No. 22-757

IN THE

Supreme Court of the United States

JONATHAN ROBERTS AND CHARLES VAVRUSKA,

Petitioners,

against

JAMES V. MCDONALD, in his official capacity as Commissioner for New York State Department of Health, et al.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENT DEPARTMENT OF HEALTH AND MENTAL HYGIENE OF THE CITY OF NEW YORK

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COUNTERSTATEMENT OF QUESTION PRESENTED

In late 2021, the federal government first authorized new COVID-19 treatments, including Paxlovid, for high-risk patients. For the next five weeks, those medications were in short supply. Soon after the authorization, the New York City Department of Health and Mental Hygiene issued nonbinding guidance advising clinicians that, in times of shortage, the treatments should be allocated based on risk and noting the well-documented connection between certain racial and ethnic backgrounds and risk of adverse outcomes from COVID-19. Its advisory followed similar nonbinding guidance issued by the New York State Department of Health. The shortage abated in early 2022, and a surplus of treatments has existed ever since. A week after the shortage ended, petitioners, two white, non-Hispanic men who never alleged that they contracted COVID-19 during the shortage, brought this case challenging the guidance under the Equal Protection Clause. The question presented is:

Did the court of appeals correctly determine that petitioners lacked standing where their claim of imminent future injury was premised on a highly attenuated chain of speculative contingencies?

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INTRODUCTION

This brief in opposition is filed on behalf of respondent Department of Health and Mental Hygiene of the City of New York. The remaining respondent is separately represented by the Office of the New York State Attorney General.

One week after the City published notice announcing that a shortage in recently authorized COVID-19 treatments had abated, the two petitioners sued under the Equal Protection Clause to challenge nonbinding guidance issued by the City and State about the distribution of those treatments during the period when they were in short supply. Petitioners never alleged that they contracted COVID-19 during the five weeks the guidance had been in effect, and the shortage necessitating the guidance was already over by the time they sued. The district court dismissed the complaint because petitioners lacked standing, and the court of appeals affirmed.

Certiorari should be denied. *First*, petitioners waited to sue until *after* the shortage arising from the treatments' initial roll-out had already abated. That fact alone defeats their claim of imminent future injury and drains the case of continuing impact. And even if petitioners were correct that they sued just before the shortage ended (and they are not), the

treatments have indisputably been widely available for over a year now, such that the same points would hold as a matter of mootness.

Second, petitioners' claims about a circuit split hold no water. The cases they cite show only that courts of appeals have sometimes found that claims of future injury qualify as "imminent" on sharply different facts from those presented in this case. The cited cases do not suggest that any other circuit would find imminent injury on the decidedly weak showing made here, and they do not stand for any identifiable principle of law that bears on this case.

Third, petitioners are likewise mistaken in arguing that the decision below conflicts with this Court's decision in *Northeast Florida Chapter of Associated General Contractors of America v. City of Jacksonville*, 508 U.S. 656 (1993). The circumstances that render petitioners' claims of future injury speculative here have no analogue in the facts of *City of Jacksonville*. Petitioners' failings are deeply fact-bound and unsuitable for a grant of certiorari.

STATEMENT

A. The well-documented reality that persons from racial and ethnic minority groups have faced heightened risks of severe illness and death from COVID-19

A consistent and well-established truth throughout the COVID-19 pandemic has been that certain racial and ethnic minorities have had a higher risk of severe illness or death from exposure to the virus (Pet. App. 84a–86a, 93a–96a).[1] In particular, Hispanic, Black, and other non-white populations have experienced much higher rates of severe disease, hospitalizations, and death, even after adjusting for socioeconomic measures (*id.*).[2]

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[1] *See also* Leo Lopez III, Louis H. Hart II & Mitchell H. Katz, *Racial and Ethnic Disparities Related to COVID-19*, 325 (8) JAMA 719–20 (2021), *available at* https://perma.cc/LP2Z-LEF8.

