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EQUAL PROTECTION AND SCARCE THERAPIES: THE ROLE OF RACE, SEX, AND OTHER PROTECTED CLASSIFICATIONS

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ABSTRACT

The allocation of scarce medical treatments, such as antivirals and antibody therapies for COVID-19 patients, has important legal dimensions. This Essay examines a currently debated issue: how will courts view the consideration of characteristics shielded by equal protection law, such as race, sex, age, health, and even vaccination status, in allocation? Part II explains the application of strict scrutiny to allocation criteria that consider individual race, which have been recently debated, and concludes that such criteria are unlikely to succeed under present Supreme Court precedent. Part III analyzes the use of sex-based therapy allocation criteria, which are also in current use, and argues that they also face substantial legal obstacles, despite only being subject to intermediate scrutiny. Parts IV and V examine the use of age and health status in allocation. Part VI discusses how the nascent law on “vaccination status” discrimination might apply to therapy allocation.

I. INTRODUCTION

In the third year of the COVID-19 pandemic, governments and hospitals have continued to struggle with the fair allocation of antibody and antiviral therapies that aim to prevent severe disease in patients who contract COVID-19.¹ Spiking hospitalizations and the ineffectiveness of some older monoclonal antibody therapies against the Omicron variant exacerbated overall therapy scarcity,

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1. Katie Shepherd, *Doctors Bemoan Limited Supply of Game-Changing Antiviral Pills Amid Winter Surge*, WASH. POST (Jan. 4, 2022, 4:17 PM), <https://www.washingtonpost.com/health/2022/01/04/antiviral-pills-supply-omicron/> [<https://perma.cc/YXJ2-UUKB>].

despite new oral antivirals.² While scarcity has abated as cases have fallen, lack of federal funding risks renewed shortages.³

Fairly distributing scarce treatments presents ethical questions.⁴ But it also presents legal ones—especially when characteristics shielded by equal protection law, such as race, sex, age, health, and even vaccination status, are considered. In this short Essay, I examine whether and when proposals for allocating scarce treatments may violate constitutional, federal, or state equal protection laws.

The legality of using some of these criteria, in particular race, was discussed during the vaccine rollout.⁵ But vaccine supply now exceeds demand in the United States,⁶ while many effective therapies are still in short supply or may become scarcer if funding is not renewed or viral drug resistance intensifies.⁷ Therapy allocation is therefore the most likely legal battleground for the near future of the COVID-19 pandemic—and is likely to arise for other pandemics and illnesses as well.

II. RACE

During the pandemic, COVID-19 deaths have “disproportionately affect[ed] Hispanic, non-Hispanic black, and non-Hispanic American Indian/Alaskan Native populations.”⁸ During the vaccine rollout, many states responded to this and other disparities by using social vulnerability indices to prioritize individuals from areas facing greater disadvantage.⁹ These indices do not base eligibility on an individual’s race, but rather on their place of residence.¹⁰ Some

2. *Id.*

3. Press Briefing, The White House, Background Press Call by Senior Administration Officials on COVID Response and Funding Needs (Mar. 15, 2022), <https://www.whitehouse.gov/briefing-room/press-briefings/2022/03/15/background-press-call-by-senior-administration-officials-on-covid-response-and-funding-needs/> [<https://perma.cc/B5KZ-NL68>] (explaining that “thousands of patients could lose access to treatments” due to lack of funding).

4. Govind Persad, Monica E. Peek & Seema K. Shah, *Fair Allocation of Scarce Therapies for Coronavirus Disease 2019 (COVID-19)*, CLINICAL INFECTIOUS DISEASES, Dec. 2021, at 2, <https://doi.org/10.1093/cid/ciab1039> [<https://perma.cc/2MJD-GS5L>].

5. *E.g.*, Govind Persad, *Allocating Medicine Fairly in an Unfair Pandemic*, 2021 U. ILL. L. REV. 1085, 1095–1117 (2021); Harald Schmidt, Lawrence O. Gostin & Michelle A. Williams, *Is It Lawful and Ethical to Prioritize Racial Minorities for COVID-19 Vaccines?*, 324 JAMA 2023, 2023–24 (2020).

6. Nate Rattner, *Covid Vaccinations Are Slowing in the U.S. as Supply Outstrips Demand. How States Are Targeting Who’s Left*, CNBC (Apr. 30, 2021, 12:23 PM), <https://www.cnbc.com/2021/04/30/covid-vaccinations-in-us-are-slowing-as-supply-outstrips-demand.html> [<https://perma.cc/4HWR-3PDG>].

7. *See supra* notes 1–3 and accompanying text.

8. *COVID-19 Mortality Overview*, CDC, <https://www.cdc.gov/nchs/covid19/mortality-overview.htm> [<https://perma.cc/M37M-6VZ4>] (Apr. 23, 2021).

