEW YORK
BINGHAMTON DIVISION

William A. Jacobson, on behalf of himself and others
similarly situated,

Plaintiff,

v.

Mary T. Bassett, in her official capacity as Acting
Commissioner of the New York Department of Health,

Defendant.

Civil Action No. 3:22-cv-
00033-MAD-ML

BRIEF OF NATIONAL BIRTH EQUITY COLLABORATIVE [OTHER AMICI] AS *AMICI CURIAE* IN OPPOSITION TO PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION

[Signature]

Counsel for Proposed Amici Curiae [Amici
names]

CORPORATE DISCLOSURE STATEMENT

National Birth Equity Collaborative is a non-profit entity and has no parent corporation. No publicly owned corporation owns 10% or more of the stocks of NBEC.

[Amici] is a non-profit entity and has no parent corporation. No publicly owned corporation owns 10% or more of the stocks of the [Amici].

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INTRODUCTION

Amici are [leading medical and scientific experts as well as organizations with direct experience on the frontlines of the COVID-19 pandemic, including in New York.] *Amici* submit this brief to underscore the substantial medical and scientific literature that supports the New York Department of Health’s acknowledgment that “longstanding systemic health and social inequities have contributed to an increased risk of severe illness and death from COVID-19” for people of “[n]on-white race or Hispanic/Latino ethnicity.”¹ There is no serious medical or public health dispute that longstanding systemic health and social factors have led to disproportionately higher rates of severe illness and death from COVID-19 among non-white individuals. *Amici* further submit this brief to outline for the Court the existing inequities in access to prevention, care, and treatment for COVID-19, and to support the Department’s authority to address those inequities through its guidance regarding prioritization of COVID-19 treatment during times of low supply.

ARGUMENT

I. COVID-19 has disproportionately harmed BIPOC and Latinx individuals.

For nearly two years, the COVID-19 pandemic has wreaked havoc in communities across the country, upended the lives of countless families, and killed more than 884,000 Americans,²

¹ *N.Y. State Dep’t of Health, Prioritization of Anti-SARS-CoV-2 Monoclonal Antibodies and Oral Antivirals for the Treatment of COVID-19 During Times of Resource Limitations*, at 2 (Dec. 29, 2021), <https://on.ny.gov/3IQXc1Z> [hereinafter *Prioritization Guidance*]; N.Y. State Dep’t of Health, *Memorandum Re: COVID-19 Oral Antiviral Treatments Authorized and Severe Shortage of Oral Antiviral and Monoclonal Antibody Treatment Products* (Dec. 27, 2021), <https://on.nyc.gov/34pKjx6> [hereinafter *Memorandum*] (“[L]ongstanding systemic health and social inequities put Black, Indigenous, and People of Color at increased risk of severe COVID-19 outcomes and death.”).

² Ctrs. for Disease Control (CDC), *COVID Data Tracker*, <https://bit.ly/3KUIIWh>, (last visited Feb. 2, 2022).

more than 66,000 of them New Yorkers.³ Although the COVID-19 pandemic has taken a toll on all New Yorkers, it has disproportionately impacted Black, Indigenous, and people of color (BIPOC) and Latinx individuals.⁴ BIPOC and Latinx individuals have experienced higher rates of COVID-19, severe COVID-19 symptoms, serious illness requiring hospitalization, and death from COVID-19 than whites.

BIPOC and Latinx individuals have experienced disproportionate rates of death from COVID-19.⁵ Based on data collected through March 7, 2021, Black individuals have died from COVID-19 at 1.4 times the rate of white individuals.⁶ One study found that, among individuals aged 25–54, the *Black and Latinx populations lost nearly 7 times, and the Indigenous population lost nearly 9 times, as many years of life before age 65 from COVID-19 as the white population.*⁷ The disparity in COVID-19 death rates holds across all age groups but is particularly acute among younger people.⁸ By the end of July 2020, 78% of children under age 21 who died from COVID-

³ New York State Department of Health, *COVID-19 Fatalities Tracker*, <https://on.ny.gov/3HINh4j>, (last visited Feb. 2, 2022).

⁴ This brief refers to non-Hispanic white racial and ethnic groups as BIPOC and Latinx individuals, except where discussing data from research that refers to one or more subsets of those groups. This brief uses the following terminology: Black, Indigenous, Latinx, and Asian American, except where quoting from a source that uses different terminology. In this brief, “white” refers to non-Hispanic white people.

⁵ See, e.g., Jeremy A.W. Gold et al., *Race, Ethnicity, and Age Trends in Persons Who Died from COVID-19 — United States, May–August 2020*, 69 *Morbidity & Mortality Wkly. Rep.* 1517 (2020), <http://dx.doi.org/10.15585/mmwr.mm6942e1>; Zirui Song et al., *Racial and Ethnic Disparities in Hospitalization Outcomes Among Medicare Beneficiaries During the COVID-19 Pandemic*, 2 *JAMA Health Forum* e214223 (2021), doi:10.1001/jamahealthforum.2021.4223.

⁶ COVID Tracking Project, *The COVID Racial Data Tracker* (last visited Feb. 2, 2022), <https://bit.ly/3KZDOSk>.

⁷ Mary T. Bassett et al., *Variation in racial/ethnic disparities in COVID-19 mortality by age in the United States: A cross-sectional study*, 18 *PLOS Med.* e1003541, at 10 (2020), <https://doi.org/10.1371/journal.pmed.1003402>.

⁸ CDC, *Disparities in Deaths from COVID-19* (updated Dec. 10, 2020), <https://bit.ly/32O5kRt>.

19 were BIPOC or Latinx.⁹ The disproportionate mortality rates for BIPOC and Latinx individuals holds even after accounting for differences in level of education.¹⁰ The inequity is stark:

If all groups had experienced the same mortality rates as college-educated non-Hispanic White individuals, there would have been 48% fewer COVID-19 deaths among adults aged 25 years or older overall, including 71% fewer deaths among racial and ethnic minority populations and 89% fewer deaths among racial and ethnic minority populations aged 25 to 64 years.¹¹

In New York State, according to a 2020 study, Black individuals comprised 16% of the population but made up 22% of COVID-19 deaths statewide.¹² Latinx individuals comprised 19% of state residents, but made up 24% of statewide COVID-19 deaths.¹³ By contrast, whites comprised 55% of New York State’s population, but made up 43% of statewide COVID-19 deaths.¹⁴ According to recent data from New York State, the COVID-19 death rate for whites has been 155 per 100,000, whereas the death rates for Asian American, Black, and Latinx individuals has been 186, 349, and 269 per 100,000, respectively.¹⁵ Outside of New York City, the age-adjusted death rate “is double or even quadruple for [Black], Latinx, and Asian New Yorkers” relative to white New Yorkers.¹⁶ In fact, after adjusting for age, *New York is the state with the*

⁹ See Danae Bixler et al., *SARS-CoV-2–Associated Deaths Among Persons Aged <21 Years — United States, February 12–July 31, 2020*, 69 *Morbidity & Mortality Wkly. Rep.* 1324 (2020), <https://bit.ly/3uiwmM8>.