[2] *See also* Nicolas E. Ingraham, et al., *Racial and Ethnic Disparities in Hospital Admissions from COVID-19: Determining the Impact of Neighborhood Deprivation and Primary Language*, 36(11) J. Gen. Internal Med. (Nov. 2021), *available at* https://perma.cc/DY2R-J53K; Shruti Magesh, et al., *Disparities in COVID-19 Outcomes by Race, Ethnicity, and Socioeconomic Status: A Systemic Review and Meta-analysis,* 4(11) JAMA Network Open (Nov. 11, 2021), *available at* https://perma.cc/PE8N-H4V6.

As a result, throughout the pandemic, the Centers for Disease Control (CDC) has emphasized the importance of ensuring that racial minorities receive access to testing, care, treatment, and, later, vaccines commensurate with the risks they face.[3] Since March 2021, in its guidance on people with conditions that put them at a higher risk of severe illness from COVID-19—such as having cancer or being a smoker—the CDC also has included people from racial and ethnic minority groups.[4] Even earlier, in 2020, the Department of Health and Human Services was similarly concerned with the disparity in outcomes that minority groups faced regarding

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[3] Ctrs. for Disease Control & Prevention, *Health Equity Considerations & Racial & Ethnic Minority Groups* (last updated Jan. 10, 2022), *available at* https://perma.cc/TB2L-2GPA.; *see* Ctrs. for Disease Control & Prevention, *Health Equity Considerations & Racial & Ethnic Minority Groups* (July 24, 2020), *available at* https://perma.cc/2QV5-5UBQ.

[4] Ctrs. for Disease Control & Prevention, *People with Certain Medical Conditions* (last updated May 2, 2022), *available at* https://perma.cc/D3DD-VDN; Ctrs. for Disease Control & Prevention, *People with Certain Medical Conditions* (Mar. 29, 2021), https://web.archive.org/web/20210329235417/https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

COVID-19.[5] And, once COVID-19 treatments became available, studies from the CDC and others showed inequalities in distribution to racial minorities, including that clinicians had been less likely to prescribe treatments like monoclonal antibodies to such groups (Pet. App. 83a, 93a–94a).

Petitioners seem to accept that medical treatment are appropriately distributed based on risk factors, and they have not disputed the data about COVID-19 risks that are documented in these sources.

B. The nonbinding State and City guidance about distributing newly approved treatments during the shortage arising from their initial roll-out

In late 2021, the Food and Drug Administration authorized several new COVID-19 treatments, including the antivirals Paxlovid and molnupiravir and the monoclonal antibody product Sotrovimab (Pet. App. 82a).

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[5] U.S. Dep't of Health & Human Servs., *HHS Initiatives to Address the Disparate Impact of COVID-19 on African Americans and Other Racial and Ethnic Minorities* (July 2, 2020), *available at* https://perma.cc/C22M-RNVD.

The CDC then issued guidance about eligibility for such treatment, focusing on patients deemed to be at "high risk" for progressing to severe COVID-19 and needing hospitalization (JA134).[6] The CDC set out a long and non-exclusive list of factors that put people at high risk, including age, obesity, and cardiovascular disease (JA135). The CDC also noted that race or ethnicity may place people at high risk for severe COVID-19, linking to its prior guidance (JA135).

In the new treatments' initial rollout, demand for the treatments was expected to exceed supply (Pet. App. 82a–83a, 91a, 99a). As a result, on December 27, 2021, the New York State Department of Health issued nonbinding guidance to health care providers about how to prioritize distribution of the treatments, advising doctors to prioritize treatment for patients at highest risk for severe COVID-19 during the initial shortage (Pet. App. 51a). Like the CDC, the State explained that the treatments were authorized for those who had a medical condition or other issue that increased their risk, and it also noted that "[n]on-white race or Hispanic/Latino

[6] "JA" refers to the joint appendix filed in the court of appeals.

ethnicity" should be considered a risk factor for severe illness and death (Pet. App. 48a–61a).