9. Harald Schmidt, Rebecca Weintraub, Michelle A. Williams, Kate Miller, Alison Buttenheim, Emily Sadecki, Helen Wu, Aditi Doiphode, Neha Nagpal, Lawrence O. Gostin & Angela A. Shen, *Equitable Allocation of COVID-19 Vaccines in the United States*, 27 NATURE MED. 1298, 1299–1300 (2021), <https://doi.org/10.1038/s41591-021-01379-6> [<https://perma.cc/KEA4-C9FA>].

10. *Id.* at 1301–05.

indices incorporate racial demographics at the neighborhood level,¹¹ but the use of race as a neighborhood-level variable is legally distinct from considering individual recipients' race.¹² The use of indices directed vaccines where they could better prevent hospitalizations and deaths; it also served to remediate racial disparities.¹³

A few states, such as Montana, Utah, and Vermont, as well as some vaccine sites, additionally or instead based eligibility on individual recipients' race.¹⁴ Many legal commentators and officials doubted such an approach satisfied current Supreme Court precedent,¹⁵ although some disagree.¹⁶ These prioritizations faced a few legal challenges or threats, but none have been adjudicated on their merits.¹⁷

For the allocation of scarce COVID-19 therapies, some health systems have

11. *Id.*

12. *See, e.g.,* Castillo v. Whitmer, 823 F. App'x 413, 416 (6th Cir. 2020); Am. C.R. Found. v. Berkeley Unified Sch. Dist., 90 Cal. Rptr. 3d 789, 792 (Ct. App. 2009). Notably, Judge Thapar, who joined the order in *Castillo*, later authored *Vitolo v. Guzman*, which found unconstitutional the use of individual race for COVID-19 relief fund eligibility. *Vitolo v. Guzman*, 999 F.3d 353, 362, 366 (6th Cir. 2021); *see also infra* note 38 and accompanying text.

13. Schmidt et al., *supra* note 9, at 1299.

14. Nambi Ndugga, Samantha Artiga & Olivia Pham, *How are States Addressing Racial Equity in COVID-19 Vaccine Efforts?*, KFF (Mar. 10, 2021), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/how-are-states-addressing-racial-equity-in-covid-19-vaccine-efforts/> [<https://perma.cc/TVVC-D7D9>]; Persad, *supra* note 5, at 1096, 1096 n.70.

15. Persad, *supra* note 5, at 1095–1117; Schmidt et al., *supra* note 5, at 2023–24.; Christopher Ogolla, *Triaging Public Health Services Based on Race: What Are the Legal Challenges?*, RACE & L. PROF BLOG (Jan. 5, 2021), <https://lawprofessors.typepad.com/racelawprof/2021/01/triaging-public-health-services-based-on-race-what-are-the-legal-challenges-by-christopher-ogolla.html> [<https://perma.cc/2ZBK-VMAB>] (arguing that “focusing on vulnerable populations in vaccine distribution is likely to succeed only if it doesn’t explicitly use racial categories”); Eugene Volokh, *Vaccination by Race, and Why It’s Unconstitutional*, VOLOKH CONSPIRACY (Dec. 10, 2020, 2:58 PM), <https://reason.com/volokh/2020/12/10/vaccination-by-race-and-why-its-unconstitutional/> [<https://perma.cc/1RA4-LA88>]; *see also* Sigal Samuel, *Should People of Color Get Access to the Covid-19 Vaccine Before Others?*, VOX (Oct. 28, 2020, 10:55 AM), <https://www.vox.com/future-perfect/2020/10/2/21493933/covid-19-vaccine-black-latino-priorityaccess/> (explaining that the National Academies of Science, Engineering, and Medicine’s vaccine allocation committee eschewed the use of individual race in part for legal reasons).

16. Seema Mohapatra & Maya Manian, *COVID Vaccine Prioritization and the Perils of Colorblind Constitutional Jurisprudence*, AM. CONST. SOC’Y: EXPERT F. (Apr. 8, 2021), <https://www.acslaw.org/expertforum/covid-vaccine-prioritization-and-the-perils-of-colorblind-constitutional-jurisprudence/> [<https://perma.cc/RR74-TB34>]; Memorandum of Law in Support of the Defendants’ Objection to Plaintiffs’ Motion for Temporary Restraining Order & Preliminary Injunction at 34, *Pietrangelo v. Sununu*, 2021 WL 1254560 (D.N.H. Apr. 5, 2021) (No. 21-cv-00124), ECF No. 13-1 (conceding that since “minority status is one of many alternative eligibility criteria that may qualify an individual to receive a vaccine through the equity allocation,” this “creates an express racial classification subject to strict scrutiny,” but arguing that the classification satisfies strict scrutiny).