¹⁰ Justin M. Feldman & Mary T. Bassett, *Variation in COVID-19 Mortality in the US by Race and Ethnicity and Educational Attainment*, 4 *JAMA Network Open* e2135967, at 1 (2021), <https://bit.ly/3sirmVs>.

¹¹ *Id.*

¹² Laurens Holmes Jr. et al., *Black–White Risk Differentials in COVID-19 (SARS-COV2) Transmission, Mortality and Case Fatality in the United States: Translational Epidemiologic Perspective and Challenges* at 7, 17 *Int’l J. Env’t Rsch. & Pub. Health* 4322, 4328 (2020), <https://doi.org/10.3390/ijerph17124322>.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ COVID-19 Health Equity Interactive Dashboard, *COVID-19 Outcomes in New York* (last visited Feb. 2, 2022), <https://covid19.emory.edu/36>.

¹⁶ Amanda Dunker & Elisabeth Ryden Benjamin, *How Structural Inequalities in New York’s Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform*, *Cmty. Serv. Soc’y* (June 4, 2020), <https://bit.ly/3KZ7JtZ>.

*highest COVID-19 mortality rate among its Black residents.*¹⁷

Indeed, from the earliest days of the COVID-19 pandemic, BIPOC and Latinx individuals have been disproportionately impacted. BIPOC and Latinx individuals experience higher rates of COVID-19 than white individuals.¹⁸ More significantly, BIPOC and Latinx individuals experience disproportionately higher rates of severe illness from COVID-19.¹⁹ As of February 1, 2022, Latinx, Black, and Indigenous people experienced 2.4, 2.5, and 3.2 times greater rates of hospitalization for COVID-19 than white people, respectively.²⁰ One study found BIPOC and Latinx individuals experience higher rates of increased COVID-19 disease severity upon admission to a hospital compared with whites, which in turn increases the likelihood of needing intubation or ICU care, and death.²¹ Another study concluded that higher positive COVID-19 test rates pointed to “more severe cases” in areas of New York City with large Black populations, with the opposite

¹⁷ APM Research Lab, *The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.* (Mar. 15, 2021), <https://bit.ly/3uqm5NU>.

¹⁸ As of May 30, 2020, data reflected that, among COVID-19 cases where the information was known, 33% were Latinx, 22% were Black, and 1.3% were Indigenous; these percentages far exceed those groups’ proportions of the U.S. population. Erin K. Stokes et al., *Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020*, 69 *Morbidity & Mortality Wkly. Rep.* 759, 763 (2020), <http://dx.doi.org/10.15585/mmwr.mm6924e2>.

¹⁹ See, e.g., Anna M. Acosta et al., *Racial and Ethnic Disparities in Rates of COVID-19–Associated Hospitalization, Intensive Care Unit Admission, and In-Hospital Death in the United States From March 2020 to February 2021*, 4 *JAMA Network Open* e2130479 (2021), doi:10.1001/jamanetworkopen.2021.30479; Eboni G. Price-Haywood et al., *Hospitalization and Mortality among Black Patients and White Patients with Covid-19*, 382 *New Eng. J. Med.* 2534 (2020), <https://bit.ly/3gfjHS9>.

²⁰ CDC, *Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity* (updated Feb. 1, 2022), <https://bit.ly/3AOrwHV>.

²¹ CDC, *Risk of Severe Illness or Death from COVID-19* (updated Dec. 10, 2020), <https://bit.ly/3ghKDAI>; see also Shruti Magesh et al., *Disparities in COVID-19 Outcomes by Race, Ethnicity, and Socioeconomic Status: A Systematic Review and Meta-analysis*, 4 *JAMA Network Open* e2134147 (2021), doi:10.1001/jamanetworkopen.2021.34147.

conclusion—less severe cases—presenting in predominantly white neighborhoods.²²

Heart disease and diabetes are two of the most common underlying medical conditions that the CDC has recognized place COVID-19 patients at increased risk of severe illness or death,²³ and these diseases disproportionately affect BIPOC and Latinx individuals.²⁴ BIPOC and Latinx individuals also experience higher rates of undiagnosed medical conditions such as diabetes,²⁵ thus increasing the likelihood of having a risk factor that goes undetected. And among people diagnosed with medical conditions such as diabetes or heart disease, BIPOC and Latinx individuals experience higher rates of more severe cases, disease-related complications, and premature death from those diseases, than their white counterparts.²⁶

Despite experiencing higher rates of severe illness and death from COVID-19, BIPOC and Latinx patients have been less likely than white patients to receive monoclonal antibody therapies

²² Jack Cordes & Marcia C. Castro, *Spatial analysis of COVID-19 clusters and contextual factors in New York City*, 34 *Spatial & Spatio-temporal Epidemiology* at 3 (2020), doi.org/10.1016/j.sste.2020.100355.

²³ See CDC, *Medical Conditions* (updated Dec. 14, 2021), <https://bit.ly/3IUxx8D>; Erin K. Stokes, *supra* n. 18.

²⁴ Pub. Health L. Watch, *COVID-19 Policy Playbook: Legal Recommendations for a Safer, More Equitable Future* (Scott Burris et al. eds., 2021), <https://bit.ly/3L0KCz6> [hereinafter COVID-19 Policy Playbook].

²⁵ See CDC, *Prevalence of Both Diagnosed and Undiagnosed Diabetes* (Dec. 29, 2021), <https://bit.ly/3s3Xiwu>.

²⁶ Shirley A. Hill, *Inequality and African-American Health: How Racial Disparities Create Sickness* 11, 60 (2016) [hereinafter *Inequality and African-American Health*]; Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Healthcare* 57 (2015) [hereinafter *Just Medicine*]; Matthew Wynia et al., *Collecting and using race, ethnicity and language data in ambulatory settings: A white paper with recommendations from the Commission to End Health Care Disparities*, Comm'n to End Health Care Disparities (2011), <https://bit.ly/3omfD6R>; Ctrs. for Medicare & Medicaid Servs., *Racial and Ethnic Disparities in Diabetes Prevalence, Self-Management, and Health Outcomes among Medicare Beneficiaries* (2017), <https://go.cms.gov/3s2Ettq>.