On the same day, the City Health Department circulated a nonbinding health advisory, which it posted to its website and emailed to approximately 75,000 people who chose to receive health alerts via email (Pet. App. 61a–70a, 84a). The City noted that the new treatments would "initially be extremely limited" and advised clinicians to adhere to the State's guidance on prioritization "during this time of severe resource limitations" (Pet. App. 62a). Like the CDC and the State, the City advised doctors to prioritize treatment for patients at highest risk for severe COVID-19 until the supply problems abated (Pet. App. 64a). Among other things, it noted that clinicians should "[c]onsider race and ethnicity when assessing an individual's risk" (Pet. App. 65a). This guidance was purely informational; the City had no way to track how clinicians used the advisory, let alone a way to take enforcement actions in relation to it (Pet. App. 87a; *see also* 2d Cir. Case No. 22-622, ECF. No. 101).

The shortage of the treatments was soon resolved as manufacturers ramped up production and COVID-19 cases started to decline. By February 1, 2022, the City distributed a new health advisory stating that the products were widely available (Pet.

App. 87a). No shortage has recurred in the almost 15 months since.

C. Petitioners' lawsuit, filed a week after the City announced that the shortage had subsided

A week after the City published notice that the treatments in question were in ample supply, petitioners brought this suit alleging that the State and City's nonbinding guidance violated the Equal Protection Clause (Pet. App. 35a–48a). Petitioners did not challenge the CDC's similar guidance. They sought declaratory and injunctive relief against all named defendants, as well as nominal damages from the City alone (Pet. App. 47a–48a).

Petitioners did not allege that they had contracted COVID-19 during the roughly five-week shortage in the treatments' availability. It is thus undisputed that they never had any need for the treatments during the shortage. Petitioners also did not allege that they had consulted their doctors to ask whether they had even followed the nonbinding guidance in relevant respects during the shortage.

The district court dismissed the complaint for lack of standing (Pet. App. 10a–34a). The court held that petitioners did not show that the advisory caused them to be treated differently than members

of other groups (Pet. App. 22a–24a). Rather than asserting "some concrete and particularized manner" of injury, petitioners 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" (*id.*).

The court of appeals unanimously affirmed in a non-precedential summary order (Pet. App. 1a–9a).[7] The court explained that, while *City of Jacksonville*, 508 U.S. 656 (1993), and its progeny help define the contours of an injury in fact in the equal protection context, those cases do not eliminate the requirement that the plaintiff show an actual or imminent injury (Pet. App. 5a). The court determined that petitioners did not allege any actual injury, where no provider had denied or delayed any treatment to them during the period of shortage. The court further concluded that petitioners had not shown any imminent future injury because their contention relied on a "highly attenuated chain of possibilities"—from whether they would test positive for COVID-19 during a time of shortage in treatment availability to whether they would seek treatment from a provider who adhered to the nonbinding guidance—

[7] The case was consolidated with another one brought against the State in the Northern District of New York. The plaintiffs in the other case have not sought certiorari.

which is insufficient to establish standing under this Court's decision in *Clapper v. Amnesty International USA*, 568 U.S. 398 (2013) (Pet. App. 5a–6a).

In a footnote, the court expressed Judge Cabranes's view that the State and City guidance would present "portentous issues" on the merits if challenged by a plaintiff with standing (Pet. App. 8a–9a).

REASONS FOR DENYING THE PETITION

A. This a poor vehicle for certiorari because the shortage in treatments abated before petitioners even sued and has not recurred since.

The petitioners challenge the aspect of the Second Circuit's ruling rejecting their claim that they face an imminent future injury sufficient to confer Article III standing. But the petition glosses over the fact that the City's challenged guidance has lacked relevance since before the suit was brought: petitioners sued only after the brief shortage arising from the treatments' initial rollout had subsided, and no similar shortage of the treatments has arisen in the year-plus since. The petition barely touches on these key points.

