UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

Jonathan Roberts and Charles Vavruska,

Plaintiffs,

-against-

Mary T. Bassett, in her official capacity as Commissioner for New York State Department of Health; New York City Department of Health and Mental Hygiene,

Defendants.

Case No. 1:22-cv-00710-NGG-RML

NOTICE OF MOTION FOR PRELIMINARY INJUNCTION

PLEASE TAKE NOTICE that on March 2, 2022, at 11:00 a.m. in Courtroom 4D South of the above-titled court, Plaintiffs Jonathan Roberts and Charles Vavruska will, and hereby do, move this Court for an order granting their motion for preliminary injunction pursuant to Federal Rule of Civil Procedure 65 and for the reasons set forth in the accompanying memorandum of law. Plaintiffs request a preliminary injunction prohibiting Defendants and their agents from using race in determining which patients receive priority for oral antivirals and monoclonal antibody treatments for COVID-19.

Respectfully submitted this 18th day of February 2022.

s/ Wencong Fa

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MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

The development of new COVID-19 treatments, including oral antivirals and monoclonal antibodies, is going to save lives. It has been said that Paxlovid may "prevent more than a million hospitalizations"[1] and has the potential to reduce transmissions, which would avert medical professional shortages, workplace disruptions, school closings, flight cancellations, and many other interruptions to the economy and people's daily affairs. But supplies remain scarce. New York has experienced severe supply shortages,[2] and the most effective oral antiviral, Paxlovid, "go[es] out of stock frequently."[3]

Amid this scarcity, and faced with a surge in COVID-19 cases prompted by the Omicron variant, both the New York State Department of Health and New York City Department of Health and Mental Hygiene ("NYC Health") directed providers to allocate treatment based on various risk factors, such as chronic disease, cancer, heart conditions, and obesity. Another risk factor cited by the Department and NYC Health is race. But as the Mayo Clinic found, "there's no evidence that people of color have genetic or other biological factors that make them more likely to be affected by COVID-19."[4] In fact, the rate of death for white non-Hispanic individuals exceeds the rate for any other group in New York.[5]

Plaintiffs are lifelong New Yorkers who object to the use of race in allocating scarce COVID-19 treatments. Plaintiff Jonathan Roberts harbors a deep-felt belief in equality before the

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[1] Andrea Kane & Nadia Kounang, *Pfizer's Covid-19 antiviral pill was hailed as a game-changer, but supplies are scarce*, CNN, Jan. 12, 2022, https://www.cnn.com/2022/01/12/health/paxlovid-pfizer-antiviral-scarce/index.html.

[2] https://coronavirus.health.ny.gov/monoclonal-antibody-therapeutics (State website); https://www1.nyc.gov/site/doh/covid/covid-19-providers-treatments.page#refer (City website). Plaintiffs respectfully request judicial notice of government websites and data in this motion. *See Wells Fargo Bank N.A. v. Wrights Mill Holding, LLC*, 127 F. Supp. 3d 156, 166 (S.D.N.Y. 2015) (collecting sources).

[3] https://www1.nyc.gov/site/doh/covid/covid-19-providers-treatments.page#refer.

[4] *See* https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirusinfection-by-race/faq-20488802.

[5] *See* https://covid19.emory.edu/.

law. His mother immigrated from Hungary when her parents sought to escape the antisemitism prevalent in Europe at the time. As a trained mathematician, Mr. Roberts believes that everyone should be treated on the basis of objective characteristics, and not on the basis of race. Yet race plays a role in Defendants' treatment allocation directives, so that a non-white or Hispanic New Yorker would be eligible to obtain the treatments, and Mr. Roberts would not. Plaintiff Charles Vavruska's experience with COVID-19 was an unpleasant one. In March 2020, Mr. Vavruska was hospitalized for ten days with the disease. He is now eligible to obtain the COVID-19 treatments but may do so only if supplies remain after identically situated non-white or Hispanic individuals obtain the treatments first.

Plaintiffs' requested relief is modest. They do not seek to prevent Defendants from continuing to distribute COVID-19 treatments based on objective race-neutral factors already in use. They only seek to prevent Defendants from distributing COVID-19 treatments on the basis of race.

STATEMENT OF FACTS

The State's Race-Based Directive

On December 27, 2021, the New York State Department of Health published a document setting eligibility for COVID-19 treatments and directing New York health care providers and facilities to follow its guidance for prioritizing patients. *See* Complaint, Exh. A, "COVID-19 Oral Antiviral Treatments Authorized and Severe Shortage of Oral Antiviral and Monoclonal Antibody Treatment Products."[6] It noted "severe resource restrictions" and an "extremely limited supply," requiring providers to prioritize treatment based on a patient's risk of suffering severe illness. *Id.*

[6] The Exhibits refer to government documents and may be judicially noticed by this Court. *See Wells Fargo*, 127 F. Supp. 3d at 166.