(mAb).²⁷ A recent large-scale study found that Latinx, Black, Asian American, and other non-white race patients received mAb 58%, 22%, 48%, and 47% less often, respectively, than white patients.²⁸ The study concluded that, “as a consequence of [BIPOC and Latinx individuals’] higher prevalence of preexisting conditions,” the mAb treatment inequity “amplif[ies] the increased risk for severe COVID-19–associated outcomes, including death among these groups.”²⁹

COVID-19’s disparate impact on BIPOC and Latinx individuals does not stop at the hospital door. BIPOC and Latinx individuals experience higher rates of serious COVID-19 related complications than white individuals. For example, according to one study, 37% of patients hospitalized for COVID-19 develop acute kidney injury.³⁰ Acute kidney injury increases the likelihood of death: 35% of COVID-19 patients with acute kidney injury died, compared with 16% of all hospitalized COVID-19 patients.³¹ The study found that Black patients were more likely than white patients to develop acute kidney injury.³² Similarly, over 70% of all reported cases of multisystem inflammatory syndrome in children—“a rare but severe condition that occurs approximately 2–4 weeks after the onset of COVID-19 in children and adolescents”—have occurred among Black or Latinx children.³³

II. The greater rates of severe symptoms and death from COVID-19 experienced by BIPOC and Latinx individuals is tied to systemic racism and bias, and is not accounted for by other observable risk factors.

Extensive literature provides two well-supported explanations for the racial and ethnic

²⁷ Jennifer L. Wiltz et al., *Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021*, 71 *Morbidity & Mortality Wkly. Rep.* 96, 96 (2022), <https://bit.ly/3scQRal>.

²⁸ *Id.* at 96.

²⁹ *Id.* at 100.

³⁰ CDC, *Disparities in Hospitalizations* (updated Jan. 27, 2022), <https://bit.ly/3ufveJj>.

³¹ Jamie S. Hirsch et al., *Acute kidney injury in patients hospitalized with COVID-19*, 98 *Kidney Int’l* 209, 210, 211 (2020), <https://doi.org/10.1016/j.kint.2020.05.006>.

³² *Id.* at 213.

³³ CDC, *Disparities in Hospitalizations*, *supra* n. 30.

inequities in COVID-19 case severity and mortality. First, the legacy of this country’s long history of racist policies—such as segregation and persistent inequities in housing, employment, and other life opportunities—has led to adverse health outcomes for racial and ethnic groups historically marginalized by systems and structures.³⁴ These social determinants of health mean that societal conditions can—and do—affect an individual’s health risk.³⁵ Second, racism and implicit bias within the medical system has resulted in lower quality healthcare for BIPOC and Latinx individuals.³⁶ Crucially, these systemic inequities manifest in an increased risk of developing severe COVID-19 symptoms relative to whites—a risk that is not captured by other immediately observable information such as age, vaccination status, and presence of underlying medical conditions.³⁷

A. The COVID-19 pandemic has disproportionately harmed BIPOC and Latinx individuals due to inequitable social determinants of health.

The COVID-19 pandemic’s disparate impact on BIPOC and Latinx individuals is neither novel nor a coincidence. The COVID-19 pandemic further exposed to mainstream scrutiny “how

³⁴ See, e.g., CDC, *Health Equity Considerations and Racial and Ethnic Minority Groups* (last updated Jan. 25, 2022), <https://bit.ly/3giQc1z>; Paula Braveman et al., *What is Health Equity?*, Robert Wood Johnson Foundation (May 1, 2017), <https://rwjf.ws/3Gkedjx>.

³⁵ See CDC, *Social Determinants of Health: Know What Affects Health* (Sept. 30, 2021), <https://bit.ly/3IWQXd3>.

³⁶ See Am. Med. Ass’n, *AMA: Racism is a threat to public health* (Nov. 16, 2020), <https://bit.ly/35xEoGE> (“[R]acism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.”).

³⁷ See generally COVID-19 Policy Playbook, *supra* n. 24; Amanda Dunker & Elisabeth Ryden Benjamin, *supra* n. 16; Benjamin Seligman et al., *Social determinants of mortality from COVID-19: A simulation study using NHANES*, 18 PLOS Med. e1003888 (2021), <https://bit.ly/3ITbxek> (Simulation “provide[d] evidence of the scale of social and economic disparities in the COVID-19 epidemic in the US,” including racial and ethnic disparities in mortality rates, and concluding simulation’s disparities were “likely underestimates of their true scope” because the “direct effects of social determinants of health on vulnerability to infection and mortality [were] not explicitly modeled”).

deeply racism and discrimination are entrenched in our laws and policies.”³⁸ Racial and ethnic disparities in health outcomes are well documented. For example, Black individuals “are three times as likely as whites to develop cardiovascular disease and twice as likely to die from it.”³⁹ In 2017, the rate of asthma deaths among adults aged 65 and older was significantly higher for Blacks, Asian Americans, and Pacific Islanders than for whites.⁴⁰ And Black women are nearly three times as likely as white women to die from pregnancy-related complications.⁴¹ Inequities in health outcomes persist “even when access-related factors, such as patients’ insurance status and income, are controlled.”⁴² It is crucial to note that “these disparities do not arise from bad individual choices or biological differences between races but the social factors that shape people’s lives every day We as a society have created them.”⁴³

Numerous social determinants of health have historically prevented people of color, and Black individuals in particular, from having the same opportunities to attain good physical health

³⁸ COVID-19 Policy Playbook, *supra* n. 24, at 6.

³⁹ *Just Medicine*, *supra* n. 26, at 57; *see also Inequality and African-American Health*, *supra* n. 26, at 11 (“African Americans not only have higher rates of sickness than Whites, but they also get sick earlier, have more severe diseases, and are more likely to die from their diseases.”).

⁴⁰ Off. Disease Prevention and Health Promotion, *Asthma deaths among adults (per million population, 65+ years) By Race/Ethnicity* (last updated Dec. 28, 2021), <https://bit.ly/3geCooT>.

⁴¹ CDC, *Pregnancy Mortality Surveillance System* (Nov. 25, 2020), <https://bit.ly/3ohnWB5>.

⁴² Inst. of Med., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 1 (2003), <https://doi.org/10.17226/10260> [hereinafter *Unequal Treatment*]; *Inequality and African-American Health*, *supra* n. 26, at 22.