17. *Pietrangelo*, 2021 WL 1254560, at *1; *Pietrangelo v. Sununu*, 15 F.4th 103, 106 (1st Cir. 2021); Eugene Volokh, *Civil Rights Commissioners Gail Heriot & Peter Kirsanow on the VA’s Planned Race-Based Vaccine Distribution*, VOLOKH CONSPIRACY (Dec. 18, 2020, 8:59 PM), <https://reason.com/volokh/2020/12/18/civil-rights-commissioners-gail-heriot-peter-kirsanow-on-the-vas-planned-race-based-vaccine-distribution/> [<https://perma.cc/X2RC-ANFV>]; Letter from Michael Buschbacher, Boyden Gray & Assocs. PLLC, & Rachel N. Morrison, Ethics & Pub. Pol’y Ctr., to Pamela Barron, Deputy Dir., C.R. Div., Off. for C.R., U.S. Dep’t of Health & Hum. Servs. (Sept. 28, 2021), https://eppc.org/wp-content/uploads/2021/09/OCR-Complaint-for-Unlawful-Racial-Set-Asides-in-NH-COVID-Vaccine-Distribution_Redacted.pdf [<https://perma.cc/L387-TG64>].

used social vulnerability indices similar to those used for vaccines.¹⁸ While some have grumbled about this,¹⁹ no lawsuits challenging these approaches have been reported. Particularly when the use of social vulnerability indices is framed in terms of preventing harm and promoting public health, rather than as a proxy for allocation by individual race, such lawsuits are unlikely to succeed.²⁰ More recently, 15% of antiviral doses have been prioritized for Federally Qualified Health Centers that serve more disadvantaged populations.²¹

In contrast, some states have instead or additionally proposed to use individual race to allocate scarce therapies.²² These proposals quickly faced criticism, legal challenges, and inquiries from elected officials; several have been withdrawn.²³ In this Part, I examine the legal framework governing these

18. Emily Rubin, Scott L. Dryden-Peterson, Sarah P. Hammond, Inga Lennes, Alyssa R. Letourneau, Parag Pathak, Tayfun Sonmez & M. Utku Ünver, *A Novel Approach to Equitable Distribution of Scarce Therapeutics: Institutional Experience Implementing a Reserve System for Allocation of COVID-19 Monoclonal Antibodies*, 160 CHEST 2324, 2325 (2021); Douglas B. White, Mark Schmidhofer, Erin McCreary, Ryan Bariola, Graham Michael Snyder, Rachel Sackrowitz, Naudia N. Jonassaint, Jessica Daley, Donald M. Yealy, Tayfun Sonmez, M. Utku Ünver, Parag Pathak, Govind Persad & Robert Truog, *Model Hospital Policy for Fair Allocation of Scarce Medications to Treat COVID-19*, UNIV. OF PITT. DEP'T OF CRITICAL CARE MED. (May 28, 2020), at 1, <https://ccm.pitt.edu/sites/default/files/2020-05-28b%20Model%20hospital%20policy%20for%20allocating%20scarce%20COVID%20meds.pdf> [<https://perma.cc/5VAN-JGFP>].

19. John B. Judis & Ruy Teixeira, *New York's Race-Based Preferential Covid Treatments*, WALL ST. J. (Jan. 7, 2022, 1:06 PM), <https://www.wsj.com/articles/new-york-race-based-covid-treatment-white-hispanic-inequity-mono-clonal-antibodies-antiviral-pfizer-omicron-11641573991> (arguing that “[w]ho should receive scarce Covid treatments should be based on genuine medical risk factors such as age and comorbidity,” although “class disparities can be relevant to deciding where to spend money to increase access to public-health benefits including vaccination and testing”).

20. The constitutionality of using individually race-neutral criteria with the purpose of addressing racial disparities has recently been disputed. *Compare* Coal. for TJ v. Fairfax Cnty. Sch. Bd., No. 21CV296, 2022 WL 579809, at *5 (E.D. Va. Feb. 25, 2022) (quoting *Miller v. Johnson*, 515 U.S. 900, 913 (1995)) (applying strict judicial scrutiny to invalidate a facially race-neutral high school admissions policy that it regarded as “motivated by a racial purpose or object”), *with* Coal. for TJ v. Fairfax Cty. Sch. Bd., No. 21-1280, 2022 WL 986994, at *1 (4th Cir. Mar. 31, 2022) (Heytens, J., concurring) (agreeing with stay of the district court decision because the disputed “policy is *race neutral*—indeed, evaluators are not told the race or even the name of any given applicant”). The Supreme Court upheld a stay of the district court decision, though three justices would have voted to vacate the stay. *Coal. For TJ v. Fairfax Cty. Sch. Bd.*, No. 21A590, 2022 WL 1209926, at *1 (U.S. Apr. 25, 2022) (mem.).

21. Amelia Templeton, *Oregon Has its First Doses of the Paxlovid Treatment for COVID-19. Here's Where it's Going*, OPB (Jan. 12, 2022, 5:50 PM), <https://www.opb.org/article/2022/01/12/oregon-paxlovid-covid-treatment-where-state-distributing/> [<https://perma.cc/R9PY-VH3V>].

22. Todd Richmond, *New Conservative Target: Race as Factor in COVID Treatment*, AP NEWS (Jan. 23, 2022), <https://apnews.com/article/coronavirus-pandemic-health-race-and-ethnicity-racial-injustice-madison-251ffe2672b6c40ca7b8a0a7341959f2> (“State health officials in Utah adopted a . . . risk calculator that grants people two points if they’re not white. Minnesota’s health department guidelines automatically assigned two points to minorities.”).

