22-622

United States Court of Appeals
for the Second Circuit

JONATHAN ROBERTS and CHARLES VAVRUSKA,

Plaintiffs-Appellants,

against

MARY T. BASSETT, in her official capacity as COMMISSIONER, NEW YORK STATE DEPARTMENT OF HEALTH, and DEPARTMENT OF HEALTH AND MENTAL HYGIENE OF THE CITY OF NEW YORK,

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of New York

BRIEF FOR APPELLEE CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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PRELIMINARY STATEMENT

When the federal government first authorized new treatments for COVID-19 in late 2021, they were hard to come by. New York City's Department of Health and Mental Hygiene therefore advised clinicians that, in times of shortage, the treatments should be allocated based on risk and noted the well-documented connection between certain racial and ethnic backgrounds and risk of adverse outcomes from COVID-19. Five weeks later, the shortage was resolved, and, since then, surplus of the treatments has existed.

After the shortage ended, plaintiffs Jonathan Roberts and Charles Vavruska, who are White and non-Hispanic, sued for injunctive and declaratory relief and nominal damages. They claimed that the City's advisory—and similar non-binding guidance from the State—violates the Equal Protection Clause. The U.S. District Court for the Eastern District of New York (Garaufis, J.) dismissed the complaint for lack of standing. This Court should affirm.

The district court correctly determined that plaintiffs have no standing because they failed to allege a cognizable injury-in-fact that is connected to the advisory. Plaintiffs did not contract COVID-19 during

the brief shortage, so they have suffered no past violation of rights that could support a claim for nominal damages. As for prospective relief, any future injury is entirely speculative. There may never be a future shortage, and plaintiffs may never contract COVID-19 during any hypothetical future shortage.

Even if they did, plaintiffs may not need the treatments in question. And even if all the above contingencies were to come to pass, plaintiffs' clinicians may not consider race at all in deciding whether to prescribe them the treatments and, moreover, may not do so in reliance on the City's non-binding advisory. The latter point is especially true where unchallenged guidance from the Centers for Disease Control (CDC)—and abundant other public information—likewise has documented that certain racial and ethnic groups are at greater risk of severe illness and death from COVID-19. In short, plaintiffs' claim of injury piles speculation upon speculation. It cannot support standing.

Standing aside, plaintiffs' claims for declaratory and injunctive relief are moot (as well as unripe). By its own terms, the challenged advisory applied only when the identified treatments were scarce—a state of affairs that no longer exists, and has not existed for some time.

Indeed, no shortage existed when plaintiffs brought suit, and none has occurred since, or is expected to occur.

For similar reasons, plaintiffs cannot show irreparable harm and are thus not entitled to a preliminary injunction, as they claim. Nor can they show a likelihood of success on the merits, as the City's informational advisory is narrowly tailored to serve the compelling interest of protecting the public health in response to COVID-19.

ISSUES PRESENTED FOR REVIEW

1. Should this Court affirm the district court's dismissal for lack of standing where (a) plaintiffs have no injury in fact caused by the City where they offer only speculation upon speculation to support their contention that the non-binding advisory might someday affect them; and (b) plaintiffs' abstract injuries could not be redressed through this lawsuit in any event, given that unchallenged CDC guidance similarly indicates that risk should be considered when prescribing and that race and risk are connected?

2. Should this Court dismiss the claims for declaratory and injunctive relief because they are moot and unripe?

3. Does plaintiffs' request for a preliminary injunction—not reached by the court below—fail on several additional grounds?

STATEMENT OF THE CASE

A. The State's guidance on prioritization for the distribution of COVID-19 treatments and the City's related Health Advisory #39

One of the most disturbing realities of the COVID-19 pandemic has been that, from its early days, racial and ethnic minority groups have had a higher risk of severe illness or death (Joint Appendix ("JA") 199–204).[1] Just one month into the pandemic, newspapers were regularly reporting that Black and Hispanic residents were dying at twice the rate of White residents.[2] As the pandemic dragged on, study after study showed the connection between race and COVID-19 risk (JA79, 190, 199–230). For example, by February 2022, a CDC data analysis showed that, over the course of the pandemic, American Indians and Alaska Natives were three

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[1] CTRS. FOR DISEASE CONTROL & PREVENTION, RISK OF SEVERE ILLNESS OR DEATH FROM COVID-19: RACIAL AND ETHNIC HEALTH DISPARITIES (last updated Dec. 10, 2020), preserved at https://perma.cc/2JB4-GS6K.

[2] *E.g.*, Jeffrey C. Mays & Andy Newman, *Virus Is Twice as Deadly for Black and Latino People Than Whites in N.Y.C.*, N.Y. TIMES, Apr. 8, 2020, preserved at https://perma.cc/G6YK-7UF6.; Editorial Board, *The Color of Coronavirus: Disturbing Data on Racial Disparities in Infections and Fatalities Begins Coming Into Focus*, N.Y. DAILY NEWS, Apr. 9, 2020, preserved at https://perma.cc/NGY9-2UKE.

times more likely to be hospitalized for COVID-19 and twice as likely to die than White people, while Black and Hispanic people were more than twice as likely to be hospitalized and about twice as likely to die than their White counterparts (JA79). These disparities persist even when accounting for other demographic and socioeconomic factors and comorbidities (JA56–57, 210–20).

As a result, the CDC has emphasized health equity, aiming to ensure that racial minorities are not unfairly denied access to vaccines or medical treatment.[3] Accordingly, along with its list of medical conditions that put people at a higher risk of severe illness from COVID-19—things like having cancer or being a smoker—the CDC explains that people from racial and ethnic minority groups are also at a higher risk, emphasizing that people from these groups tend to develop chronic medical conditions at earlier ages and die younger from COVID-19.[4]

Against this backdrop, in late 2021, the federal Food and Drug Administration (FDA) authorized several treatments for COVID-19 that

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[3] CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH EQUITY CONSIDERATIONS & RACIAL & ETHNIC MINORITY GROUPS (last updated Jan. 10, 2022), preserved at https://perma.cc/TB2L-2GPA.