⁴³ COVID-19 Policy Playbook, *supra* n. 24, at 7; *see also* Yin Paradies, *A systematic review of empirical research on self-reported racism and health*, 35 *Int’l J. of Epidemiology* 888, 888 (2006), <https://bit.ly/3IX87qS> (“The manifestations of racism vary considerably across time and place but in general ensue from societal systems that produce an unequal distribution of power (and hence resources) in societies based on the notion of ‘race’, where race is a social rather than a biological construct related to the notion of essentialized innate phenotypical, ancestral, and/or cultural difference.”); *Unequal Treatment*, *supra* n. 42, at 1 (“The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants at several levels”).

as white individuals.⁴⁴ Inequitable living, working, and other life conditions can negatively impact an individual's health in obvious ways. Living in heavily polluted areas may worsen one's asthma, for example.⁴⁵

Across all social determinants of health, however, stress is a primary pathway for disparate health outcomes. Racism, discrimination, and inequitable living circumstances can cause chronic stress, which is linked to a wide array of poor health outcomes through various psychophysiological pathways.⁴⁶ Chronic stress “degrades physiological systems,” resulting in “greater susceptibility to pathogens” and decreased “effectiveness of the immune system and resistance to infections, leading to serious illness.”⁴⁷ Researchers “have documented a direct link between social stress and sickness, with stressful life events predicting illnesses as serious as heart disease.”⁴⁸ Researchers have similarly documented an association between chronic stress and elevated blood pressure.⁴⁹

Exposure to racial and ethnic discrimination in daily life is a significant determinant of health. Extensive research has documented that racism itself negatively impacts health over time

⁴⁴ CDC, *Health Equity Considerations and Racial and Ethnic Minority*, *supra* n. 34.

⁴⁵ Anthony Nardone et al., *Associations between historical residential redlining and current age-adjusted rates of emergency department visits due to asthma across eight cities in California: an ecological study*, 4 *Lancet Planet Health* e24, e28 (2020), <https://bit.ly/3rjYeh1>.

⁴⁶ David R. Williams, *Discrimination and racial disparities in health: evidence and needed research*, 32 *J. Behav. Med.* 20, 37 (2009), <https://doi.org/10.1007/s10865-008-9185-0>; Camara Jules P. Harrell et al., *Multiple Pathways Linking Racism to Health Outcomes*, 8 *Du Bois Rev.* 143, 143 (2011), doi:10.1017/S1742058X11000178; *Inequality and African-American Health*, *supra* n. 26, at 5.

⁴⁷ *Inequality and African-American Health*, *supra* n. 26, at 74.

⁴⁸ *Inequality and African-American Health*, *supra* n. 26, at 16.

⁴⁹ *See, e.g.*, Kosuke Inoue et al., *Urinary Stress Hormones, Hypertension, and Cardiovascular Events: The Multi-Ethnic Study of Atherosclerosis*, 78 *Hypertension* 1640 (2021), <https://bit.ly/3ITeQ5e>; Tanya M. Spruill, *Chronic Psychosocial Stress and Hypertension*, 12 *Current Hypertension Reps.* 10 (2010), <https://bit.ly/3oeBBc8>; Akilah Johnson & Nina Martin, *How COVID-19 Hollowed Out a Generation of Young Black Men*, ProPublica (Dec. 22, 2020), <https://bit.ly/3ohfJgc>.

through a process called weathering. A review of 138 empirical studies on the health effects of racism showed a clear link between racism and ill health for oppressed racial groups, even after adjustment for confounding factors.⁵⁰ Another meta-analysis of 293 studies concluded that “racism is significantly related to poorer health.”⁵¹ In a 2011 study, more than 90% of Black individuals reported having experienced racial discrimination.⁵² Racial discrimination can cause chronic stress, which, as noted, is linked to a wide array of poor health outcomes. A study found that exposure to discrimination and segregation during juvenile years predicts adult inflammation by age 28, and that the effect was “considerably more robust than that of traditional health risk factors such as diet, exercise, smoking, and low SES [socioeconomic status].”⁵³ Racial discrimination need not be intended: “[e]vidence has revealed that unconscious bias in interpersonal interactions is strong, widespread and deeply rooted, and could potentially take a heavy toll on health.”⁵⁴

Living in a racially segregated community is another prime example of a negative social determinant of health. Poverty is concentrated in racially segregated areas,⁵⁵ and poverty is linked to adverse health outcomes. Children who live in poverty are “two to four times more likely to

⁵⁰ Paradies, *supra* n. 43, at 895.

⁵¹ Yin Paradies et al., *Racism as a Determinant of Health: A Systematic Review and Meta-Analysis*, 10 PLOS One e0138511, at 24 (2015), <https://doi.org/10.1371/journal.pone.0138511>.

⁵² *Inequality and African-American Health*, *supra* n. 26, at 16.

⁵³ Ronald S. Simons et al., *Discrimination, segregation, and chronic inflammation: Testing the weathering explanation for the poor health of Black Americans*, 54 *Developmental Psychology* 1993, 1994 (2018), <https://doi.org/10.1037/dev0000511>; *see also* Christopher W. Kuzawa & Elizabeth Sweet, *Epigenetics and the embodiment of race: Developmental origins of US racial disparities in cardiovascular health*, 21 *Am. J. of Hum. Biology* 2, 2 (2009), <https://doi.org/10.1002/ajhb.20822> (“[E]nvironmentally responsive phenotypic plasticity, in combination with . . . acute and chronic effects of social-environmental exposures,” better explains the “persistence of CVD [cardiovascular disease] disparities between members of socially imposed racial categories” than does genetics.”).

⁵⁴ Paula Braveman et al., *supra* n. 34, at 5.

⁵⁵ Douglas S. Massey & Mary J. Fischer, *How segregation concentrates poverty*, 23 *Ethnic & Racial Stud.* 670, 671 (2000), <https://bit.ly/3IUXbu3>.

have disease than children who do not.”⁵⁶ Housing in segregated communities is disproportionately poorer quality and more crowded.⁵⁷ Racially segregated neighborhoods also have lower quality schools, another factor linked to adverse health outcomes.⁵⁸ Segregation has also been linked to an increased risk of low birth weight and preterm births, and later-stage diagnosis of cancers and lower cancer survival rates.⁵⁹ New York City is one of the most racially segregated metropolitan areas in the country. Many of the city’s Black and Latinx residents live in largely segregated neighborhoods that “are poor, not well served by public institutions, and vulnerable to crime.”⁶⁰ Most of Long Island’s Black residents live in just 11 of the island’s 291 communities.⁶¹ And almost 90% of Brooklyn’s Black residents live in segregated neighborhoods.⁶²

Access to healthcare services is also restricted in racially segregated neighborhoods. One study found that “[c]ommunities with high proportions of [B]lack and Hispanic residents were four times as likely as others to have a shortage of physicians, regardless of community income.”⁶³ In New York, numerous policies over the past several decades have resulted in underfunded and under-resourced hospital systems in communities of color.⁶⁴ Treatment options may also be

⁵⁶ *Inequality and African-American Health*, *supra* n. 26, at 159.

⁵⁷ *Id.*; CDC, *Health Equity Considerations and Racial and Ethnic Minority Groups*, *supra* n. 34.

⁵⁸ Paula Braveman et al., *supra* n. 34, at 5.

⁵⁹ David R. Williams et al., *Racism and Health: Evidence and Needed Research*, 40 *Ann. Rev. Pub. Health* 105, 108 (2019), doi:10.1146/annurev-publhealth-040218-043750.