23. *Id.*; see also Plaintiff’s Memorandum in Support of Motion for a Preliminary Injunction at 1, *Jacobson v. Bassett*, 2022 WL 1039691 (N.D.N.Y. Mar. 25, 2022) (No. 22-CV-00033), ECF No. 34-1; Ricardo Torres, *SSM Health Will Not Use Race and Gender to Determine Who Gets COVID Treatment After Receiving Letter from WILL*, MILWAUKEE J. SENTINEL (Jan. 14, 2022, 2:39 PM), <https://www.jsonline.com/story/money/business/2022/01/14/ssm-health-not-use-race-and-gender-determine-who-gets-covid-treatment/6525813001/> [<https://perma.cc/EW5B-LW9S>]; Letter from Sen. Marco Rubio to Dr. Janet Woodcock, Acting Comm’r, FDA (Jan. 11, 2022),

prioritization proposals and conclude that the states were wise to withdraw their guidance given current precedent.²⁴

Since 1995, the Supreme Court has required that any governmental consideration of individuals' race to allocate benefits satisfy strict scrutiny.²⁵ Strict scrutiny requires that such consideration serve a compelling government interest and be narrowly tailored to realize that interest.²⁶ While strict scrutiny does not prohibit all consideration of race,²⁷ therapy allocation based on individual race—even as one factor among many²⁸—will struggle to satisfy these criteria, in particular narrow tailoring.

A. COMPELLING INTEREST

At least three different governmental interests might be advanced by using individual race to allocate scarce therapies. One is preventing hospitalization and death: if an individual's race predicts their likelihood of death or hospitalization if infected, allocating scarce treatments based on race could help reduce death and hospitalization. This is undoubtedly a compelling interest.²⁹ But using it to justify race-based therapy allocation will be challenging. For instance, while prior to the advent of vaccines Black and Hispanic Americans faced disparately high risk of death and hospitalization, it is less clear that this reflected greater risk *once infected*, as opposed to greater risk of infection, or that it could not be accounted for by social vulnerability and high risk medical conditions (all factors that, of course, are shaped by structural racism).³⁰ Most COVID-19

https://www.rubio.senate.gov/public/_cache/files/1d457672-82b6-4b92-8d42-15d213d86710/84F5BB025531D006E9F743F727BE5D19.01.11.21-rubio-letter-to-fda-covid-drugs-race-qualifier.pdf [<https://perma.cc/UG43-VWDN>].

24. My focus in this short Essay is applying current equal protection law to a novel scenario, rather than critiquing that law. For critiques, see, for example, Ian Haney-López, *Intentional Blindness*, 87 N.Y.U. L. REV. 1779, 1876 (2012).

25. *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 224 (1995) (“[A]ny person, of whatever race, has the right to demand that any governmental actor subject to the Constitution justify any racial classification subjecting that person to unequal treatment under the strictest judicial scrutiny.”).

26. *Id.* at 224–25.

27. *Contra* James G. Hodge Jr. & Jennifer L. Piatt, *Legal Decision-Making and Crisis Standards of Care*, JAMA HEALTH F. 1, 1 (2022) (“Manifold considerations, including patients’ race and ethnicity, skin color, and sex, are expressly forbidden from the decision-making process by law.”).

28. *Contra* Lawrence O. Gostin & David Beier, *Race Alone Should Not Be Used to Allocate Scarce Covid-19 Treatments*, STAT (Feb. 2, 2022), <https://www.statnews.com/2022/02/02/race-alone-should-not-be-used-to-allocate-scarce-covid-19-treatments/> [<https://perma.cc/TVK9-PX8W>] (“[T]he CDC should urgently issue ethical guidelines that may include race, but not as the singular factor in making life-or-death decisions.”).

29. See, e.g., *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 67 (2020).

30. E.g., Gbenga Ogedegbe et al., *Assessment of Racial/Ethnic Disparities in Hospitalization and Mortality in Patients With COVID-19 in New York City*, 3 JAMA NETWORK OPEN 1, 2, 10 (2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2773538> [<https://perma.cc/VDH5-48ZZ>]; Joshua M. Landman, Karen Steger-May, Karen E. Joynt Maddox, Gmerice Hammond, Aditi Gupta, Adriana M. Rauseo, Min Zhao & Randi E. Foraker, *Estimating the Effects of Race and Social Vulnerability on Hospital Admission and Mortality From COVID-19*, 4 J. AM. MED. INFORMATICS ASS'N OPEN 1, 2–5 (2021), <https://academic.oup.com/jamiaopen/article/4/4/ooab111/6479002> [<https://perma.cc/E3JL-7429>].