[4] CTRS. FOR DISEASE CONTROL & PREVENTION, PEOPLE WITH CERTAIN MEDICAL CONDITIONS (last updated May 2, 2022), preserved at https://perma.cc/D3DD-VDNV.

were found to be effective in reducing the risk of hospitalizations and deaths in high-risk individuals (JA53–54). The approved treatments included two antiviral therapies (Paxlovid and Molnupiravir) and one monoclonal antibody product (Sotrovimab) (*id.*). In late December, the CDC issued guidance on what conditions make people eligible for these treatments, where it listed many of the same conditions from its guidance on risk factors (JA135). In explaining that the authorization was not limited to people with the conditions listed, the CDC stated that "[o]ther medical conditions or factors (for example, race or ethnicity) may also place individual patients at high risk for progression to severe COVID-19" and linked to its prior guidance (*id.*). Plaintiffs acknowledge but do not challenge the CDC guidance in their complaint (JA20).

In the immediate aftermath of the emergency use authorization, demand for the treatments far exceeded supply (JA54). The early data also showed that racial minorities were underutilizing these treatments (JA55). As a result, on December 27, 2021, the State Department of Health issued guidance to health care providers on how to prioritize distribution of the treatments (JA27–31). The State's guidance explained that the FDA authorized oral antiviral treatments for patients meeting

certain criteria (JA28). One criterion was that the individual had "a medical condition or other factors that increase [a patient's] risk for severe illness" (JA28). After noting this criterion, the State added a subpoint 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" (*id*).

The State also issued a chart with recommendations for how to prioritize distribution of the treatments "when logistical or supply constraints make it impossible to offer the therapy to all available patients" (JA36–38). The five priority groups are classified based on immunocompromised status, age, vaccination status (with higher priority to unvaccinated persons), and risk factors for severe illness (JA37). To be considered a member of any "risk group" for "prioritization," a person under 65 years old would need to have at least one risk factor for severe illness (*id.*). The State's guidance also pointed to the CDC for further information on risk (JA38).

The same day the State issued its guidance, the City circulated 2021 Health Advisory #39 (JA40–44). The City noted that the new

treatments would "initially be extremely limited," and it advised clinicians to adhere to the State's guidance on prioritization "during this time of severe resource limitations" (JA40–41). The City explained that the treatments should be given to those most at risk of severe illness and death, specifically noting that the unvaccinated, the elderly, and immunocompromised people were at higher risk (JA41–42). The advisory also noted that clinicians should "[c]onsider race and ethnicity when assessing an individual's risk" because "[i]mpacts of longstanding systemic health and social inequalities put Black, Indigenous, and People of Color at increased risk of severe COVID-19 outcomes and death" (JA42). The City's advisory does not contain any risk matrix or assign points based on race. The Health Department posted the advisory to its website and emailed it to approximately 75,000 people who had signed up to receive health alerts (JA55).

The Health Department's Chief Medical Officer, Dr. Michelle Morse, explained that the advisory was "not meant to replace a medical provider's sound clinical judgment of what course of treatment is best for patients" (*id.*). Driving the point home, Dr. Morse explained that the guidance "does not prevent any individual from receiving treatments

should they contract COVID-19" (JA57). And she also explained that, because the advisory was "not a mandate," the City "will not take any enforcement actions against hospitals or medical providers in relation to it" (*id.*). Nor were there even any "mechanisms in place" to track how clinicians used the advisory (*id.*).

The reference to race was instead intended to raise awareness of the evidence that people of color have been disproportionately affected by COVID-19, and to remind clinicians to consider *all* factors that have been shown to contribute to poor outcomes (JA56). Dr. Morse pointed to the medical research from the CDC and others showing that COVID-19 disproportionately affected marginalized racial and ethnic groups, including studies showing that, even after adjusting for various socioeconomic measures, significant racial disparities remained in disease severity and hospitalization (JA56–57). Indeed, during the Omicron surge, a higher proportion of Black New Yorkers were hospitalized (JA53).

The shortages that prompted the guidance resolved when manufacturers ramped up production. By February 1, 2022, the city had a surplus of the treatments (JA57). That day, the City distributed a new

health advisory explaining that these products were widely available (JA57–58). The State followed suit a few weeks later (JA250). Manufacturers continue to increase production of these treatments. Pfizer, for example, is on track to manufacture 120 million courses of Paxlovid by the end of 2022.[5]

B. Plaintiffs' equal protection action and the district court's decision dismissing the case for lack of standing

A week after the City made clear that the treatments were in ample supply, plaintiffs brought this claim against the City's Department of Health and Mental Hygiene and the State Health Commissioner, alleging that the guidance constituted racial discrimination in violation of the Equal Protection Clause (JA12–25).

Plaintiffs are White non-Hispanic New York City residents who are vaccinated against COVID-19 (JA14–15, 45–47). They allege that the State and City guidance requires healthcare providers to distribute treatments based on race and that such a policy disadvantages them and cannot survive strict scrutiny (JA13, 23). Plaintiffs "want the ability to

[5] Rebecca Robbins, *35 Companies Sign on to Produce Generic Versions of Pfizer's Covid Pill*, N.Y. TIMES, Mar. 17, 2022, preserved at https://perma.cc/Z3SS-ZB3V.

access" the treatments without regard to race if they contract COVID-19 (JA16). They never alleged that they were denied such treatments.

They seek: (1) a declaration that the guidance is unconstitutional; (2) a permanent injunction barring the State and the City from "using race in determining which patients receive priority for oral antiviral and monoclonal antibody treatments for COVID-19"; and (3) nominal damages (JA13). Plaintiffs also moved for a preliminary injunction (EDNY ECF No. 19). In opposition, the City argued that plaintiffs lacked standing and that, in any event, they were not entitled to a preliminary injunction because they were unlikely to succeed on the merits (EDNY ECF No. 20).

The district court held that plaintiffs lacked standing and dismissed the complaint (JA251–70). In explaining that plaintiffs lacked an injury in fact, the court noted that that the advisory was nonbinding and merely advised clinicians to consider race as one of many factors when assessing a patient (JA260). The court found that plaintiffs did not show that the advisory caused them to be treated differently than members of other groups and, rather than asserting "some concrete and particularized manner" of injury, they brought merely a "generalized

grievance" about "nonbinding guidance that directs medical practitioners to consider race and ethnicity as one factor in prescribing the [t]reatments" (JA261–62). They never alleged more than the existence of the advisory to show that they faced a barrier to treatment (JA262).