⁶⁰ Richard Alba & Steven Romalewski, *The End of Segregation? Hardly*, *Ctr. for Urban Res.* (Mar. 2012), <https://bit.ly/3sfF238>.

⁶¹ Olivia Winslow, *Long Island Divided Part 10: Dividing Lines, Visible and Invisible*, *Newsday* (Nov. 17, 2019), <https://bit.ly/34ug7AG>.

⁶² Themis Chronopoulos, “*What’s Happened to the People?*” *Gentrification and Racial Segregation in Brooklyn*, 24 *J. African-Am. Stud.* Vol. 549, 570 (Sept. 5, 2020), <https://bit.ly/3L90D6m>.

⁶³ M. Komaromy et al., *The role of black and Hispanic physicians in providing health care for underserved populations*, 334 *New Eng. J. Med.* 1305, 1305 (1996), <https://bit.ly/3Lf13Im>.

⁶⁴ Amanda Dunker & Elisabeth Ryden Benjamin, *supra* n. 16.

limited in racially segregated communities. A study found, for example, that “[d]espite similar prevalence of [opioid use disorder] among Black and white adults,” Black patients were often limited to an inferior treatment option due to their location.⁶⁵ The impact of living in a racially segregated neighborhood is encapsulated in the following devastating statistic: “African American boys living in cities at the age of 16 have only a 50 to 62 percent chance of surviving to the age of 65, compared to an 80 percent chance for white boys living in similar situations.”⁶⁶ The CDC identified several access-related factors as potential explanations for the documented racial and ethnic inequities in COVID-19 mAb treatment, including “systemic factors such as limited access to testing and care because of availability constraints, inadequate insurance coverage, and transportation challenges; lack of a primary care provider to recommend treatment; variations in treatment supply and distribution; potential biases in prescribing practices; and limited penetration of messaging in some communities about mAb availability and effectiveness to prevent disease progression.”⁶⁷

Working conditions also greatly influence health outcomes. Racial and ethnic inequities in employment opportunities lead to adverse health outcomes for several reasons. BIPOC and Latinx individuals have disproportionately lower-paying jobs, leaving them with less money to spend on healthcare.⁶⁸ They are also less likely to hold jobs that provide health insurance, and are therefore “significantly more likely to be underinsured than the white population.”⁶⁹ Many New Yorkers

⁶⁵ COVID-19 Policy Playbook, *supra* n. 24, at 121.

⁶⁶ *Inequality and African-American Health*, *supra* n. 26, at 156.

⁶⁷ Jennifer L. Wiltz, *supra* n. 27, at 99.

⁶⁸ U.S. Dep’t of Lab., *Median annual earnings by sex, race and Hispanic ethnicity* (last visited Feb. 1, 2022), <https://bit.ly/3rhy5PX>. See also David R. Williams, *Racism and Health*, *supra* n. 59, at 4 (“In 2016, for every dollar of income that white households received, Hispanics earned 73 cents and blacks earned 61 cents.”).

⁶⁹ COVID-19 Policy Playbook, *supra* n. 24, at 90.

lost their health coverage during the pandemic, but “African Americans in New York City reported losing health insurance twice as often,” and “Latinx New Yorkers reported losing health insurance nearly four times as often,” as white New Yorkers.⁷⁰ Researchers have cited social determinants of health including lack of transportation, lack of paid time off, and lack of insurance, as barriers to COVID-19 vaccine access and accommodations.⁷¹

Researchers have concluded that inequitable social determinants of health contribute to BIPOC and Latinx individuals’ disproportionate rates of severe illness and death from COVID-19.⁷² An individual’s job opportunities and work conditions, access to healthcare, exposure to racism, and segregated living conditions often go hand in hand, leading to a cumulative increase

⁷⁰ Amanda Dunker & Elisabeth Ryden Benjamin, *supra* n. 16.

⁷¹ Savanna L. Carson et al., *COVID-19 Vaccine Decision-making Factors in Racial and Ethnic Minority Communities in Los Angeles, California*, 4 JAMA Network Open e2127582, at 5-6 (2021), doi:10.1001/jamanetworkopen.2021.27582.

⁷² See Ankur K. Dalsania et al., *The Relationship Between Social Determinants of Health and Racial Disparities in COVID-19 Mortality*, J. Racial & Ethnic Health Disparities, Jan. 5, 2021, <https://doi.org/10.1007/s40615-020-00952-y> (“This study demonstrates that social determinants of health contribute to COVID-19 mortality for Black Americans at the county level”); Nicholas Verdini et al., *Social Determinants of Health Amplify the Association Between Ethnicity and COVID19: A Retrospective-Cohort study*, 9 Int’l J. Med. Students 282, 284 (updated Jan. 6, 2022), <https://doi.org/10.5195/ijms.2021.1125> (“[O]ur results show that those who are Hispanic are at an increased risk of COVID-19 infection and those who are Hispanic and have a SDOH risk factor are at an even greater risk.”); Sarah B. Maness et al., *Social Determinants of Health and Health Disparities: COVID-19 Exposures and Mortality Among African American People in the United States*, 136 Pub. Health Reps. 18, 18 (2020), <https://doi.org/10.1177/0033354920969169> (“SDH underlie health disparities that increase the potential for exposure to, and higher death rates from, COVID-19 among African American people across the United States.”); Amanda Dunker & Elisabeth Ryden Benjamin, *supra* n. 16 (“[S]ocial determinants of health are major drivers of the substantial racial disparities observed during the COVID-19 pandemic.”); see also Christopher T. Rentsch et al., *Patterns of COVID-19 testing and mortality by race and ethnicity among United States veterans: A nationwide cohort study*, 17 PLOS Med. e1003379, at 1, 13 (2020), <https://bit.ly/3giLlgV> (finding that “Black and Hispanic individuals are experiencing an excess burden of SARS-CoV-2 infection not entirely explained by underlying medical conditions or where they live or receive care,” and noting “[t]he observed disparities may be due to differential social determinants of health”).

in risk of severe illness or death from COVID-19 associated with a person’s non-white race or Latinx ethnicity.⁷³ For an individual, inequitable social determinants of health may manifest, for instance, in high blood pressure, increased inflammation, and earlier onset of, and more severe forms of, medical conditions such as heart disease, thereby compounding the risk of getting severely ill or dying from COVID-19 in a way that is not captured by consideration of the presence of heart disease alone. At bottom, “conditions of marginalization led, before COVID-19, to higher morbidity and mortality among Black Americans [and other BIPOC and Latinx individuals], which then resulted in a higher burden of underlying vulnerability to COVID-19, manifesting in disproportionate disease severity and death.”⁷⁴

B. BIPOC and Latinx individuals receive lower quality healthcare than whites due to medical racism and bias.

Racism against BIPOC and Latinx individuals within the healthcare system also results in adverse health outcomes and makes race and ethnicity itself a risk factor worth considering in determining the appropriate COVID-19 treatment.⁷⁵

Healthcare inequities are “differences in treatment experienced in the quality of healthcare received by racial and/or ethnic minorities even when access to care is equal.”⁷⁶ Numerous studies show that BIPOC and Latinx patients receive lower quality treatment by healthcare providers, “even when variations in such factors as insurance status, income, age, co-morbid conditions, and

⁷³ See, e.g., Nicholas Verdini et al., *supra* n. 69, at 284 (“The Hispanic population has been shown to experience discrimination, inadequate healthcare access and utilization, inequities in education access, wealth gaps, and increased congested housing, all of which increase the risk of contracting COVID-19.”).