The City issued its nonbinding advisory in December 2021, during a time of "severe resource limitations" on the treatments (Pet. App. 62a). By its own terms, the advisory applied only "until more product bec[ame] available" (Pet. App. 64a). A week before petitioners sued, the City issued a new advisory explaining that the treatments were widely available (Pet. App. 87a). The State followed suit (Pet. App. 101a–102a).

Thus, even before they sued, petitioners had no nonspeculative claim of future injury because any purported prioritization of treatments based on the guidance was no longer necessary. That fact alone defeats any contention that petitioners faced a future injury that was "certainly impending." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013). And even if the end of the shortage had occurred after petitioners sued, as they mistakenly suggest (Pet. App. 19 n.8), the persistent surplus in availability of the treatments for over a year now would plainly render their claims for prospective relief moot. *See O'Shea v. Littleton*, 414 U.S. 488, 495–496 (1974) ("Past exposure to illegal conduct does not in itself show a present case or controversy regarding injunctive relief … if unaccompanied by any continuing, present adverse effects.").

The short of it is that City's advisory is unlikely ever to be in effect again—and that has been true since before petitioners sued or, at the very worst, soon after they sued. When the challenged guidance was issued, the FDA had just approved the medications in question, and, understandably, production had been limited to that point. Predictably, the drug manufacturers then ramped up production significantly. The market worked as intended, and the

treatments have been widely available ever since.[8] This reality defeats petitioners' claim of future injury as a matter of standing or mootness or both, and it also drains this highly fact-bound dispute of any continuing significance.

Petitioners brush off these impediments to certiorari in two conclusory and unpersuasive footnotes (Pet. App. 19 n. 8, 9). They first incorrectly assert that "[s]upplies remained limited" when they filed suit (Pet. App. 19 n. 8), though the record shows the treatments were widely available in New York City by that time (Pet. App. 87a). In any case, there is no dispute that any shortage has by now long since abated. While petitioners invoke the principle that standing is assessed at the time that the complaint is filed (Pet App. 19 n. 8), it is well settled that claims for declaratory and injunctive relief may become moot based on post-filing developments. *See Preiser v. Newkirk*, 422 U.S. 395, 401 (1975) ("[A]n actual controversy must be extant at all stages of review, not merely at the time the complaint is filed").

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[8] U.S. Dep't of Health & Human Servs., *Side-by-Side Overview of Therapeutics Authorized or Approved for the Treatment of Mild to Moderate COVID-19* at 5 (Feb. 2023), *available at* https://perma.cc/VUQ9-J3EX.

Petitioners next retreat to the bare assertion that the case "comfortably fits" within the exception to the mootness doctrine for disputes that are capable of repetition but likely to evade review (Pet. App. 19 n.9). But they don't explain how this is true. The "capable of repetition" doctrine applies only in "exceptional situations." *Spencer v. Kemna*, 523 U.S. 1, 17 (1998). And this dispute clearly does not meet its requirements, as there is no "reasonable expectation" that petitioners "would be subjected to the same action again." *Weinstein v. Bradford*, 423 U.S. 147, 149 (1975). As already explained, production of the treatments has ramped up considerably since the initial shortage. Petitioners invoke the truism that supply chain shortages "can occur at any time" (Pet. App. 19 n. 8), but such "anything is possible" reasoning is the definition of speculation.

Perhaps recognizing the shortcomings in their claims of imminent future harm, petitioners also include a footnote mentioning their claim against the City for retrospective nominal damages. But they have no predicate for such a claim. Petitioners never alleged that they contracted COVID-19 during the initial shortage, so the challenged nonbinding guidance never became relevant to them personally. They certainly have not suffered any completed constitutional violation that could support nominal damages. Their claim amounts to one alleging

abstract stigma arising from or a personal objection to the bare existence of the guidance. But that is not enough. *See Uzuegbunam v. Preczewski*, 141 S. Ct. 792, 802 (2021) ("nominal damages provide the necessary redress for a *completed violation* of a legal right") (emphasis added).