SUMMARY OF ARGUMENT

This Court should affirm the district court's order dismissing the complaint for lack of standing—a question of law that this Court reviews de novo. *Shain v. Ellison*, 356 F.3d 211, 214 (2d Cir. 2004). Even accepting as true the allegations in the complaint and other materials plaintiffs submitted, *Fair Hous. in Huntington Comm. v. Town of Huntington*, 316 F.3d 357, 363 (2d Cir. 2003); *see Cacchillo v. Insmed, Inc.*, 638 F.3d 401, 404 (2d Cir. 2011), plaintiffs do not come close on their showing of standing.

Primarily, plaintiffs have not alleged that they have sustained, or likely will sustain, an injury in fact that could be attributable to the City. Though they bring a nominal damages claim, they have suffered no past violation of their rights, since they never contracted COVID-19 during the shortage to begin with. As to future injury, their complaint contains

no allegations that, if true, suggest there will ever be a shortage again that might trigger the City's advisory.

But that is only the beginning of the chain of contingencies presented here. It is speculative whether plaintiffs will contract COVID-19 during any such time of future shortage. It is further speculative whether, even if they did, their clinicians would consider race in deciding whether to prescribe the treatments in question. It is yet again speculative whether the clinicians, if they took such steps, would even know about or have considered the City's advisory—let alone that they would have taken those steps because of the advisory, as opposed to countless other sources of information, including the CDC's unchallenged guidance connecting race and risk and abundant public studies doing the same. This chain of speculation upon speculation is far too attenuated to establish an actual or imminent injury-in-fact traceable to the City's advisory.

For overlapping reasons, plaintiffs' purported injury is not redressable through this lawsuit. An order striking down the advisory would not give plaintiffs what they claim to want—access to treatment

without regard to race. That's because the CDC's guidance will still be in place, as will the extensive medical evidence that supports it.

This Court may also dismiss the claims for declaratory and injunctive relief as moot and unripe. Plaintiffs have no reasonable expectation that the City's advisory—which applies only in times of shortage, a situation that does not currently exist and is not likely to—will ever again become relevant. Mootness is especially plain regarding plaintiffs' claim for a preliminary injunction, as there is no pressing need for immediate relief—the core requirement for a preliminary injunction.

If the Court were to disagree, it should decline plaintiffs' request to address the merits of their application for a preliminary injunction now. Instead, remand would be the appropriate step, given that the court below did not reach the motion for a preliminary injunction. In any event, any preliminary injunction is wholly unwarranted. Plaintiffs cannot show irreparable harm when they have no need to be considered for the treatments and may never have one. Nor are they likely to succeed on the merits. While we believe rational basis review applies here, the advisory would survive even strict scrutiny because it is narrowly

tailored to protect the public health. There could hardly be a more compelling interest.

ARGUMENT

POINT I

THE DISTRICT COURT PROPERLY CONCLUDED THAT PLAINTIFFS LACK STANDING

Plaintiffs have not alleged or provided specific facts that establish that they have standing to challenge the City's advisory. Standing is a threshold question in every case to determine whether the action presents a proper case or controversy for the court's resolution under Article III. *Jackson-Bey v. Hanslmaier*, 115 F.3d 1091, 1095 (2d Cir. 1997). To meet the "constitutional minima" for that showing, a plaintiff must show (1) an injury in fact that is concrete, particularized, and actual or imminent; (2) that was likely caused by the defendant; and (3) that is redressable through the litigation. *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2203 (2021); *Comer v. Cisneros*, 37 F.3d 775, 787 (2d Cir. 1994). "If the plaintiff does not claim to have suffered an injury that the defendant caused and the court can remedy, there is no case or controversy for the federal court to resolve." *TransUnion*, 141 S. Ct. at 2203 (cleaned up). Standing is assessed at the time the claim is brought.

Comer, 37 F.3d at 787. Plaintiffs have not pleaded facts satisfying these elements in their complaint or added facts to support them with their preliminary injunction motion.

A. Plaintiffs have not shown an injury in fact that is fairly traceable to the City.

An injury in fact is "an invasion of a legally protected interest" that is (1) "concrete and particularized," and (2) "actual or imminent, not conjectural or hypothetical." *Northeastern Fla. Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville*, 508 U.S. 656, 663 (1993). But, in certain equal protection cases where the plaintiff claims that "the government erects a barrier that makes it more difficult for members of one group to obtain a benefit than it is for members of another group," the injury is "the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit." *Id.* Accordingly, such a plaintiff must show the denial of equal treatment through the existence of a barrier that causes his group to be treated differently from members of another group—not that he would have obtained the benefit but for the barrier. *Comer*, 37 F.3d at 793; *see City of Jacksonville*, 508 U.S. at 663.

But it is still not enough for plaintiffs to "complain merely because other members of their racial group might be injured by government conduct" to have standing to recover for such an injury. *Vaughn v. Consumer Home Mortg. Co.*, 297 F. App'x 23, 26 (2d Cir. 2008). For equal protection claims, standing covers only injuries to those "personally denied equal treatment by the challenged discriminatory conduct." *In re U.S. Catholic Conference*, 885 F.2d 1020, 1025 (2d Cir. 1989) (cleaned up). The injury must be "particularized" to the plaintiff rather than "conjectural or hypothetical." *MGM Resorts Int'l Global Gaming Dev., LLC v. Malloy*, 861 F.3d 40, 45 (2d Cir. 2017). A claim of "abstract stigmatic injury" is not cognizable. *Allen v. Wright*, 468 U.S. 737, 755 (1984). Under this established law, plaintiffs cannot show an injury-in-fact traceable to the City's actions.

1. Any claim of concrete and particularized injury rests upon speculation piled upon speculation.

Plaintiffs assert a nominal damages claim predicated on a past injury and a claim for injunctive and declaratory relief predicated on future injury. But neither is sustainable. As to past injury, plaintiffs suffered no past violation of their rights because neither had COVID-19

during the time of the shortage—which ended before they filed their complaint (JA14–16, 22, 45–48). The question of whether they would receive the treatments in question thus never arose. Plaintiffs cannot merely rely on the label "nominal damages" to meet their burden: for standing purposes, "nominal damages provide the necessary redress for a *completed violation* of a legal right." *Uzuegbunam v. Preczewski*, 141 S. Ct. 792, 802 (2021) (emphasis added). Plaintiffs have not shown a violation personal to them.