⁷⁴ COVID-19 Policy Playbook, *supra* n. 24, at 13.

⁷⁵ See Am. Med. Ass’n, *New AMA policy recognizes racism as a public health threat* (Nov. 16, 2020), <https://bit.ly/3L6mXgy>.

⁷⁶ G.L.A. Harris, *Cultural Competence: Its Promise for Reducing Healthcare Disparities*, 33 J. Health & Hum. Servs. Admin. 2, 4 (2010), <https://bit.ly/3ogbEZK>.

symptom expression are taken into account.”⁷⁷ The research links these racial and ethnic differences in treatment to adverse health outcomes for BIPOC and Latinx individuals. The following sample of racial and ethnic healthcare inequities illustrates their severity:

- BIPOC and Latinx individuals are less likely than whites to receive preventive care and routine medical procedures.⁷⁸
- Black patients are treated less for pain than white patients.⁷⁹ For example, “sickle-cell patients who are in severe pain waited longer in emergency rooms to get pain medication than white patients with a similar painful disease (for example, renal colic).”⁸⁰
- Black patients are less likely than white patients to receive kidney transplants.⁸¹
- Doctors are almost twice as likely to refer white patients to a specialist than they are to refer Black patients.⁸²
- Black and Latinx individuals are less likely to receive appropriate cardiac medication or to undergo cardiac bypass surgery than whites.⁸³ Although Black individuals are three times as likely to develop cardiovascular disease than whites, and twice as likely to die from it, they are more likely than whites “to receive older conservative coronary treatments than newer or more expensive therapies . . . [which are] more readily available to whites.”⁸⁴
- An estimated 83,560 BIPOC and Latinx individuals die each year due to healthcare disparities.⁸⁵

Extensive research shows that healthcare inequities are due not to clinical factors but to

⁷⁷ *Unequal Treatment*, *supra* n. 42, at 2–3; see also *Just Medicine*, *supra* n. 26, at 35.

⁷⁸ *Unequal Treatment*, *supra* n. 42, at 123; Matthew Wynia et al., *supra* n. 26, at 6; *Just Medicine*, *supra* n. 26, at 1.

⁷⁹ Kelly M. Hoffman et al., *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites*, 113 PNAS 4296, 4296 (2016), <https://doi.org/10.1073/pnas.1516047113>; *Just Medicine*, *supra* n. 26, at 61.

⁸⁰ *Inequality and African-American Health*, *supra* n. 26, at 95.

⁸¹ *Id.* at 90.

⁸² *Id.* at 91.

⁸³ *Unequal Treatment*, *supra* n. 42, at 2-3.

⁸⁴ *Just Medicine*, *supra* n. 26, at 57–58.

⁸⁵ *Id.* at 1.

racism within the medical system.⁸⁶ One study found, for example, that “many white medical students and residents”—73% of the study sample—“hold beliefs about biological differences between blacks and whites, many of which are false and fantastical in nature, and that these false beliefs are related to racial bias in pain perception.”⁸⁷ Another study found that among children who visited emergency departments, Black and Latinx children were less likely to “have their care needs classified as immediate/emergent” and “experienced significantly longer wait times and overall visits as compared to whites.”⁸⁸ The researchers concluded the “difference could not be fully explained by possible confounding factors available in the dataset, such as demographic, socioeconomic, or clinical variables.”⁸⁹ Additionally, “Black newborns have significantly lower mortality if they’re cared for by Black doctors rather than white ones.”⁹⁰ Another study of 495 mostly white, male physicians found that they were less likely to prescribe an aggressive HIV treatment to Black men than white men due to negative racial bias.⁹¹

In 2007, researchers produced “the first evidence of unconscious (implicit) race bias among physicians, its dissociation from conscious (explicit) bias, and its predictive validity.”⁹² The

⁸⁶ See, e.g., Am. Med. Ass’n, *New AMA policy recognizes racism as a public health threat*, *supra* n. 72; Med. News Today, *Racism in healthcare: What you need to know* (Sept. 16, 2020), <https://bit.ly/3okjoK6>.

⁸⁷ Kelly M. Hoffman, *supra* n. 76, at 4299.

⁸⁸ Xingyu Zhang, *Racial and Ethnic Disparities in Emergency Department Care and Health Outcomes Among Children in the United States*, 7 *Frontiers in Pediatrics*, at 1, Dec. 19, 2019, <https://doi.org/10.3389/fped.2019.00525>.

⁸⁹ *Id.*, at 5.

⁹⁰ Akilah Johnson & Nina Martin, *supra* n. 49; see also Brad Greenwood et al., *Physician-patient racial concordance and disparities in birthing mortality for newborns*, 117 *PNAS* 21194, 21194 (2020), <https://bit.ly/3gkmg5m>.

⁹¹ Laura M. Bogart, *Factors Influencing Physicians’ Judgments of Adherence and Treatment Decisions for Patients with HIV Disease*, 21 *Med. Decision Making* 28, 34 (2001), <https://doi.org/10.1177/0272989X0102100104>.

⁹² Alexander R. Green et al., *Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 *Soc’y of Gen. Internal Med.* 1231, 1231 (2007), DOI: 10.1007/s11606-007-0258-5.

researchers concluded that physicians' implicit bias contributed to racial and ethnic disparities in the use of medical procedures such as thrombolysis for myocardial infarction.⁹³ The study also showed that as physicians' IAT (implicit bias) scores increased, their likelihood of treating Black patients with thrombolysis decreased. A 2015 systematic review of 15 studies measuring implicit bias and health outcomes confirmed that healthcare professionals hold the same level of implicit bias against Black, Latinx, and dark-skinned people as the general population, and that "implicit bias was significantly related to patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes."⁹⁴ A 2017 systematic review of 37 studies confirmed the substantial evidence of "pro-White or light-skin/anti-Black, Hispanic, American Indian or dark-skin bias among a variety of [healthcare professionals] across multiple levels of training and disciplines."⁹⁵

Research has shown that a person can hold strong implicit biases against BIPOC and Latinx groups even where they express no explicit bias and believe themselves to be race-neutral.⁹⁶ Studies show that implicit bias influences behavior more directly than conscious bias does.⁹⁷ Perhaps paradoxically, the evidence reveals that "implicit race biases are as prevalent among professionals in the health care industry as they are among the American public generally."⁹⁸ Most

⁹³ *Id.*

⁹⁴ William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 *Am. J. of Pub. Health* e60, e60 (2015), doi: 10.2105/AJPH.2015.302903.