According to the document, a person is eligible for oral antiviral treatments if he or she meets the following criteria:

- Age 12 years and older weighing at least 40 kg (88 pounds) for Paxlovid, or 18 years and older for molnupiravir
- Test positive for SARS-CoV-2 on a nucleic acid amplification test or antigen test; results from an FDA-authorized home-test kit should be validated through video or photo but, if not possible, patient attestation is adequate
- Have mild to moderate COVID-19 symptoms
- Patient cannot be hospitalized due to severe or critical COVID-19
- Able to start treatment within 5 days of symptom onset
- Have a medical condition or other factors that increase their risk for severe illness.

Id. According to the document, "non-white race or Hispanic/Latino ethnicity should be considered a risk factor." *Id*.

In a subsequent guidance document, the Department established five "risk groups," 1A–1E, which determine a person's priority when seeking treatment. *See* Prioritization of Anti-SARS-CoV-2 Monoclonal Antibodies and Oral Antivirals for the Treatment of COVID-19 During Times of Resource Limitations," Complaint, Exh. B ("Guidance"). Patients assigned to Group 1A are considered the highest priority, those in Group 1B are the next highest priority, and so on. According to the Guidance, each eligible patient should be assigned to a group and then prioritized within the respective group based on age and a person's number of risk factors. For groups 1D and

1E, providers and facilities can also prioritize based on receipt of a booster shot and time since last vaccination. *See id.*

Group 1A includes individuals of "any age with moderate to severe immunocompromise regardless of vaccine status," "[a]ge 65 and older and not fully vaccinated with at least one risk factor for severe illness," or "[a]ge 65 or older that is a resident of a long-term care facility environment." *Id.* Group 1B includes persons "under 65 years of age and not fully vaccinated with two or more risk factors for severe illness or over 65 and not fully vaccinated (no risk factors.)." *Id.* Group 1C includes persons "under 65 years of age and not fully vaccinated with at least one risk factor for severe illness." *Id.* Group 1D includes individuals "over age 65 and fully vaccinated with at least one risk factor for severe illness." *Id.* Group 1E includes persons "under 65 years of age and fully vaccinated with at least one risk factor for severe illness or age 65 and older and fully vaccinated with no other risk factors." *Id.*

This scheme makes race, alone, determinative in two ways. First, among members in the same risk group, individuals that are non-white or of Hispanic/Latino ethnicity receive higher priority for treatment over others who are of the same age and have the same number of race-neutral risk factors. Second, because race is itself considered a risk factor, being a member of any minority group could move an individual to a higher risk group.

Aside from declaring that "[n]on-white race or Hispanic/Latino ethnicity" are to be considered risk factors, the Department's Guidance does not define "risk factors." Instead, it links to a United States Centers for Disease Control and Prevention (CDC) webpage.[7] That page lists several risk factors that may cause individuals "of any age" to be "more likely to get severely ill

[7] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html.

from COVID-19," including: cancer; chronic kidney disease; chronic liver disease; chronic lung diseases; dementia or other neurological conditions; diabetes; Down syndrome; heart conditions; HIV infection; an immunocompromised state; mental health conditions; obesity and being overweight; pregnancy; sickle cell disease or thalassemia; smoking; solid organ or blood stem cell transplant; stroke or cerebrovascular disease; substance use disorders; and tuberculosis. Like the Department, the CDC also considers being non-white or Hispanic/Latino to be an independent risk factor.

Thus, under the State's directive, a white non-Hispanic person with cancer is treated the same as a non-white or a Hispanic person who is disease-free. Two 66-year-old vaccinated individuals with diabetes who would otherwise have equal standing in Group 1D would see a person of "[n]on-white race or Hispanic/Latino ethnicity" receive priority over a white non-Hispanic person. Race can also determine whether a person is even eligible for oral antivirals or whether similarly situated individuals are put into different risk groups.

The City's Race-Based Directive

New York City follows the state guidance. On December 27, 2021, NYC Health published a health advisory that sets out eligibility criteria for New York City patients who wish to receive oral antiviral treatments and instructs providers on how to prioritize access. Complaint, Exh. C, "COVID-19 Oral Antiviral Treatments Authorized and Severe Shortage of Oral Antiviral and Monoclonal Antibody Treatment Products" (Health Advisory #39). Health Advisory #39 instructs health care providers to "[a]dhere to New York State Department of Health (NYS DOH) guidance on prioritization of high-risk patients for anti-SARS-CoV-2 therapies during this time of severe

resource limitations," and instructs providers to "consider race and ethnicity when assessing an individual's risk."[8]

Plaintiffs

Jonathan Roberts was born and raised in New York City. Roberts Decl. ¶ 2. His mother immigrated from Hungary, where her family faced antisemitism that prevailed in Europe at that time. *Id.* Mr. Roberts tested into the prestigious Bronx High School of Science and from there earned a math degree at Harvard—the only four years of his life in which he lived outside of New York. *Id.* He now lives in Manhattan with his wife of over 30 years. *Id.* Mr. Roberts is 61 years old and fully vaccinated against COVID-19 with no known risk factors for severe illness that could result from COVID-19. *Id.* ¶ 3. He does not therefore qualify for inclusion in any tier of the "risk groups" established by the State Department of Health or NYC Health for prioritization of certain COVID-19 treatments. *Id.* ¶ 4. If he were any race but white, he would qualify for the last tier (1E) of the risk groups.