therapies are only prescribed to people who have tested positive.³¹ Additionally, the prevalence of immunity due to vaccination or prior infection and, as of 2022, the replacement of prior variants by the Omicron variant are likely to make pre-vaccine and pre-Omicron risk data less predictive of present risk.³² For instance, over the first four months of 2022, the CDC reports that the share of COVID-19 deaths among Black Americans has almost exactly equaled their share of the U.S. population; the share of deaths among Hispanic Americans has been a third less than their share of the population; and the share of deaths among non-Hispanic white Americans has been nearly one-fifth above their share of the population.³³ (However, non-Hispanic white Americans nevertheless continue to have a lower than average risk of dying early in life from COVID-19: during 2022, they comprised less than half of deaths among people younger than 50.³⁴) In contrast, during 2020, COVID-19 deaths among Black Americans were one and one-quarter times higher than their share of the proportion, while deaths among non-Hispanic white Americans and Hispanic Americans roughly equaled their share of the population.³⁵ The share of Asian American deaths was less than their share of population during both years, and the reverse for Native Americans, but the share of total deaths occurring in each of these groups decreased between 2020 and 2022.³⁶

The other two interests that could support the use of individual race are, first, reducing racial disparities, and second, rectifying historical racial discrimination. These interests, however, may not always reach a legally compelling level. Rectifying historical discrimination has only been accepted as legally compelling when a past discriminator is rectifying its own missteps.³⁷ Meanwhile, courts may question whether reducing racial disparities in medical outcomes constitutes a compelling interest.³⁸

B. NARROW TAILORING

Even if a compelling interest such as reducing death and hospitalization can

31. See Shepherd, *supra* note 1.

32. See *Health Disparities: Provisional Death Counts for Coronavirus Disease 2019 (COVID-19)*, CDC, at tbl.1, https://www.cdc.gov/nchs/nvss/vsrr/covid19/health_disparities.htm [<https://perma.cc/SZN5-DVYK>] (Apr. 13, 2022) (showing decline in the proportion of Black, Hispanic, and Asian American deaths following universal availability of vaccines) [hereinafter *Health Disparities*]; see also Max Kozlov, *Omicron Makes a Feeble Attack on the Lungs*, 601 NATURE 177, 177 (2022), <https://www.nature.com/articles/d41586-022-00007-8> [<https://perma.cc/Z5N9-P5PT>].

33. See *Health Disparities: Provisional Death Counts for Coronavirus Disease 2019 (COVID-19)*, CDC, at tbl.1, https://www.cdc.gov/nchs/nvss/vsrr/covid19/health_disparities.htm [<https://perma.cc/SZN5-DVYK>] (Apr. 13, 2022) [hereinafter *Health Disparities*].

34. *Id.*

35. *Id.*

36. *Id.*

37. See *Concrete Works of Colo., Inc. v. City and County of Denver*, 321 F.3d 950, 958 (10th Cir. 2003) (“[A]n effort to alleviate the effects of *societal* discrimination is not a compelling interest.”).

38. *Id.*; cf. *Vitolo v. Guzman*, 999 F.3d 353, 362 (6th Cir. 2021) (“[W]hen it comes to general social disparities, there are simply too many variables to support inferences of intentional discrimination.”).

be established, using individual race to allocate novel, scarce therapies is likely to fail a narrow tailoring analysis. Narrow tailoring can be understood as requiring that the consideration of individual race be the only, or best, way of achieving the compelling interest at issue.³⁹ Narrow tailoring disallows uses of individual race that are overinclusive (prioritizing people whose prioritization would not serve the compelling interest) or underinclusive (failing to prioritize some people whose prioritization would serve that interest).⁴⁰

Post-*Adarand*, uses of individual race often fail on the narrow tailoring analysis.⁴¹ This is likely to be especially true for definitions that do not make distinctions within racial groups or lump racial groups together.⁴² Assigning the same number of priority points to all treatment candidates who are not white is not narrowly tailored because it lumps together candidates whose race-associated risks vary substantially. Prioritizing specific racial groups over others would likely still be both over and underinclusive. For instance, even though Asian-American race may now be associated with lower risk, specific Asian-American groups have been at high risk in the pandemic.⁴³ Additionally, associations between race and risk are likely to be confounded by other factors, such as vaccination status: while Asian-Americans have recently died at lower rates than some other racial groups,⁴⁴ they are also highly vaccinated.⁴⁵

More fundamentally, the use of individual race will likely fail narrow tailoring because, in the COVID-19 pandemic, racial identity is an (imperfect) proxy for exposure to societal factors that increase risk, rather than itself a cause of risk.⁴⁶

39. See, e.g., *Eng'g Contractors Ass'n of S. Fla. v. Metro. Dade County*, 122 F.3d 895, 926 (11th Cir. 1997) (“The essence of the ‘narrowly tailored’ inquiry is the notion that explicitly racial preferences . . . must be only a ‘last resort’ option.”); *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 493 (1989) (plurality opinion) (explaining that the narrow tailoring requirement “ensures that the means chosen ‘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”).

40. *Vitolo*, 999 F.3d at 362 (“[A] policy is not narrowly tailored if it is either overbroad or underinclusive in its use of racial classifications.”).

41. E.g., *Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 735 (2007); *Faust v. Vilsack*, 519 F. Supp. 3d 470, 476 (E.D. Wis. 2021); *Wynn v. Vilsack*, 545 F. Supp. 3d 1271, 1282–83 (M.D. Fla. 2021).