Although a plaintiff can also establish an injury in fact to obtain injunctive or declaratory relief by pointing to a future injury, such an injury "will be sufficient only if the threatened injury is certainly impending, or there is a substantial risk that the harm will occur." *Dorce v. City of N.Y.*, 2 F.4th 82, 95 (2d Cir. 2021); *see Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158 (2014). Although this standard is "somewhat elastic," it "cannot be stretched beyond its purpose, which is to ensure that the alleged injury is not too speculative for Article III purposes." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013).

In terms of future injury, plaintiffs here can only assert a string of speculative contingencies that would all have to occur before they would

have any injury that could even plausibly be traced to the City's advisory. *See id.* at 410–414 ("speculative chain of possibilities does not establish that injury based on potential future" injury is "certainly impending or is fairly traceable" to defendant). At a minimum, among the contingencies is that (1) there would need to be a future shortage of the treatments; (2) plaintiffs would need to contract COVID-19 with symptoms that would make the treatments effective (mild to moderate symptoms) during such a shortage; (3) a clinician would need to consider race in assessing whether to prescribe them the treatments; (4) do so with awareness and upon consideration of the City's advisory; and (5) do so due to the City's advisory, rather than for some other reason.

Unlike in *City of Jacksonville*, where contractors were ready and able to bid on contracts and a binding city policy created a barrier to their equal access to such contracts, 508 U.S. at 668–69, here numerous factors beyond the City's control prevent plaintiffs from identifying any injury. On the front end, plaintiffs would need to contract COVID-19 during a time of shortage before the advisory would even be potentially relevant. Nothing similar was present in *City of Jacksonville*. Moreover, on the back end, if the advisory ever became relevant to plaintiffs, they would

face nothing akin to the centralized and binding government process that was at issue in *City of Jacksonville*, much less anything similar to the minority set-asides presented in that case. Prescription decisions are decentralized and controlled by innumerable health care providers—mostly private actors—and the City's advisory is not binding on those providers.

At bottom, there are simply too many contingencies that would have to come to pass before the plaintiffs could plausibly be injured in a manner traceable to the City's advisory. First, there is no basis to assume that there will ever be a future shortage of the treatments or that plaintiffs will contract COVID-19 during such a shortage. Plaintiffs did not do so during the shortage that occurred immediately after the FDA approved the drugs, and it is speculative to suggest that they might contract it in the future during a time of shortage. They point to the possibility that "supply chain disruptions can occur at any time" (Brief for Appellants ("App. Br.") 24), but that is the very definition of speculation. Besides, standing is assessed at the time the claim is brought, *Comer*, 37 F.3d at 787, and there was a surplus of the treatments at that time (JA57–58). Had plaintiffs contracted COVID-19

any time since the filing of their complaint and if they contract it in the future, the treatments would have been, and remain, easily obtainable.

Plaintiffs' affidavits highlight how speculative even this link in the chain is. Vavruska claims that he engages in "activities that subject [him] to an increased risk of contracting" COVID-19, which he enumerates as "regularly meet[ing] with people for work and for social reasons;" and "frequently tak[ing] public transportation" including the subway (JA48). But even with those activities—which many other New Yorkers regularly take part in as well—it is speculative that he will ever be sick with COVID-19 or have the right symptomology for these treatments. Roberts asserts only that he "would seek" Paxlovid "as a possible treatment if [he] were to contract COVID-19" (JA47). But that mere desire to use the drug does not mean that he will ever have the need for it and does not put his injury beyond conjecture.

Second, even if plaintiffs did contract COVID-19 during a shortage—a big if—a court could only speculate that their clinicians would consider race in assessing whether to prescribe the treatments in question. Indeed, plaintiffs' complaint does not allege that a single person has ever been denied treatment. By plaintiffs' reading, the City's advisory

requires clinicians to "prioritize" people of color when distributing COVID-19 treatments (App. Br. 20). But the advisory does no such thing. Unlike in *Gratz v. Bollinger*, 539 U.S. 244 (2003), where the defendant assigned points for college admission based on race, the City's advisory is non-binding, contains no matrix or point system, and says only that clinicians should "consider race and ethnicity" in assessing a patient's risk (JA42). It "does not prevent any individual from receiving treatments should they contract COVID-19" (JA57). As the district court found, this case is not like those where courts found barriers because there is no "predetermined" number or percentage of treatments reserved for New Yorkers of color or a "threshold" or "target" number of points to obtain treatment that takes into account race (JA260).[6]

Third, even if plaintiffs contracted COVID-19 during a shortage, and their clinicians considered race in assessing whether to prescribe them the treatments, more speculation would be required on the question of causation or traceability. *See Chevron Corp. v. Donziger*, 833 F.3d 74, 121 (2d Cir. 2016); *Nat'l Council of La Raza v. Mukasey*, 283 F. App'x 848,

[6] *Grutter v. Bollinger*, 539 U.S. 306 (2003), is similarly unhelpful (App. Br. 20 n.18). That plaintiff suffered a concrete injury when she was denied admission to the University of Michigan Law School.

851 (2d Cir. 2008). Their clinicians might decline to prescribe the treatments in question for any number of reasons unrelated to the City's advisory. And where a plaintiff's injury could just as easily be "attribut[ed] to the independent acts of some other person not before the court," the plaintiff has no standing. *Chevron*, 833 F.3d at 121.

Even when the City's advisory was in effect, clinicians were free to ignore it, assuming they were aware of it. To be sure, as plaintiffs note, an advisory opinion that produces a coercive effect on a third-party actor can give rise to traceability (App. Br. 26). *See Bennett v. Spear*, 520 U.S. 154, 169–70 (1997) (opinion was rarely ignored due to risk of "substantial civil and criminal penalties, including imprisonment"). But here, there were no "adverse consequences" for ignoring the advisory (JA57). *See La Raza*, 283 F. App'x at 852 (no standing to challenge federal policy enforced by states where states that ignored the policy did not suffer any adverse consequences). No law even requires medical providers to consult the City's health advisories, and the City similarly has no mechanism in place to check to see who complies with them.