Charles Vavruska is an electrical engineer and a resident of Queens. Vavruska Decl. ¶ 2. A lifelong resident of New York, Mr. Vavruska is white and not Hispanic, 55 years old, and vaccinated against COVID-19. *Id.* ¶ 3. In March 2020, Mr. Vavruska contracted COVID-19 and was hospitalized for 10 days. *Id.* He has at least one risk factor (overweight and obesity) for severe illness that could result from another bout with COVID-19. *Id.* ¶ 4. He therefore qualifies for inclusion in the last tier (1E) of the risk groups for prioritization of certain COVID-19 treatments.

Mr. Roberts and Mr. Vavruska remain at risk for contracting COVID-19. Infections from the virus remain high in New York. In fact, emergency orders related to COVID-19 are still in effect in both New York and New York City. And according to Acting Commissioner Janet

[8] All prescriptions in the City are filled exclusively by Alto Pharmacy, which provides "free, same day home delivery regardless of insurance or immigration status." *See* Complaint, Exh. C.

Woodcock of the United States Food and Drug Administration, "most people are going to get covid." Aaron Blake, *"Most people are going to get covid": A momentous warning at a Senate hearing*, Washington Post, Jan. 11, 2022. Meanwhile, COVID-19 treatments are often in short supply. Providers frequently report low stock[9] and the Department of Health has recognized an "extreme shortage" of supply. *See* Complaint, Exh. B. The state and city directives are already affecting people on the basis of their race. One Staten Island doctor said he filled two prescriptions for Paxlovid and was asked by the pharmacist to disclose the race of the patients before the treatment was authorized.[10] Mr. Roberts and Mr. Vavruska have brought this civil rights lawsuit because they seek equal access to oral antiviral or monoclonal antibody treatments without regard to their race. Roberts Decl. ¶ 5; Vavruska Decl. ¶ 6.

STANDARD OF REVIEW

The Second Circuit requires parties seeking a preliminary injunction to show: "(a) irreparable harm and (b) either (1) likelihood of success on the merits or (2) sufficiently serious questions going to the merits to make them a fair ground for litigation and a balance of hardships tipping decidedly toward the party requesting the preliminary relief." *Citigroup Global Markets, Inc. v. VCG Special Opportunities Master Fund Ltd.*, 598 F.3d 30, 35 (2d Cir. 2010) (quoting *Jackson Dairy, Inc. v. H.P. Hood & Sons, Inc.*, 596 F.2d 70, 72 (2d Cir. 1979)). The *Citigroup* court confirmed that this standard survived the Supreme Court's decision in *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7 (2008). *Citigroup*, 598 F.3d at 38.

[9] https://www.nytimes.com/2022/01/06/business/covid-paxlovid-antibodies-omicron.html.
[10] Jon Levine, *NYC will consider race when distributing life-saving COVID treatments*, New York Post, Jan. 1, 2022, https://nypost.com/2022/01/01/nyc-considering-race-in-distributing-life-saving-covid-treatment/).

ARGUMENT

I. Plaintiffs Have Standing to Pursue Their Claims

A party invoking this Court's jurisdiction must show that he faces an "injury in fact" that is "fairly traceable" to Defendants and is redressable by a favorable decision. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992). Plaintiffs satisfy all three factors here.

Plaintiffs suffer an injury of a serious kind: the denial of equal treatment due to their race. The injury in fact in an equal protection case involving racial discrimination is not the ultimate denial of the benefit, but the erection of "a barrier that makes it more difficult for members of one group to obtain a benefit than it is for members of another group." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville, Fla.*, 508 U.S. 656, 666 (1993); *see also Grutter v. Bollinger*, 539 U.S. 306, 317 (2003) (noting that the plaintiff "clearly has standing" to bring a lawsuit challenging the use of race as one of many factors).