⁹⁵ Ivy W. Maina et al., *A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test*, 199 *Soc. Sci. & Med.* 219, 219 (2018), <https://doi.org/10.1016/j.socscimed.2017.05.009>.

⁹⁶ *Just Medicine*, *supra* n. 26, at 46.

⁹⁷ *Id.* at 39.

⁹⁸ *Id.* at 41.

healthcare professionals, like most whites, “are low in explicit and high in implicit” bias.⁹⁹ In other words, many healthcare professionals unconsciously hold negative biases against BIPOC and Latinx groups, and these negative biases may cause them to provide—entirely unintentionally—a lower quality of care to their BIPOC and Latinx patients than they might provide to similarly situated white patients. Research has shown that strategies based on ignoring group differences do not eliminate bias, whereas making healthcare professionals aware of their own biases and stereotypes does.¹⁰⁰ Researchers have concluded that “[i]nterventions targeting implicit attitudes among health care professionals are needed.”¹⁰¹

Consistent with this evidence, the CDC has identified “potential biases in prescribing practices” as one reason for the observed racial and ethnic disparity in mAb treatment.¹⁰² Most relevant here, racism or implicit bias may influence physicians’ decisions about which patients should receive potentially life-saving treatments.

III. Considering a patient’s non-white race or ethnicity as a risk factor when prioritizing COVID-19 treatments during times of low supply is supported by a strong basis in evidence.

The Food and Drug Administration has recently authorized for emergency use two treatments for COVID-19: anti-SARS-CoV-2 monoclonal antibodies (mAbs), and oral antivirals. COVID-19 patients eligible for these treatments must have mild to moderate symptoms, and be able to begin the treatment within 5 days of symptom onset for oral antivirals, and 10 days of symptom onset for mAbs.¹⁰³ On December 27, 2021, the New York Department of Health issued a memorandum stating that healthcare providers and facilities should adhere to the Department’s

⁹⁹ Michelle van Ryn et al., *The Impact of Racism on Clinician Cognition, Behavior, and Clinical Decision Making*, 8 Du Bois Rev. 199, 204 (2011), doi: 10.1017/S1742058X11000191.

¹⁰⁰ *Just Medicine*, *supra* n. 26, at 66–67, 165, 167.

¹⁰¹ William J. Hall et al., *supra* n. 94, at e60.

¹⁰² Jennifer L. Wiltz, *supra* n. 27, at 99.

¹⁰³ Prioritization Guidance, *supra* n. 1, at 2.

guidance on prioritization of the COVID-19 treatments during times of low supply.¹⁰⁴ Both the Memorandum and the Prioritization Guidance state that healthcare providers should prioritize, where necessary, immunocompromised patients and patients who are age 65 and older, not fully vaccinated, and have at least one risk factor for severe illness.¹⁰⁵

The Prioritization Guidance sets forth five risk groups. The criteria for all risk groups include having a specified number of risk factors identified by the CDC,¹⁰⁶ except the highest risk group that also includes unvaccinated patients aged 65 and older who reside in a long-term care facility, regardless of whether they have any other risk factors. In listing the factors that increase a person’s likelihood of getting severely ill from COVID-19, the CDC states that “[l]ong-standing systemic health and social inequities have put various groups of people at increased risk of getting sick and dying from COVID-19, including many people from certain racial and ethnic minority groups”¹⁰⁷ Consistent with CDC’s statement, the Prioritization Guidance notes that “[n]on-white race or Hispanic/Latino ethnicity should be considered a risk factor, as longstanding systemic health and social inequities have contributed to an increased risk of severe illness and death from COVID-19.”¹⁰⁸

[Contrary to the plaintiff’s assertions,] as discussed above, a wealth of evidence supports the Prioritization Guidance’s consideration of this factor. First, as a result of myriad factors, including inequitable social determinants of health, BIPOC and Latinx individuals experience higher rates of severe COVID-19 symptoms, hospitalizations, and death from COVID-19 than white individuals. Research shows that, among people who have medical conditions such as heart

¹⁰⁴ Memorandum, *supra* n. 1, at 2.

¹⁰⁵ *Id.*; Prioritization Guidance, *supra* n. 1, at 1.

¹⁰⁶ Prioritization Guidance, *supra* n. 1, at 2; CDC, *Medical Conditions*, *supra* n. 23.

¹⁰⁷ CDC, *Medical Conditions*, *supra* n. 23.

¹⁰⁸ Prioritization Guidance, *supra* n. 1, at 3.

disease and diabetes—two of the most common underlying medical conditions among COVID-19 patients—BIPOC and Latinx individuals’ conditions tend to be more severe than white individuals’. BIPOC and Latinx individuals thus are at an increased risk that the Prioritization Guidance’s remaining risk factors, such as age and presence of underlying medical conditions, do not account for.

To illustrate, suppose a Black individual with heart disease and high blood pressure is eligible for one or more of the COVID-19 treatments during a time of low supply. The Prioritization Guidance directs a healthcare provider to consider the patient’s heart disease as a risk factor.¹⁰⁹ But the Prioritization Guidance does not capture the likelihood that the Black individual’s heart condition manifested earlier, and is severer than, a white individual’s of the same age with the same condition. Nor does the Prioritization Guidance account for the Black individual’s increased risk of developing heart failure,¹¹⁰ increased risk of inflammation, or any of the other increased risks associated with their non-white race that do not apply to a similarly situated white COVID-19 patient. The Prioritization Guidance may not even require the provider to consider the Black individual’s high blood pressure.¹¹¹ Given these risks and the increased rates of serious illness and death from COVID-19 associated with non-white race or Latinx ethnicity, it

¹⁰⁹ See Prioritization Guidance, *supra* n. 1, at 2 (hyperlinking risk factors to CDC web page listing risk factors); CDC, *Medical Conditions*, *supra* n. 23 (listing “heart conditions such as heart failure” as medical condition that increases a person’s risk of getting severely ill from COVID-19).

¹¹⁰ Daniel Pan et al., *The impact of ethnicity on clinical outcomes in COVID-19: A systematic review*, 23 *EClinicalMedicine*, at 6, June 3, 2020, doi:10.1016/j.eclinm.2020.100404 (“The prevalence of left ventricular hypertrophy was three times higher amongst Black patients compared to White patients, which may contribute to their increased risk of developing heart failure.”).