42. See *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 227 (1995).

43. Rong-Gong Lin II, *Coronavirus Has Besieged Filipino, Vietnamese Americans in Bay Area*, L.A. TIMES (Dec. 31, 2020, 8:06 AM), <https://www.latimes.com/california/story/2020-12-31/filipino-vietnamese-americans-coronavirus-silicon-valley>.

44. See *Health Disparities*, *supra* note 32.

45. Lindsay M. Monte, *Household Pulse Survey Shows Many Don't Trust COVID Vaccine, Worry About Side Effects*, U.S. CENSUS BUREAU (Dec. 28, 2021), <https://www.census.gov/library/stories/2021/12/who-are-the-adults-not-vaccinated-against-covid.html> [<https://perma.cc/Z3GJ-JZ9F>].

46. Despite other disagreements, race being a proxy for—not a cause of—risk has been emphasized both by public health experts who are interested in rectifying racial disparities and by critics of race-based allocation. Compare Meera Jagannathan, *Should Black and Latino People Get Priority Access to a COVID-19 Vaccine?*, MARKETWATCH (Sept. 7, 2020, 7:50 AM), <https://www.marketwatch.com/story/should-black-and-latino-people-get-priority-access-to-a-covid-19-vaccine-2020-07-16> [<https://perma.cc/6B6K-FNMW>], and Rohan Khazanchi, Jasmine Marcelin, Jacinda Abdul-Mutakabbir & Utibe Essien, *Race, Racism, Civil Rights Law, and the Equitable Allocation of Scarce COVID-19 Treatments*, HEALTH AFFS. FOREFRONT (Feb. 10, 2022), <https://www.healthaffairs.org/doi/10.1377/forefront.20220208.453850/> [<https://perma.cc/PYU5-9PMT>], with Volokh, *supra* note 15.

This makes the use of individual race to allocate therapies legally different from its use to diversify workplace or educational settings,⁴⁷ where appropriate representation of people with specific racial identities *is* the governmental interest at issue, or to counterbalance historical identity-based racism.⁴⁸ Using race as a proxy for societal factors that elevate medical risk is also different from using race as a proxy for biological factors such as genetics or ancestry—a medical practice whose legality remains unsettled.⁴⁹ Even a clear association between race and risk is not enough: narrow tailoring will require approaches that address the social factors that link race with medical risk, not the shortcut of using race as a proxy. Using individual race as a proxy for these factors may appear administratively convenient,⁵⁰ but is insufficient to satisfy narrow tailoring. Analogously, Asian-Americans on average score highest on the mathematics section of some college entrance examinations,⁵¹ but this correlation would not license dispensing with examinations and prioritizing students who identify as Asian-American for admission, even as one factor among many, given the better tailored alternative of using examination results themselves. Strict scrutiny disallows the use of individual race as a proxy for medical risk if the compelling interest could instead be realized either by directly assessing the risk factors for which race is proxying or by using alternative proxies for risk, such as social vulnerability indices that may include race as a neighborhood variable.⁵²

Additionally, courts have also required “serious, good faith consideration of

47. *Fisher v. Univ. of Tex. at Austin*, 579 U.S. 365, 388 (2016); *Petit v. City of Chicago*, 352 F.3d 1111, 1114 (7th Cir. 2003); *cf. Samuel*, *supra* note 15 (explaining how the use of race in affirmative action programs differs from its use as a proxy in medical allocation).

48. *See Concrete Works of Colo., Inc. v. City and County of Denver*, 321 F.3d 950, 958 (10th Cir. 2003).

49. *See Mitchell v. Washington*, 818 F.3d 436, 446 (9th Cir. 2016); *Hines v. Youseff*, 914 F.3d 1218, 1235 (9th Cir. 2019).

50. *See Jagannathan*, *supra* note 46 (“[R]ace could serve as a proxy for other data points that aren’t available, such as income, education and racism — one ‘quick question’ that helps get at other questions.”); Salvador Rizzo, *Former Trump Adviser Falsely Claims States Are Rationing Scarce COVID Treatments Based Largely on Race*, WASH. POST (Feb. 10, 2022, 10:53 AM), <https://www.washingtonpost.com/health/2022/02/10/conservatives-covid-treatments-race/> [<https://perma.cc/K7P8-TKKS>] (reporting statement by Harvard Medical School professor noting a general desire to use “race as a proxy”). Additionally, the use of individual race may face unique administrability challenges, given the lack of agreed-upon standards for adjudging membership in a racial group, in contrast to criteria like place of residence, age, poverty, Medicaid reciprocity, vaccination status, or medical conditions.

51. Ember Smith & Richard V. Reeves, *SAT Math Scores Mirror and Maintain Racial Inequity*, BROOKINGS (Dec. 1, 2020), <https://www.brookings.edu/blog/up-front/2020/12/01/sat-math-scores-mirror-and-maintain-racial-inequity/> [<https://perma.cc/UJ4Q-438E>].