By using race as an independent risk factor, Defendants' directives disadvantage Plaintiffs on account of their race. For instance, race is the reason that Mr. Roberts is categorically ineligible to receive potentially lifesaving COVID-19 treatment under the guidelines. *See* Roberts Decl. ¶ 4. Given his age, vaccination status, and current health, Mr. Roberts would be eligible to receive the treatments if only he were non-white or Hispanic. *Id.* The directives injure Mr. Vavruska in a similar way. Although Mr. Vavruska is eligible for the COVID-19 treatments listed in the directives, he must hope that supplies remain after non-white or Hispanic individuals with the exact same age, vaccination status, and health condition receive them first. *See* Vavruska Decl. ¶ 4. And Mr. Vavruska's need for the treatments is even more pronounced, given that he participates in in-person meetings and frequently takes public transportation. *Id.* ¶ 5.

It is of no moment that neither Plaintiff currently has COVID-19. Article III of the U.S. Constitution does not require a showing that an imminent injury is certain, but instead that there is a "substantial risk that the harm will occur." *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158 (2014). As the Acting Commissioner of the FDA noted recently, most people will contract COVID-19. *See "Most people are going to get covid*," *supra*, at 7. Further, requiring a person to wait until he has tested positive for the virus before allowing him to file suit is impractical at best. New York itself states that patients must be "able to start treatment within 5 days of symptom onset." It would be a tall, if not impossible, task to see a doctor, receive a prescription, retain a lawyer, file a complaint and motion for a temporary restraining order, and obtain an injunction all within that time span.

At this Court's pre-motion conference, counsel for Defendants relayed that they recently heard that there is currently an oversupply of the treatments at issue. But that poses no barrier to this Court's review. Although cases involving the Omicron variant have decreased in the past weeks, experience from the past two years teaches that COVID-19 creates unpredictable scenarios. Defendants do not, and cannot, represent that supplies of COVID-19 treatments will outnumber demand indefinitely. Perhaps for that reason, they have not retracted the directives challenged in this case, which anticipate "[t]imes of [r]esource [l]imitations." Complaint, Exh. B; *cf.* New York Dep't of Health, *Updated Advisory on Return-to-Work Protocols for Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2* (Feb. 4, 2022) (guidance expressly superseding previous guidance issued on January 4).[11] Moreover, any oversupply would not eliminate the injury suffered by one plaintiff, who is currently ineligible for treatment given his lack of risk factors (including race) *regardless* of supply.

[11] At a minimum, this case falls within the capable of repetition yet evading review exception to mootness. *See Irish Gay & Lesbian Org. v. Giuliani*, 143 F.3d 638, 647–49 (2d Cir. 1998).

Plaintiffs' injury is fairly traceable to Defendants and is redressable by a favorable decision from this Court. The state's directive instructs providers to treat individuals differently on the basis of race, and the city's directive doubles down on that unconstitutional instruction. The injury is redressable because a favorable decision from this Court would allow Plaintiffs to access treatment without regard to race.

Defendants may argue that the directives do not expressly provide a penalty for those who do not follow it. But that does not deprive this Court of its jurisdiction to hear this case. As the Second Circuit has noted, the Supreme Court "appears willing to presume that the government will enforce the law as long as the relevant statute is recent and not moribund." *Hedges v. Obama*, 724 F.3d 170, 197 (2d Cir. 2013) (internal citation and quotation marks deleted). Here, Defendants' recent directives presume that providers of the treatments will follow them—particularly because there is only one provider for New York City and often only one provider for many of the counties in the State of New York. *See* Complaint, Exh. A (listing Alto Pharmacy as the only provider of oral antivirals in New York City, Rite Aid as the only provider in Niagara County, and Kinney Drugs as the only provider in Onondaga County). True enough, Plaintiffs' injury may also be attributable to those providers, but that does not prevent that injury from being "fairly traceable" to Defendants. *Carter v. HealthPort Technologies, LLC*, 822 F.3d 47, 59 (2d Cir. 2016).[12]

II. Plaintiffs Are Likely to Prevail on the Merits

Plaintiffs are likely to succeed on their claim that Defendants' race-based allocation of COVID-19 treatments violates the Equal Protection Clause of the Fourteenth Amendment. Racial classifications, whatever the government's motivation for enacting them, are "presumptively

[12] It is passing strange that the government defends its directives by hypothesizing that no one follows them. The government's hypothesis strains credulity. As just one example, it rests on the counterintuitive assumption that providers that must obtain oral antivirals from the government and obtain the government's approval to distribute them would somehow ignore the government's directives on how to distribute its limited supply.

invalid." *Personnel Adm'r of Mass. v. Feeney*, 442 U.S. 256, 272 (1979). All such classifications are subject to strict scrutiny because they are "simply too pernicious to permit any but the most exact connection between justification and classification." *Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 720 (2007) (internal quotations omitted).