B. There is no relevant circuit split.

In addition to skating over their vehicle problems, petitioners offer an unconvincing claim that the decision below opens a circuit split about how to assess claims of standing rooted in claims of imminent future harm. The cases they cite show only that some courts have found such claims to be non-speculative on markedly different facts. Nothing suggests that any other circuit would have found petitioners to have standing on the facts presented here.

None of the cases cited by petitioners resemble this one. Petitioners' claim of imminent future injury is speculative here because it rests on a string of rank contingencies, including but not limited to whether (a) a future shortage of the treatment will occur; (b) petitioners will contract COVID-19 during

any such future shortage;[9] (c) petitioners will be eligible for treatment because of the presentation of their disease; (d) the providers who treat them will be aware of the nonbinding guidance; and (e) the providers will opt to consider race in reliance upon it.

The other cases involve nothing similar. In *Sierra Club v. Jewell*, 764 F.3d 1 (D.C. 2014), the D.C. Circuit held that environmental and historic preservation organizations had standing to bring an administrative challenge to the delisting of a battlefield from the National Register of Historic Places. The court found imminent injury from the delisting because it would eliminate protections against surface mining on the battlefield, where coal companies had already engaged in mining in the vicinity, held

[9] Petitioners quote the district court's expression of skepticism that a plaintiff would have to wait until they contracted COVID-19 before suing (Pet. App. 11). But whether that contingency alone would defeat standing is a different question from whether it contributes, in combination with other contingencies, to the attenuated nature of petitioners' claim of imminent injury. In any event, concerns like those cited by the district court may support recognition of third-party standing on the part of health-care providers, *see Singleton v. Wulff*, 428 U.S. 106, 114–118 (1976), but they are not a basis to sanction speculative theories of standing by individuals who do not allege they have ever suffered from the pertinent medical condition since a challenged measure's adoption. No health-care provider is named as a plaintiff here.

mining permits encompassing the battlefield, and asserted an expectation of mining in the battlefield. *Id.* at 7–8.

In *McCardell v. U.S. Department of Housing and Urban Development*, 794 F.3d 510 (5th Cir. 2015), the Fifth Circuit found standing in a Fair Housing Act case brought by a neighbor challenging a plan to redevelop public housing on the basis that it would concentrate poverty and segregation. The court thought it "probable" that development would occur in accordance with a pending plan, and meanwhile two expert reports in the record found that the planned development would intensify segregation. *Id.* at 520–21.

The remaining two cases, *Attias v. CareFirst, Inc.*, 865 F.3d 620 (D.C. Cir. 2017), and *Remijas v. Neiman Marcus Group, LLC*, 794 F.3d 688 (7th Cir. 2015), both involve claims brought against companies by their customers whose personal data were breached in a cyberattack on its system. The courts reasoned that the plaintiffs had shown a non-speculative risk that they would suffer identify theft because those who hack computer systems to obtain personal data typically intend to use that data for improper purposes.

Regardless of whether the cited cases are correctly decided, they have little relevance to this case. Their analysis is highly fact-dependent, and the relevant facts differ sharply from those presented by petitioners. The various cases yield no apples-to-apples comparison with the extreme facts presented here.

Petitioners try to paper over this problem by framing matters at a high level of generality, suggesting that the other circuit courts recognize that "a plaintiff's injury is imminent where it flows from a predictable course of events that results from a defendant's conduct," whereas the Second Circuit supposedly does not (Pet. App. i, 13),

But the Second Circuit has not rejected the principle that standing can be established based on a "predictable" course of events. Rather, in the decision below, the court simply recognized that the course of events required for petitioners' asserted injury to ripen was not a predictable one. And the court's conclusion is entirely unsurprising: it is hardly predictable, for example, that a future shortage will ever occur, or that petitioners will contract COVID-19 during one if it does occur, or that the specific providers who ended up treating petitioners if those contingencies came to pass would know about or follow the challenged nonbinding guidance

to deny petitioners' treatment. Those fact-specific points are the key ones, and the petition has little to nothing to say about them. There is certainly no circuit split about them.