Moreover, even if a clinician were to take race into account in prescribing, that judgment may not turn on the City's advisory. As

plaintiffs concede, CDC guidance—unchallenged in this lawsuit—indicates that certain racial and ethnic minority groups are at increased risk of severe illness and death from COVID-19 (JA20, 199).[7] Those elevated risks have been widely covered in medical literature and the media. It is purely speculative to suggest that a prescriber's decision will hinge on the City's advisory, rather than the CDC's guidance or the clinician's own independent knowledge of the extensive medical research linking race to outcomes. *See Simon v. E. Ky. Welfare Rights Organization*, 426 U.S. 26, 42–43 (1976).

To be sure, the "barrier" cases instruct that the mere fact that the advisory may not be outcome-determinative for plaintiffs in receiving the treatments is not alone dispositive. But here, in contrast to those cases, the relevant decision process is decentralized and committed largely to private actors, and the City's advisory is not binding upon those actors. If certain clinicians were to someday treat plaintiffs for COVID-19 during a time of shortage, they may not even be aware of the City's advisory. If they were, they may not consider it when treating plaintiffs. If they did

[7] Indeed, because plaintiffs mainly attribute their injury to the way they would be classified under the State guidance, they cannot trace their injury to the City's advisory independent of the State guidance.

consider the advisory, it may not figure into their decision. If it did figure into their decision, the similar guidance and information available from other sources may have had the same effect even in its absence. In the end, plaintiffs' claim is reliant on "speculation about the decisions of independent actors" and their "unfettered choices"—which the courts have rejected as insufficient to support standing. *Clapper*, 568 U.S. at 414 & n.5.

2. Plaintiffs cannot skirt standing requirements by recasting their injury as a marginally increased "risk."

Plaintiffs' only other contention about injury on appeal is a new one: relying on *Baur v. Veneman*, 352 F.3d 625 (2d Cir. 2003)—a case they merely cited in passing on reply below (*see* EDNY ECF No. 27 at 4)—they assert that they have standing as a result of "an increased risk of suffering the negative effects of COVID-19" (App. Br. 22–23). To the extent that this Court can consider this new argument, it is unavailing and their reliance on *Baur* is misplaced.

Baur was a challenge to an FDA policy that allowed human consumption of "downed livestock"—meaning livestock that were too ill to stand or walk—a practice that could transmit mad cow disease and

other progressive neurological diseases. 352 F.3d at 627. Over a sharp dissent, this Court held that the policy put the plaintiff at an increased risk of future injury and that he therefore had standing under statutes aimed at eliminating even small risks of disease carried in the food supply. *Id.* at 643. But this Court limited its holding to finding that, "in the specific context of food and drug safety suits[,]" alleged "exposure to potentially harmful products" is an injury in fact. *Baur*, 352 F.3d at 632–34. This Court declined to resolve whether "enhanced risk generally qualifies as sufficient injury to confer standing." *Id.* at 634.

This is not a case about food or drug safety. In *Baur* and the environmental regulation cases this Court found analogous there, "unreasonable exposure to risk"—which flowed from the government regulation itself—was sufficient to demonstrate a cognizable injury. *Id.* The same cannot be said here. Plaintiffs do not sue under federal statutes that are crafted to eliminate small and probabilistic risks—which was a core element of *Baur*'s reasoning. Moreover, the City's advisory does not put anyone in harm's way at all, or block anyone from being considered for the COVID-19 treatments by a medical professional.

This Court has continued to cabin *Baur*'s divided holding to food and drug safety and environmental cases. *See, e.g., Nicosia v. Amazon.com, Inc.*, 834 F.3d 220, 239 (2d Cir. 2016). And, in any event, this Court has also explained that standing under *Baur* requires "actual future exposure to [some] increased risk." *Id.* Plaintiffs' risk of contracting COVID-19 remains hypothetical, as does their claim that they would be denied the treatments. *Baur* does not change the imminence analysis for their purported injury.[8] Nor can plaintiffs find support in *Baur*'s statement that an "injury-in-fact may be found although the asserted harm is widely shared." 352 F.3d at 635 (App. Br. 23). The problem for plaintiffs is not the number of people who could claim an injury under their theory of standing; it is that their injury is not "sufficiently concrete and particularized" and does not involve a "discrete, individual risk of personal harm," as the *Baur* Court explained

[8] Plaintiffs also cite *Carter v. HealthPort Technologies., LLC*, 822 F.3d 47 (2d Cir. 2016) for the proposition that "a liability, including a contingent liability, may be a cognizable legal injury." *Id.* at 55. But this Court clearly was referring to a financial liability, and none is imposed on plaintiffs by the advisory here. Nor did *Carter* suggest that a chain of contingencies on the order of those presented here would suffice even in the context of a financial liability.

in the part of the paragraph that plaintiffs cite but fail to quote. *Baur*, 352 F.3d at 635 & n.9.

B. Plaintiffs' claimed injuries also are not redressable by a favorable court decision for prospective relief.

The final element of standing—redressability—also stands in plaintiffs' way when it comes to their claims for injunctive and declaratory relief. Plaintiffs do not even allege, and certainly cannot show, that the clinicians who might someday treat them would act differently in the absence of the City's advisory. Their complaint itself notes that the CDC also connects race and risk assessment (JA20). Thus, plaintiffs' clinicians would likely make the same prescribing decisions no matter what happens with this lawsuit, if the occasion to prescribe the treatments in question ever should present itself in a circumstance where the advisory might be relevant.

Redressability "focuses on whether a plaintiff personally would benefit in a tangible way from the court's intervention." *Chevron*, 833 F.3d at 121 (cleaned up). He must show that "a favorable decision will relieve a discrete injury to himself." *Id.* In other words, "[i]t must be likely, as opposed to merely speculative, that the injury will be redressed

by a favorable decision." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992) (cleaned up). The district court rightly found that an order striking down the State guidance and City advisory would not redress the claimed injury—not having race-neutral access to COVID-19 treatments—for two reasons.

First, because the CDC is not a party, the CDC's guidance that connects racial or ethnic background with level of risk for serious illness from COVID-19 would remain in place even if plaintiffs were to win this case. Second, and relatedly, a ban on the City's advisory would not prevent the clinicians who might someday treat plaintiffs from considering race in deciding whether to prescribe these treatments to their patients. Those clinicians might rely on the CDC guidance or on scientific research about the relationship between severe COVID-19 and race, which clinicians could find persuasive even without government guidance pointing to it. Plaintiffs thus cannot show that their clinicians would behave differently absent the guidance if they were to someday confront the hypothetical question at the core of this lawsuit. *See Simon,* 426 U.S. at 42 (no redressability where it was speculative to find that vacatur of IRS policy "would result in [the plaintiffs] receiving the

hospital services they desire"); *Town of Babylon v. Federal Housing Financial Agency*, 699 F.3d 221, 229–30 (2d Cir. 2012) (no redressability where vacatur of federal policy would not require banks to alter lending practices plaintiffs objected to). In the end, if there is a barrier to plaintiffs receiving equal access to treatments, that barrier was facilitated by medical research, and created by CDC and state guidance rather than the City's health advisory.