Defendants' directives contain racial classifications that "distribute[] burdens or benefits on the basis of [race]." *Id.* at 721 (citations omitted). The directives direct health providers to prioritize scarce COVID-19 treatments to individuals on the basis of age, vaccination status, and risk factors such as chronic kidney disease, heart disease, cancer, and "[n]on-white race or Hispanic/Latino ethnicity."[13] *See* Complaint, Exh. B. Because race is an independent risk factor, the directives instruct providers to allocate treatments to non-white individuals over identically situated white individuals who are the same age, have the same vaccination status, and the exact same number of risk factors apart from race.

Defendants' directives are therefore subject to strict scrutiny. Under this demanding standard, "the government has the burden of proving that racial classifications 'are narrowly tailored measures that further compelling governmental interests.'" *Johnson v. California*, 543 U.S. 499, 505 (2005) (quoting *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 227 (1995)). Defendants must show that their race-based COVID-19 directives both: (1) further a compelling interest; and (2) are narrowly tailored to further those interests. They cannot do either.

A. Defendants' Race-Based COVID-19 Directives Do Not Further a Compelling Interest

The compelling interest requirement is necessary to "assur[e] that the legislative body is pursuing a goal important enough to warrant use of a highly suspect tool." *City of Richmond v.*

[13] For ease of reference, Plaintiffs use "white" to refer to individuals who are both white and not Hispanic.

J.A. Croson Co., 488 U.S. 469, 493 (1989) (plurality op.). The Supreme Court has recognized only two interests as compelling enough to justify racial classifications: (1) remedying the past effects of de jure discrimination; and (2) diversity in higher education. *Parents Involved*, 551 U.S. at 720–22. Neither is applicable here. Defendants' use of racial classifications is instead based on a conclusory assertion that "longstanding systemic health and social inequities have contributed to an increased risk of severe illness and death from COVID-19." Complaint, Exh. B at 3. This is insufficient for three reasons.

First, Defendants have not come close to establishing the "factual predicate" for their race-based directives. *See Croson*, 488 U.S. at 498. Besides a general assertion that "longstanding systemic health and social inequities have contributed to an increased risk of severe illness and death from COVID-19," Complaint, Exh. B at 3, Defendants have offered no evidence to support their claims. This omission is yet more striking because the evidence points in the opposite direction. According to the latest data from the CDC, the rate of death for individuals who are white exceeds the death rate for any other racial group in New York.[14] So even assuming, for the sake of argument, that group-based comparisons were relevant, Defendants cannot establish a "strong basis in evidence for [the] conclusion that remedial action was necessary." *Croson*, 488 U.S. at 500 (citations omitted).

Second, although race may be associated with certain risk factors, "there's no evidence that people of color have genetic or other biological factors that make them more likely to be affected" by COVID-19.[15] Thus, any disparities that Defendants may be able to conjure will be untethered to evidence of discrimination. *See Croson*, 488 U.S. at 499–500 (criticizing the district

[14] https://covid19.emory.edu/ (compiling CDC data).
[15] https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirusinfection-by-race/faq-20488802.

court's reliance on speculative statistics and finding they did not amount to evidence of discrimination). The Sixth Circuit recently explained that an "observation that prior, race-neutral relief efforts failed to reach minorities is no evidence at all that the government enacted or administered those policies in a discriminatory way." *Vitolo v. Guzman*, 999 F.3d 353, 362 (6th Cir. 2021). By the same token, that risk factors like diabetes might affect some groups more than others does not call for racial preferences, but instead begets race-neutral alternatives that focus on risk instead of race.

Third, Defendants' directives appear to pursue parity between all racial groups. *See* Complaint, Exh. B at 3 (alleging, without citation, that some racial groups suffer from "increased risk of severe illness and death from COVID-19"). Yet even taking Defendants' claim of "longstanding systemic health and social equities" at face value, *id.*, an interest in achieving equal outcomes among racial groups is not compelling enough to justify race-based distribution of COVID-19 treatment. *See Shaw v. Hunt*, 517 U.S. 889, 909–10 (1996) ("[A]n effort to alleviate the effects of societal discrimination is not a compelling interest."); *Croson*, 488 U.S. at 505 ("To accept [government's] claim that past societal discrimination alone can serve as the basis for rigid racial preferences would be to open the door to competing claims for 'remedial relief' for every disadvantaged group.").

B. Defendants' Race-Based COVID-19 Directives Are Not Narrowly Tailored

Defendants' race-based COVID-19 directives also fail narrow tailoring. Narrow tailoring requires a court to scrutinize "the means chosen" by the government, and to ensure that they "fit th[e] compelling goal so closely that there is little or no possibility that the motive for the classification was illegitimate racial prejudice or stereotype." *Croson*, 488 U.S. at 493 (plurality opinion).