C. The speculative harms alleged here bear no resemblance to those in *City of Jacksonville*.

No better founded is petitioners' claim that the court of appeals' decision "conflicts" with this Court's decision in *City of Jacksonville* (Pet. App. i. 17–21).

The rule in *City of Jacksonville* is that, "[w]hen 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 relevant injury that needs to be shown for standing is "the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit." 508 U.S. at 663. The court of appeals assumed that petitioners here could show the existence of a barrier to fair process, as defined in *City of Jacksonville* (Pet. App. 5a).

The problem for petitioners is that a series of speculative contingencies would have to occur before they would ever personally face any such barrier. Nothing similar was present in *City of Jacksonville*. There, the plaintiffs were ready and able to bid on

contracts and a binding city policy created a race-based quota system for awarding those contracts. 508 U.S. at 668–69. Under those circumstances, the plaintiffs did not need to establish that they would have been awarded contracts in the absence of a quota system as a prerequisite to having standing.

But this case is very different because a chain of speculative contingences would need to occur before petitioners would ever experience the process-based unfairness that their claims allege. On the front end, a future shortage would need to occur, and petitioners would need to contract COVID-19 during such a shortage, before the advisory would even be potentially relevant to their treatment. To put the case in the framework of *City of Jacksonville*, petitioners were not "able and ready" to seek the treatments in circumstances where the guidance would even be relevant.

This case becomes yet further afield at the back end. If petitioners were ever to seek treatment during a time of shortage—itself speculative—they would face nothing akin to the centralized and binding government process that was at issue in *City of Jacksonville*. Prescription decisions are decentralized and controlled by innumerable health care providers—mostly private actors. And in New York City, the City's advisory has no binding legal effect

on those providers. Prescribers do not even have to sign up to receive them, let alone follow their advice. So it is speculative whether a provider who treated petitioners during a hypothetical future shortage would consider race in reliance upon the City's guidance in doing so. *City of Jacksonville* has nothing to say about any of these points.

Petitioners also call the decision in *Department of Commerce v. New York*, 139 S. Ct. 2551 (2019), "instructive," (Pet. App. 17–18), but it is not clear why. There, the Court concluded that the states' standing did "not rest on mere speculation about the decisions of third parties" but was grounded in "the predictable effect of Government action on the decisions of third parties." *Dep't of Commerce*, 139 S. Ct. at 2566.

The circumstances in *Department of Commerce* were far different from the facts here: the question was whether states had standing to challenge the reinstatement of a citizenship question on the census when their concern was downstream effects on their funding because of the statistically likely aggregate effect of their residents' projected reluctance to respond to the census as a result. But petitioners are two individuals; no such aggregation is relevant in their case. And it is anyone's guess how *Department of Commerce* could be relevant to whether a future

shortage of the treatments will occur and whether petitioners will contract COVID-19 during such a shortage if one ever does occur.

Nor do petitioners suggest that the fact-bound standing questions presented here have nationwide importance. Instead, they pivot to touting the supposed importance of the merits of their equal protection claim (Pet. App. 21, *id.* at 21–24). But the merits are not before the Court: neither lower court addressed them, and petitioners omitted them from their questions presented—which address standing alone. In any case, petitioners themselves cast defendants' guidance as "idiosyncratic" and identify only one other purportedly similar measure (Pet. App. 22–23). And, of course, if petitioners are correct that analogous merits issues will recur, then the Court will have ample opportunity to address them in a later case where the plaintiffs have standing. That would provide no basis to grant certiorari here, where petitioners clearly lack it, and where the merits are not even presented.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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