Plaintiffs' argument on these points is lacking (App. Br. 27–29). They speculate that clinicians in the city are more likely to follow the City's advisory than CDC guidance, again mischaracterizing the advisory by calling it a "crude counting of the number of risk factors"—something they claim the CDC guidance does not do (*id.* at 28). But the City's advisory says only that clinicians should "[c]onsider race and ethnicity when assessing an individual's risk" (JA42)—which cannot be read as anything other than urging a holistic evaluation of a patient. Plaintiffs have thus failed to show that it is likely, as opposed to merely speculative, that the particular clinicians who might someday treat them during a hypothetical future shortage would distribute the treatments differently if the City's advisory were vacated.

POINT II

THE CLAIMS FOR DECLARATORY AND INJUNCTIVE RELIEF SHOULD BE DISMISSED AS MOOT OR UNRIPE

Plaintiffs' claims for declaratory and injunctive relief against the City should also be dismissed on the additional ground that they have been moot since the day plaintiffs sued.[9] That is because the City's advisory is no longer in effect, as there is a surplus of the treatments.

A claim is moot "when the issues presented are no longer live or the parties lack a legally cognizable interest in the outcome." *White River Amusement Pub, Inc. v. Town of Hartford*, 481 F.3d 163, 167 (2d Cir. 2007) (cleaned up). The City issued the advisory in December 2021, during a time of "severe resource limitations" on the treatments (JA40–41). A week before plaintiffs sued, the City issued a new advisory explaining that the treatments were widely available (JA57–58). Accordingly, even before filing suit, plaintiffs had no cognizable interest

[9] Plaintiffs assert that their request for nominal damages precludes mootness (App. Br. 31). However, a request for nominal damages does not salvage an entitlement to declaratory and injunctive relief. *Nat'l Rifle Ass'n of Am. v. Hochul*, No. 20-3187-cv, 2021 U.S. App. LEXIS 33909, at *2–*3 (2d Cir. Nov. 16, 2021) (summary order).

in declaratory and injunctive relief regarding an advisory that was no longer in effect.

Plaintiffs similarly have "no reasonable expectation that the wrong will be repeated," making it "impossible for the court to grant any effectual relief whatever to the prevailing party." *White River Amusement Pub*, 481 F.3d at 167 (cleaned up). The relevant conditions have changed substantially in that production of these treatments has ramped up significantly. Thus, the advisory is unlikely ever to be in effect again.

Plaintiffs argue that the controversy is not moot because the new advisory itself "says nothing about superseding" the earlier one (App. Br. 30). That is unavailing because, even without such direct language, it is obvious to any reader that the first advisory was in effect when there were "severe resource limitations" on the treatments (JA40–41) and the second one explained that there was no longer a supply issue (JA57–58). The mere possibility of a future supply shortage that plaintiffs suggest (App. Br. 30) is not enough to defeat mootness, especially where production of the treatments have increased.

Nor can plaintiffs prevail under the exception to mootness for controversies that are "capable of repetition, yet evading review" (*id.*).

That doctrine applies "only in exceptional situations," *Dennin v. Conn. Interscholastic Athletic Conference*, 94 F.3d 96, 101 (2d Cir. 1996), and plaintiffs cannot show that they meet either of the required elements. First, they have no "reasonable expectation" that there will be a future shortage. *Exxon Mobil Corp. v. Healey*, 28 F.4th 383, 395–96 (2022). There have been increases in COVID-19 cases in the city since the December 2021 surge that have not created shortages. Moreover, more pharmacies are carrying the treatment and federal programs have facilitated an increased supply. Second, should a shortage someday occur, plaintiffs have no basis to believe it would "be of too short a duration" to prevent the case from being fully litigated. *Id.* That contention, too, is entirely speculative. The unpredictable nature of a shortage makes it impossible to predict when one might occur or how long it could last.

Finally, and relatedly, the dispute as to prospective relief is not ripe. Under this doctrine, a court "cannot entertain a claim which is based upon contingent future events that may not occur as anticipated, or indeed may not occur at all." *Thomas v. City of N.Y.*, 143 F.3d 31, 34 (2d Cir. 1998) (cleaned up). As plaintiffs all but concede in their bid to avoid

mootness, their claim to injunctive and declaratory relief is premised on pure speculation, which bars the courts from considering it.

POINT III

EVEN ASSUMING PLAINTIFFS HAVE STANDING, THEY ARE NOT ENTITLED TO A PRELIMINARY INJUNCTION

Plaintiffs' brief seeks not only vacatur of the dismissal on standing grounds, but also a ruling on the merits of their preliminary injunction request. As an initial point, the preliminary injunction request is quite clearly moot, independent of whether their broader request for permanent injunctive and declaratory relief presents a live controversy (which it does not).

This Court assesses the grant or denial of a preliminary injunction only to "prevent the injustice of burdening a party with a manifestly erroneous decree while the ultimate merits of a dispute are being litigated." *Independence Party v. Graham*, 413 F.3d 252, 256 (2d Cir. 2005). But "[w]here the event giving rise to the necessity of preliminary injunctive relief has passed, the harm-preventing function cannot be effectuated" by assessing the denial of a preliminary injunction. *Id.* at 256 (cleaned up). Nor will this Court review a mooted preliminary

injunction request under the "capable of repetition yet evading review" exception to mootness, because taking that approach would "unnecessarily and inappropriately preempt the district court's resolution of the controversy before it." *Id.* at 257.

If the Court were to disagree on the matter of justiciability, it should still decline to reach the merits of the request for a preliminary injunction, which the district court did not reach, and should instead remand the matter for further proceedings. In any event, for reasons we will explain, plaintiffs have no entitlement to a preliminary injunction.