The Supreme Court has established several benchmarks for determining whether a law is narrowly tailored. For instance, narrow tailoring requires individualized consideration. *Grutter v. Bollinger*, 539 U.S. 306, 334 (2003). A law that uses race in a rigid, mechanical way fails the test. Narrow tailoring also demands a close fit between the ends sought by the government and the means used to advance those ends. For instance, race-based decision-making is unconstitutional where it is overinclusive by providing gratuitous benefits to individuals on the basis of race. In addition, Defendants must engage in "serious, good faith consideration of workable race-neutral alternatives" that would allow them to achieve the interest they believe to be compelling. *Id.* at 339. Race must be used only as a last resort. The directives fail on all these counts.

First, a narrowly tailored law must provide "individualized consideration" and use race "in a flexible, nonmechanical way." *Id.* at 334. The directives, however, use race in a rigid, mechanical manner. They treat race as one risk factor for every individual who is not white—regardless of whether that person is likely to suffer adverse effects from COVID-19 or is the healthiest human being in the State of New York.

The directives' mindless application of a racial preference is not narrowly tailored. It is instead similar to the unconstitutional admissions policy in *Gratz v. Bollinger*, 539 U.S. 244, 271–72 (2003), which invalidated on narrowing tailoring grounds the automatic award of "20 points to every single applicant from an 'underrepresented minority' group." New York may be using race as a proxy for socioeconomic status or other risk factors. But the directives prioritize a "third generation Japanese American from a wealthy family and with a graduate degree from MIT" over an otherwise identically situated Iraqi immigrant. *Builder's Ass'n of Greater Chicago v. City of Chicago*, 298 F. Supp. 2d 725, 739–40 (N.D. Ill. 2003).

Second, "the means chosen [must] 'fit' th[e] compelling goal so closely that there is little or no possibility that the motive for the classification was illegitimate racial prejudice or stereotype." *Croson*, 488 U.S. at 493 (plurality opinion). Yet Defendants' use of race is overinclusive because it gives a preference to non-white individuals who are perfectly healthy. A non-white baseball player for the New York Yankees (or Mets) is eligible for COVID-19 treatment, but Plaintiffs Jonathan Roberts and Charles Vavruska are not.

Defendants' use of race is also overinclusive because it grants a racial preference to every non-white racial group. Thus, even if Defendants had produced evidence to support their claim that "longstanding systemic health and social inequities" leads to "increased risk of severe illness" for members of some racial groups, it strains credulity to believe that Defendants can do so for *every* non-white racial group. Complaint, Exh. B at 3. On the contrary, the "random inclusion of racial groups" for which there is no evidence of "longstanding systemic health and social inequities" demonstrates that a program is not narrowly tailored. *See Croson*, 488 U.S. at 506.

Third, Defendants failed to engage in "serious, good faith consideration of workable race-neutral alternatives" that would allow them to achieve the interest they believe to be compelling. *Grutter*, 539 U.S. at 339. This is particularly concerning here because such alternatives appear readily available. For instance, Defendants could have distributed scarce COVID-19 treatments to those who are more likely to contract COVID-19 (e.g., those who use public transportation to commute to work). They could also employ the same set of race-neutral risk factors that they use now, including chronic diseases and obesity. Indeed, the shortage in COVID-19 treatments is not confined to New York but has plagued other states as well. Most of those states do not use race in allocating COVID-19 treatments, and the ones that did have since reversed course. Utah Dep't of Health, *UDOH announces changes to risk assessment process for accessing scarce COVID-19*

treatments (Jan. 21, 2022).[16] There is no reason that Defendants cannot follow in their footsteps and disengage from the "sordid business" of "divvying us up by race." *League of United Latin Am. Citizens v. Perry*, 548 U.S. 399, 511 (2006) (Roberts, C.J., concurring in part, concurring in the judgment in part, and dissenting in part).

III. Plaintiffs Satisfy the Remaining Preliminary Injunction Factors

Because Plaintiffs are likely to succeed on the merits of their equal protection claim, they need only show that they would suffer irreparable harm in the absence of preliminary relief. *Citigroup*, 598 F.3d at 35. "Irreparable harm is an injury that is not remote or speculative but actual and imminent, and 'for which a monetary award cannot be adequate compensation.'" *Tom Doherty Assocs., Inc. v. Saban Entm't, Inc.*, 60 F.3d 27, 37 (2d Cir. 1995). A violation of constitutional rights is presumed to cause irreparable harm. *Conn. Dep't of Envtl. Prot. v. OSHA*, 356 F.3d 226, 231 (2d Cir. 2004); *Diaz v. N.Y.C. Bd. of Elections*, 335 F. Supp. 2d 364, 367 (E.D.N.Y. 2004) (alleging violation of Equal Protection Clause of Fourteenth Amendment satisfies "irreparable harm" standard); *see also Elrod v. Burns*, 427 U.S. 347, 373 (1976) (deprivation of constitutional rights "for even minimal periods of time, unquestionably constitutes irreparable harm"); *A.H. by and through Hester v. French*, 985 F.3d 165, 184 (2d Cir. 2021).