¹¹¹ See CDC, *Medical Conditions*, *supra* n. 23 (“Having heart conditions such as heart failure, coronary artery disease, cardiomyopathies, and *possibly* high blood pressure (hypertension) can make you more likely to get severely ill from COVID-19.” (emphasis added)); CDC, *Underlying Medical Conditions* (updated Oct. 14, 2021), <https://bit.ly/3HmC0kb> (listing “Hypertension, possibly” as a co-morbidity supported by “mixed evidence”).

is appropriate for healthcare providers to take a COVID-19 patient’s BIPOC or Latinx race or ethnicity into account when evaluating their risk of progressing to severe illness. Indeed, medical and scientific literature and numerous studies demonstrate that these inequitable health outcomes are the result of centuries and decades of racism, inequitable social determinants of health, and myriad other factors.

Second, the mechanism by which the Prioritization Guidance considers a COVID-19 patient’s non-white race or Latinx ethnicity—by including it as one of the risk factors for severe illness¹¹²—is justified by both the strong correlation between BIPOC and Latinx race or ethnicity and increased risk of severe illness from COVID-19 as well as the potential influence of racism or implicit bias within the medical system. In New York, Black persons experience at least twice the rate of death from COVID-19 than white persons. This increased prevalence of death from COVID-19 is similar to that of patients with obesity,¹¹³ and significantly larger than that of patients with a history of smoking,¹¹⁴ two other risk factors under the Prioritization Guidance. Medical practitioners commonly consider a patient’s race as a risk factor in treatment decisions where justified by the evidence. For example, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine’s recommendations regarding low-dose aspirin prophylaxis for the prevention of preeclampsia consider “Black race (as a proxy for underlying

¹¹² Prioritization Guidance, *supra* n. 1, at 3.

¹¹³ See Lyudmyla Kompaniyets et al., *Body Mass Index and Risk for COVID-19–Related Hospitalization, Intensive Care Unit Admission, Invasive Mechanical Ventilation, and Death — United States, March–December 2020*, 70 *Morbidity & Mortality Wkly. Rep.* 355 (2021), <https://bit.ly/34cIXWG>.

¹¹⁴ Roengrudee Patanavanich & Stanton A. Glantz, *Smoking is associated with worse outcomes of COVID-19 particularly among younger adults: a systematic review and meta-analysis*, 21 *BMC Pub. Health* 1554 (2021), <https://doi.org/10.1186/s12889-021-11579-x>.

racism)” a risk factor.¹¹⁵ The American College of Cardiology and American Heart Association guideline on prevention of cardiovascular disease also takes into account that “[t]he prevalence of stage I hypertension . . . among US adults is 46% higher in [B]lacks, Asians, and Hispanic Americans” in estimating a patient’s risk.¹¹⁶

Because racism and implicit racial and ethnic biases are known to inform medical care, thereby contributing to healthcare disparities and inequities, medical professional associations such as the American Medical Association have called for “acknowledging the harm caused by racism and unconscious bias within medical research and health care” and “identifying tactics to counter racism and mitigate its health effects.”¹¹⁷ By requiring healthcare professionals to take a COVID-19 patient’s BIPOC or Latinx race or ethnicity into account, the Prioritization Guidance can help counteract racism and negative implicit biases against people of color that might otherwise inappropriately influence healthcare professionals’ prioritization decisions. Incorporating equity into “scarce resource allocation protocols,” as the Prioritization Guidance does, also accords with researchers’ and CDC’s recommendations,¹¹⁸ and medical professional organizations’ principles of patient-centered care.¹¹⁹ Evidence suggesting that BIPOC individuals

¹¹⁵ Am. Coll. of Obstetricians & Gynecologists, *Practice Advisory: Low-Dose Aspirin Use for the Prevention of Preeclampsia and Related Morbidity and Mortality* (Dec. 2021), <https://bit.ly/3IZIKom>.

¹¹⁶ Am. Coll. of Cardiology, *2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease* (Mar. 17, 2019), <https://bit.ly/35FVbr7>.

¹¹⁷ Am. Med. Ass’n, *New AMA policy recognizes racism as a public health threat*, *supra* n. 72; *see also* Am. Acad. of Fam. Physicians, *Institutional Racism in the Health Care System*, <https://www.aafp.org/about/policies/all/institutional-racism.html> (last visited Feb. 1, 2022).

¹¹⁸ COVID-19 Policy Playbook, *supra* n. 24, at 162; *see, e.g., id.*; Anna M. Acosta, *supra* n. 19; CDC, *COVID-19 Racial and Ethnic Health Disparities* (updated Dec. 10, 2020), <https://bit.ly/3AVhrZv>.

¹¹⁹ *See, e.g.,* Am. Coll. of Obstetricians and Gynecologists, *Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care*, *ACOG Committee Opinion No. 729*, 131 *Obstetrics & Gynecology* e43, e44 (2018), <https://bit.ly/3GqzIVc> (“A

have more severe outcomes in response to COVID is moreover an issue of public health. Allocating treatment to those known to have the most adverse outcomes will alleviate the crisis of hospital overcrowding and demands on our healthcare system.¹²⁰

Indeed, failing to consider BIPOC and Latinx individuals' increased risk of getting severely ill or dying from COVID-19 in prioritizing COVID-19 treatments during times of low supply would almost certainly result in BIPOC and Latinx COVID-19 patients continuing to get severely ill and to die from COVID-19 at disproportionate rates relative to white patients; in effect, their risk factors would be underappreciated. Only by accounting for the increased risk of severe illness from COVID-19 that BIPOC and Latinx individuals face will their assigned risk group accurately reflect their level of risk.¹²¹

CONCLUSION

For the reasons stated above and in Defendant's filings, [Amici] urge this Court to deny Plaintiff's motion for a preliminary injunction.

Respectfully submitted,

[Signature]

[*Counsel for Proposed Amicus Curiae*]

patient-centered approach to care recognizes the role of . . . historical and contemporary forces in clinical encounters.”).

¹²⁰ See Sharon Otterman & Joseph Goldstein, *More Patients, Fewer Workers: Omicron Pushes New York Hospitals to Brink*, NY Times (Jan. 7, 2022), <https://nyti.ms/3HqmMe5>.

¹²¹ See also Anna M. Acosta, *supra* n. 19, at 2 (“Equitable access to COVID-19 preventive measures, including vaccination, is needed to minimize the gap in racial and ethnic disparities of severe COVID-19.”).

CERTIFICATE OF SERVICE

I hereby certify that on _____, a true and accurate copy of the foregoing motion was electronically filed with the Court using the CM/ECF system. Service on counsel for all parties will be accomplished through the Court's electronic filing system.

/s/

Date: _____, 2022