52. Some medical analyses do not address the doctrinal difference between race and alternative proxies for risk. *E.g.*, Khazanchi et al., *supra* note 46 (“Race-conscious allocation, just like allocation prioritizing people who are pregnant, immunocompromised, or have chronic medical conditions, will ensure medications are distributed to individuals and communities in greatest need.”); *see also* Brief of National Birth Equity Collaborative et al. as *Amici Curiae* in Opposition to Plaintiff’s Motion for a Preliminary Injunction & in Support of Defendant’s Motion to Dismiss at 21–25, *Jacobson v. Bassett*, 2022 WL 1039691 (N.D.N.Y. Mar. 25, 2022) (No. 22-CV-00033), ECF No. 50 (extensively describing associations between race and risk but not addressing legal precedents such as *Adarand* or *Parents Involved* that constrain governmental use of race as a proxy).

workable race-neutral alternatives” prior to the implementation of policies that classified individuals by their race.⁵³ Indeed, prior failed trials of race-neutral alternatives were relevant even under earlier precedents that applied only intermediate scrutiny to classification by individual race.⁵⁴ This presents further problems for an initial allocation rule for a novel therapy that begins by using individual race.

Is a pandemic different? Current litigation over therapy allocation has already been dismissed for want of standing as scarcity abates.⁵⁵ But other decisions during the pandemic further suggest that, if courts were to reach the merits, use of individual race—particularly before individually race-neutral alternatives for distribution have been tried—will be highly unlikely to pass muster under current precedent.⁵⁶ And the Supreme Court of 2022 is substantially *more* skeptical of racial classifications than the courts that decided *Adarand* and *Parents Involved*.

While the law applying to allocation policies voluntarily implemented by private hospitals or clinics is slightly different, allocation decisions based on individual race face similar obstacles. This is particularly true where the institution allocating therapies receives governmental funds and so comes under the umbrella of federal law.⁵⁷ Standards appear more lenient for a private organization that receives no federal funds, but the legal situation is highly uncertain.⁵⁸ In addition, some states further limit the use of race in decision-making,⁵⁹ which could support state-law legal challenges to prioritization rules.

Last, prioritization based on Native American status would likely fare better legally than prioritization based on individual race. But even this is in flux in the courts, with the Supreme Court set to hear arguments that classifications based on Native American status should be treated more like racial classifications.⁶⁰

53. *Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 735 (2007) (quotation omitted).

54. *Metro Broad., Inc. v. FCC*, 497 U.S. 547, 589–90 (1990).

55. *E.g.*, *Roberts v. Bassett*, No. 22-CV-710 (NGG) (RML), 2022 WL 785167, at *1, *7 (E.D.N.Y. Mar. 15, 2022) (dismissing a plaintiff’s challenge to New York’s therapy allocation guidance for lack of standing and noting that “[i]n this period of surplus . . . the State Guidance is not in effect, and the City Guidance has been superseded”); *Jacobson v. Bassett*, No. 22-CV-33, 2022 WL 1039691, at *5 (N.D.N.Y. Mar. 25, 2022) (dismissing plaintiff’s challenge because “plaintiff cannot satisfy injury in face requirement of Article III standing”).

56. *See Vitolo v. Guzman*, 999 F.3d 353, 360 (6th Cir. 2021) (striking down use of individual race as a criterion for access to COVID-19 relief fund); *see also Collins v. Meyers*, No. 21-cv-2713, 2021 WL 4739513, at *3 (D. Colo. Oct. 12, 2021), *clarified by* No. 21-cv-2713, 2021 WL 4890584 (D. Colo. Oct. 15, 2021) (granting temporary restraining order to prevent implementation of COVID-19 relief program with “minority-owner business” preference, because the court “cannot conclude that the statute will survive strict scrutiny”); *Cocina Cultura LLC v. Oregon*, No. 20-CV-02022, 2020 WL 7181584, at *1 (D. Or. Dec. 7, 2020) (citation omitted) (“The Fund explicitly and unambiguously requires that applicants ‘are majority-owned by people who identify as Black.’ This race-based criterion may very well not survive strict scrutiny . . .”); *cf. Roberts*, 2022 WL 785167, at *5 (explaining that guidance at issue was “nonbinding” and that plaintiffs “have alleged neither a concrete and particularized nor actual or imminent injury”).

57. *See Gratz v. Bollinger*, 539 U.S. 244, 276 n.23 (2003).

58. *See Doe v. Kamehameha Schs./Bernice Pauahi Bishop Est.*, 470 F.3d 827, 842 (9th Cir. 2006).

59. *Persad*, *supra* note 5, at 1100–01.

60. *See Brackeen v. Haaland*, 994 F.3d 249, 396 (5th Cir. 2021) (en banc), *cert. granted*, 142 S. Ct. 1205 (2022).

Ultimately, the use of social vulnerability indices or other population-level classifications is clearly the legally soundest approach to mitigating harm as well as addressing disparities. And, under current precedent, eschewing the consideration of individual treatment candidates' race makes the biggest legal difference—not describing individual race as just one factor among many (which is still likely to fail) or avoiding the use of even neighborhood-level racial data (which is likely unnecessary).