Here, Plaintiffs' irreparable harm stems from Defendants' "erect[ion] [of] a barrier that makes it more difficult for members of one group to obtain [COVID-19 treatments] than it is for members of another group." *See Ne. Fla. Ass'n of Gen. Contractors*, 508 U.S. at 666. "[I]n an equal protection case of this variety," a plaintiff is harmed when "the denial of equal treatment result[s] from the imposition of the barrier." *Id.* Absent preliminary relief, Plaintiffs do not have the ability to seek effective COVID-19 treatments on equal footing with other individuals of

[16] https://health.utah.gov/featured-news/udoh-announces-changes-to-risk-assessment-process-for-accessing-scarce-covid-19-treatments

similar age and vaccination status and who have the same number of objective, health-based risk factors. Instead, Defendants have erected a race-based "barrier" that gives non-white and Hispanic or Latino individuals an advantage over Plaintiffs. No amount of monetary compensation can mitigate the inability to seek medical treatment on equal footing—treatment that must be received within days of the onset of COVID-19 symptoms. *See* Complaint, Exh. A (directing patients to start treatment within five days of symptom onset). As discussed above, because Plaintiffs have shown a likelihood of success on their claim that Defendants' discriminatory barrier is unconstitutional, Plaintiffs are entitled to preliminary relief.

In the alternative, Plaintiffs are entitled to preliminary relief because they have raised "sufficiently serious questions going to the merits to make them a fair ground for litigation," and the "balance of hardships" tips substantially in their favor.[17] *Citigroup*, 598 F.3d at 35. This Court has previously held that "depriv[ing] someone of constitutional rights is to inflict a hardship, and an especially heavy one where the rights are to . . . equal protection." *Able v. United States*, 847 F. Supp. 1038, 1045 (E.D.N.Y. 1994). A sister district court has also suggested that an allegation of an equal protection violation tips the balance towards the plaintiff. *See Legal Aid Soc'y v. Ass'n of Legal Aid Att'ys*, 554 F. Supp. 758, 761 (S.D.N.Y. 1982) ("[P]laintiff has alleged the deprivation of rights that are among the most sacred in our constitutional system: the rights to equal access to the courts, to equal protection of the laws, and to counsel in criminal proceedings . . . . Such adverse effect has been alleged, and constitutes in the Court's view, a 'balance of hardships tipping decidedly toward the party requesting relief.'").

[17] Preserving constitutional rights is "always in the public interest." *G & V Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994); *A.H. by and through Hester*, 985 F.3d at 184. In contrast, erecting race-based barriers for accessing medical treatment violates Plaintiffs' constitutional rights. Defendants' directives are not, therefore, in the public interest. *See Carey v. Klutznick*, 637 F.2d 834, 839 (2d Cir. 1980) ("the public interest … requires obedience to the Constitution"); *ACLU v. Ashcroft*, 322 F.3d 240, 247 (3d Cir. 2003) ("[T]he Government does not have an interest in the enforcement of an unconstitutional law." (internal quotation marks omitted)).

That is the case here, where Plaintiffs suffer significant hardship absent preliminary relief. Because Plaintiffs must seek out the treatments at issue in this case within days of the onset of COVID-19 symptoms—and because they are disadvantaged in receiving those treatments due only to their race—an injunction is necessary to avoid significant hardship, including potential death. Defendants, on the other hand, have no interest in enforcing directives with serious constitutional questions, and can still prioritize the administration of COVID-19 treatments in short supply by maintaining objective, risk-based groups on a race-neutral basis even with an injunction. Thus, Plaintiffs are still entitled to preliminary relief even if the Court holds that they have not shown a likelihood of success on the merits.

IV. No Bond Should Be Required

Federal Rule of Civil Procedure 65(c) states that a preliminary injunction may issue "only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." The qualifying "amount that the court considers proper" language provides this Court with "wide discretion in the matter of security and it has been held proper for the court to require no bond where there has been no proof of likelihood of harm" to the enjoined party. *Doctor's Assoc's, Inc. v. Stuart*, 85 F.3d 975, 985 (2d Cir. 1996) (quoting *Ferguson v. Tabah*, 288 F.2d 665, 675 (2d Cir. 1961)). This is such a case. Should this Court preliminarily enjoin Defendants' use of race in prioritizing COVID-19 medical treatments, Defendants will still be able to prioritize based on objective, race-neutral factors that consider an individual's medical need. As a result, Defendants will suffer no likelihood of harm if the Court later determines a preliminary injunction to have been unwarranted.

CONCLUSION

For the foregoing reasons, Plaintiffs' Motion for Preliminary Injunction should be granted.