A preliminary injunction is "an extraordinary and drastic remedy … that should not be granted unless the movant, by a *clear showing*, carries the burden of persuasion." *Sussman v. Crawford*, 488 F.3d 136, 139 (2d Cir. 2007). To obtain a preliminary injunction, plaintiffs must meet a four-prong test, establishing that: they are "likely to succeed on the merits," they are "likely to suffer irreparable harm in the absence of preliminary relief," "the balance of equities tips in [their] favor," and "an injunction is in the public interest." *Hartford Courant Co., LLC v. Carroll*, 986 F.3d 211, 223 (2d Cir. 2021). Plaintiffs have not done so—to the extent their request is even live.

A. Plaintiffs will not suffer irreparable harm without an injunction.

Because irreparable harm is "the single most important prerequisite for the issuance of a preliminary injunction." *Rodriguez v. DeBuono*, 175 F.3d 227, 233–34 (2d Cir. 1998), plaintiffs' failure to meet it means that their request must fail. To satisfy this requirement, plaintiffs must establish that, absent a preliminary injunction, "they will suffer 'an injury that is neither remote nor speculative, but actual and imminent,' and one that cannot be remedied 'if a court waits until the end of trial to resolve the harm.'" *Freedom Holdings, Inc. v. Spitzer*, 408 F.3d 112, 114 (2d Cir. 2005) (quoting *Rodriguez*, 175 F.3d at 234).

Plaintiffs are suffering no irreparable harm for reasons similar to those that make their preliminary injunction request moot. Because plaintiffs are not suffering at all while they do not have COVID-19 and do not need the treatments, they do not need a preliminary injunction. Nor can they make any showing that they would be denied access to the treatments where there is a surplus and the City's advisory is not even in effect. Should the Court reinstate the complaint, plaintiffs can renew their motion for an injunction if they happen to get sick at a time when the advisory is in effect.

Plaintiffs primarily rely on the principle that irreparable harm is presumed where plaintiffs allege a violation of their constitutional rights (App. Br. 33) (citing *Conn. Dep't of Envtl. Prot. v. Occupational Safety & Health Admin.*, 356 F.3d 226, 231 (2d Cir. 2004)). But it is not enough to simply claim an impairment of a constitutional right. *We the Patriots USA, Inc. v. Hochul*, 17 F.4th 266, 294 (2d Cir. 2021). The equitable remedy of a preliminary injunction is still only available where there is a "real or immediate threat" that *the plaintiff* will be injured. *City of Los Angeles v. Lyons*, 461 U.S. 95, 111 (1983). And, as already explained, plaintiffs cannot show any threat to them now.

Plaintiffs also claim a risk of illness in "times of scarcity" (App. Br. 38). But there has not been a scarcity at any time since plaintiffs sued. To the contrary, there has been a surplus of the treatments. Thus, even on plaintiffs' own terms, a contingent event would need to happen before they would suffer any irreparable harm. That contingency has not manifested. On these facts, plaintiffs have not shown even the possibility—let alone the likelihood—that their constitutional rights will be impaired absent a preliminary injunction.

B. Neither the balance of the equities nor the public interest supports the requested injunction.

When the defendant is the government, the court "must balance the equities by exploring the relative harms to applicant and respondent, as well as the interests of the public at large." *Hartford Courant*, 986 F.3d at 224 (cleaned up). Unable to show that they will suffer any harm—let alone an irreparable one—without a preliminary injunction, plaintiffs also cannot show that the balance of equities tips in their favor. Indeed, without harm, plaintiffs can place nothing on the scale. All they offer is that a preliminary injunction will "assure[]" them "equal access" to the treatments (App. Br. 38). But they already have equal access with a surplus of treatments and, even with the advisory in effect, their access would still be controlled by their prescribing clinician. And they are again wrong that an injunction will allow the allocation of treatments "on the basis of any factor except race" (*id.*) when clinicians—not the City—are the ones who directly allocate the treatments, and plaintiffs admit that the CDC guidance that will be left undisturbed similarly indicates that people of color are at greater risk for serious illness from COVID-19.

On the other side of the scale, plaintiffs seek to enjoin the City's efforts to remind medical providers of empirical data showing that

COVID-19 disproportionately affects people of color, even adjusting for various socioeconomic measures (JA55–57). The plaintiffs seek to block that information merely because it involves race, which could lead medical providers to be less informed. Blocking the distribution of medical information during a pandemic is not in the public interest.

C. Plaintiffs have also failed to demonstrate that they have a likelihood of prevailing on the merits.

Further analysis is not required. But plaintiffs also fail to demonstrate a likelihood of success on the merits of their underlying equal protection claim. Such claim requires a showing that the defendant "intentionally discriminated against them on the basis of race." *Hayden v. Cnty. of Nassau*, 180 F.3d 42, 48 (2d Cir. 1999). And plaintiffs cannot make such a showing.[10]

To start, while policies that expressly classify individuals on the basis of race are subject to strict scrutiny, the City's advisory does not make any such classification and is thus subject to rational basis review. *Hayden*, 180 F.3d at 48. The City's advisory suggests that, when supplies

[10] We limit our discussion of the merits to the City health advisory and defer to the State Health Commissioner's brief on the constitutionality of the State guidance.

are short, clinicians allocate treatment by risk. While certain races are subject to increased risk, the advisory also points clinicians to many other generally understood risk factors (JA42)—as plaintiffs acknowledge (App. Br. 32). There is no "instruction" to "allocate treatments to non-white individuals over identically situated white individuals," as plaintiffs falsely claim.

And the advisory certainly doesn't involve an "explicit" racial classification, like *Mitchell v. Washington*, 818 F.3d 436 (9th Cir. 2016), which plaintiffs rely on (App. Br. 32), where a doctor employed by the government refused to provide certain medication to the plaintiff because "it did not work on African Americans." Rational basis review therefore applies, and plaintiffs do not claim that the advisory fails rational basis review. *Heller v. Doe*, 509 U.S. 312, 319 (1993) (policy under rational basis review is "accorded a strong presumption of validity"); *Fed. Commc'ns Comm'n v. Beach Commc'ns*, 508 U.S. 307, 313, 315 (1993) (plaintiffs "have the burden to negate every conceivable basis which might support" policy); *Kane v. de Blasio*, 19 F.4th 152, 166 (2d Cir. 2021) (policy must be rationally related to legitimate goal).