Respectfully submitted this 18th day of February 2022.

s/ Wencong Fa

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**Pro Hac Vice*

AFFIRMATION OF SERVICE

I, Wencong Fa, declare under penalty of perjury that I filed the foregoing with the Clerk of the Court of the Eastern District of New York though the CM/ECF system, which will serve notice of said filing on all counsel of record.

s/ Wencong Fa
Attorney for Plaintiffs

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

Jonathan Roberts and Charles Vavruska,

Plaintiffs,

-against-

Mary T. Bassett, in her official capacity as Commissioner for New York State Department of Health; New York City Department of Health and Mental Hygiene,

Defendants.

Case No. 1:22-cv-00710-NGG-RML

Declaration of Jonathan Roberts in Support of Plaintiffs' Motion for Preliminary Injunction

I, Jonathan Roberts, declare as follows:

1. The facts set forth in this declaration are based on my personal knowledge, and if called as a witness, I could and would competently testify thereto under oath. As to those matters which reflect a matter of opinion, they reflect my personal opinion and judgment upon the matter.

2. I was born in Manhattan and raised in the Flushing area of Queens in New York City. My mother immigrated to the United States from Hungary as a child, where her family faced anti-Semitism that prevailed in Europe at that time. For high school, I tested into Bronx High School of Science. After high school I attended Harvard where I earned a math degree. My time at Harvard was the only time of my life in which I lived outside of New York. I currently reside in Manhattan.

3. I am 61 years old and fully vaccinated against COVID-19. I reviewed the list of risk factors on a CDC website entitled "Persons with Certain Medical Conditions," and confirmed that I have none of the risk factors listed on the website. The link to the website appears on footnote 8 to the complaint in this case.

4. I identify as white and non-Hispanic. I have reviewed the New York guidelines attached as Exhibit B to the complaint in this case. I do not qualify for inclusion in any tier of the "risk groups" established by the New York State Department of Health or New York City's Department of Health and Mental Hygiene for prioritization of certain COVID-19 treatments. If I were any race but white or if I were Hispanic, I would qualify for the last tier (1E) of the risk groups.

5. I want the ability to access any medication that would be beneficial for me to take. I am especially interested in Paxlovid and have been fascinated by the science of the drug from videos I have watched. I would seek the drug as a possible treatment if I were to contract COVID-19.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on February 17, 2022.

Jonathan Roberts

JONATHAN ROBERTS

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

Jonathan Roberts and Charles Vavruska,

Plaintiffs,

-against-

Mary T. Bassett, in her official capacity as Commissioner for New York State Department of Health; New York City Department of Health and Mental Hygiene,

Defendants.

Case No. 1:22-cv-00710-NGG-RML

Declaration of Charles Vavruska in Support of Plaintiffs' Motion for Preliminary Injunction

I, Charles Vavruska, declare as follows:

1. The facts set forth in this declaration are based on my personal knowledge, and if called as a witness, I could and would competently testify thereto under oath. As to those matters which reflect a matter of opinion, they reflect my personal opinion and judgment upon the matter.

2. I am an electrical engineer and a lifelong resident of Queens, New York, where I currently reside.

3. I am white and not Hispanic, 55 years old, and fully vaccinated against COVID-19. In March 2020, I contracted COVID-19 and was hospitalized for 10 days.

4. I reviewed the list of risk factors on a CDC website entitled "Persons with Certain Medical Conditions," that I have one of the risk factors (overweight and obesity) listed on the website. The link to the website appears on footnote 8 to the complaint in this case. I have reviewed the New York guidelines attached as Exhibit B to the complaint in this case. According to the guidelines, I qualify for inclusion in the last tier (1E) of the risk groups established by the New York State Department of Health and New York City's Department of Health and Mental Hygiene

for prioritization of certain COVID-19 treatments. But an otherwise identical situated person who is either non-white or Hispanic would be prioritized for COVID-19 treatment over me.

5. I engage in activities that subject me to an increased risk of contracting Coronavirus. For example, I regularly meet with people for work and for social reasons. In addition, I frequently take public transportation such as the subway in New York City.

6. I want the ability to access any medication that would be beneficial for me to take. I want equal access to COVID-19 treatments such as Paxlovid, Molnupiravir, and monoclonal antibodies if I were to contract COVID-19.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on _____.

_____
CHARLES VAVRUSKA

or Hispanic would be prioritized for COVID-19 treatment over me.

5. I engage in activities that subject me to an increased risk of contracting Coronavirus. For example, I regularly meet with people for work and for social reasons. In addition, I frequently take public transportation such as the subway in New York City.

6. I want the ability to access any medication that would be beneficial for me to take. I want equal access to COVID-19 treatments such as Paxlovid, Molnupiravir, and monoclonal antibodies if I were to contract COVID-19.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on February 18, 2022

Charles Vavruska

CHARLES VAVRUSKA