Even if strict scrutiny applies, plaintiffs still have not shown that they are likely to succeed on the merits. While strict scrutiny is exacting, "[n]ot every decision influenced by race is equally objectionable" and it is not meant "to invariably lead to the invalidation of governmental action but instead to provide a framework for carefully examining the importance and the sincerity of the reasons advanced by the governmental decisionmaker for the use of race in that particular context." *Grutter*, 539 U.S. at 327. The City's advisory survives strict scrutiny because it is narrowly tailored to further a compelling government interest. *Jana-Rock Constr., Inc. v. N.Y. State Dep't of Econ. Dev.*, 438 F.3d 195, 200 (2d Cir. 2006).

Plaintiffs do not seriously dispute what the medical evidence shows: Certain minority groups are at dramatically higher risk of hospitalization or death when they contract COVID-19. The City has a compelling interest in tackling this alarming trend. *See We the Patriots USA*, 17 F.4th at 295*; Kane*, 19 F.4th at 166; *see also Roman Catholic Diocese v. Cuomo*, 141 S. Ct. 63, 67 (2020) (per curiam) ("Stemming the spread of COVID-19 is unquestionably a compelling interest."). To the extent that the socio-economic effects of past discrimination contributed

to the racial disparities in COVID-19 outcomes or racial biases could affect the evaluation of patients and prescription of the treatments, the City is allowed to combat those problems. *See Richmond v. J. A. Croson Co.*, 488 U.S. 469, 509 (1989) (government may "tak[e] action to rectify the effects of identified discrimination within its jurisdiction").

Plaintiffs mistakenly claim that the Supreme Court has limited the universe of compelling interests to "remedying the past effects of de jure discrimination" and "diversity in higher education" (App. Br. 33). But the case they cite expressly addressed only "the school context"—and thus does not apply here. *Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 720 (2007). The Supreme Court has also said—albeit in dicta—that targeting African Americans for outreach about sickle cell anemia would "no doubt" satisfy strict scrutiny. *Bush v. Vera*, 517 U.S. 952, 984 (1996); *see also Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 310 (1978) ("It may be assumed that in some situations a State's interest in facilitating the health care of its citizens is sufficiently compelling to support the use of a suspect classification."); *Mitchell*, 818 F.3d at 446 ("It is not difficult to imagine the existence of a compelling justification [to use race] in the context of medical treatment."). Plaintiffs otherwise do

not elaborate on why the City's desire to address known racial disparities in health outcomes is not compelling.

Among the factors for determining whether a policy is narrowly tailored are: "the necessity for relief and the efficacy of alternative remedies"; its "flexibility and duration"; "the relationship of the numerical goals" to the relevant population; and "the impact … on the rights of third parties." *Jana-Rock*, 438 F.3d at 205–06. Applying these standards, the City's advisory could hardly be more narrowly tailored.

The predicate facts are stark: American Indians, African Americans, and Hispanics who contract COVID-19 are hospitalized and die at much greater rates than Whites (JA79). In response, the City was more than justified in issuing the advisory noting the higher risks faced by those groups—an advisory that was both non-binding and of very limited duration. By design, the advisory was in effect only during a shortage that lasted only about two months. Plaintiffs are silent about this limitation.

The advisory is also flexible because it embraces "individualized consideration." *See Grutter*, 539 U.S. at 335. It contemplates individualized assessment of patients who have tested positive for

COVID-19 and seek the treatments. In conducting that assessment, clinicians are advised to take into account various factors outside of race, such as age, vaccination status, immunocompromised status, and other medical conditions to determine whether the individual will benefit from the treatments. The advisory merely reminds prescribers that they may consider race as one of many factors. Indeed, plaintiffs do not even allege that a single person was denied the treatments, even during the shortage. To the contrary, one of the news articles they cite expressing alarm over the City's consideration of race states that two White patients received prescriptions, even when there was a shortage (App. Br. 12).

The advisory is also flexible in another way: it is merely guidance. Clinicians are not bound to follow it in circumstances where it does not align with their sound medical judgment. Because the advisory is not a mandate, the City will not take any enforcement action against clinicians in relation to it and has not even created enforcement mechanisms. A clinician may even find that someone is a good candidate for treatment because of factors not mentioned in the advisory, and that would be no bar to providing treatment to that patient. The advisory did not bar anyone from receiving the treatment.

Plaintiffs are wrong in painting the advisory as instead "rigid" and "mechanical" (App. Br. 35). By its plain terms, the guidance says only that clinicians should "consider race and ethnicity" in assessing risk (JA42). The City's guidance does not involve points, set-asides, or formulas, and thus the cases plaintiffs cite involving such systems are irrelevant (App. Br. 35–36 (citing *Gratz,* 539 U.S. 244 (point system); *Croson*, 488 U.S. at 506 (set-asides)). But we note that, in the education admissions context, the Supreme Court has held that a school can "consider race or ethnicity more flexibly as a 'plus' factor in the context of individualized consideration of each and every applicant." *Grutter*, 539 U.S. at 334. The advisory certainly does no more—and in fact does considerably less—than that.

Plaintiffs claim that the City did not engage in "the serious, good faith consideration of workable race-neutral alternatives" that narrow tailoring requires. *Grutter*, 539 U.S. at 339 (App. Br. 37). But plaintiffs have not identified any such alternative. Their only concrete suggestion is to distribute the treatments to those "who are more likely to contract COVID-19" (*id.*), which of course makes no sense. These are not prophylactic measures; they are treatments prescribed *after* someone has

become infected and displays symptomology appropriate for them. In times of scarcity, the treatments cannot be given to people who are not sick.

Plaintiffs' other suggestion is to stay silent about racial disparities in COVID-19 outcomes (*id.*). The Equal Protection Clause simply does not require that, and ignoring medical evidence under the guise of equal protection would be a disservice to public health. Moreover, silence on this front from the City would not necessarily lead to different outcomes, especially when the CDC's guidance already acknowledges the racial disparities. By advising clinicians to consider all medically relevant risk factors and by reminding them that racial and ethnic background is such a risk factor, the advisory is the narrowest way to advocate that the treatments should be made available to those most at risk of serious illness when they are in limited supply.

CONCLUSION

This Court should affirm the district court's order and judgment.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief was prepared using Microsoft Word, and according to that software, it contains 9,302 words, not including the table of contents, table of authorities, this certificate, and the cover.

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