III. SEX

During the COVID-19 pandemic, male sex has been associated with greater risk of hospitalization and death,⁶¹ though experts debate what factors explain this association. Some frameworks, such as Utah's initial risk assessment process, have accordingly prioritized males for therapy.⁶²

Constitutionally, governmental classifications by sex are generally subject to intermediate rather than strict scrutiny, which “requires the government to show that its ‘gender classification . . . is substantially related to a sufficiently important government interest.’”⁶³ Compared to strict scrutiny, intermediate scrutiny is more lenient about the strength of the governmental interest required and the exactness of fit between means and ends.⁶⁴

Therapy prioritization using male sex as a proxy for risk can only plausibly realize the government interest in preventing COVID-19 harm: unlike prioritization based on minority race, prioritizing men does not address historical or present subordination. Unlike strict scrutiny, intermediate scrutiny does not regard the use of sex as a proxy as inherently inappropriate. Rather, it focuses on whether sex is in fact an effective proxy.⁶⁵ How effective it must be is debated: while distinguished scholars have argued that a proxy must be completely accurate to be upheld,⁶⁶ courts have also upheld the use of sex as an

61. Hannah Peckham, Nina M. de Grujter, Charles Raine, Anna Radziszewska, Corziana Ciurtin, Lucy R. Wedderburn, Elizabeth C. Rosser, Kate Webb & Claire T. Deakin, *Male Sex Identified by Global COVID-19 Meta-Analysis as a Risk Factor for Death and ITU Admission*, 11 NATURE COMM'NS 1, 2 (2020), <https://www.nature.com/articles/s41467-020-19741-6> [<https://perma.cc/W7X7-D4NJ>].

62. *UDOH Statement on COVID-19 Treatment Risk Score Calculator*, UTAH DEP'T OF HEALTH (Jan. 11, 2022), <https://health.utah.gov/featured-news/udoh-statement-on-covid-19-treatment-risk-score-calculator> [<https://perma.cc/5T7B-HA76>] [hereinafter *UDOH Statement*]. However, Utah eventually removed sex from their risk assessment procedure. *UDOH Announces Changes to Risk Assessment Process for Accessing Scarce COVID-19 Treatments*, UTAH DEP'T OF HEALTH (Jan. 21, 2022), <https://health.utah.gov/featured-news/udoh-announces-changes-to-risk-assessment-process-for-accessing-scarce-covid-19-treatments> [<https://perma.cc/23P6-6CAB>]. Another large health system similarly used and then removed priority for males. See Torres, *supra* note 23.

63. Glenn v. Brumby, 663 F.3d 1312, 1315–16 (11th Cir. 2011) (citation omitted).

64. See, e.g., Ensley Branch, NAACP v. Seibels, 31 F.3d 1548, 1581 (11th Cir. 1994) (“The principal purpose of intermediate scrutiny is not so much to make sure that gender-based classifications are used only as a ‘last resort’ . . .”).

65. See Sessions v. Morales-Santana, 137 S. Ct. 1678, 1696 (2017) (discussing “the close means-end fit required to survive heightened scrutiny”).

66. Mary Anne Case, “*The Very Stereotype the Law Condemns*”: *Constitutional Sex Discrimination Law as a Quest for Perfect Proxies*, 85 CORNELL L. REV. 1447, 1449–50 (1999).

admittedly “imperfect proxy.”⁶⁷

How would Utah’s framework have fared against this backdrop? Particularly since it favored men rather than women,⁶⁸ the imperfection of sex as a proxy would likely have weighed against it, as might the translation of sex into a points system.⁶⁹ For instance, Utah assigned one priority point to male sex—the same amount of priority that a seventy-year-old received over a forty-five-year-old.⁷⁰ Yet, studies show that even one decade of age increases risk substantially more than male sex alone does.⁷¹ Framing the prioritization as based on a biological rather than social difference may improve its prospects,⁷² though challengers could object that sex-associated differences in risk in fact reflect social differences or their medical consequences rather than biological inevitability.⁷³

Beyond this constitutional analysis, sex-based prioritization may also violate § 1557 of the Affordable Care Act, which “prohibits discrimination on the basis of sex in health programs or activities.”⁷⁴ There is little case law applying the sex discrimination provisions of § 1557, however, with most reported cases decided only at the motion-to-dismiss stage.⁷⁵ It is unclear whether agency interpretation of § 1557 would permit or proscribe sex-based prioritization for therapies. The agency’s advice—seemingly treating § 1557 claims as paralleling constitutional Equal Protection claims—states that “a covered entity must show that the sex-based classification is substantially related to the achievement of an important health-related or scientific objective.”⁷⁶ But it also asserts that covered entities must “provide individuals equal access to health programs and activities

67. *E.g.*, *In re* Est. of Miltenberger, 753 N.W.2d 219, 221 (Mich. 2008).

68. *See* *Eline v. Town of Ocean City*, 452 F. Supp. 3d 270, 278 (D. Md. 2020) (citation omitted) (“[L]aws may acknowledge the physical differences between men and women, so long as such gender-based classifications do not ‘create or perpetuate the legal, social, and economic inferiority of women.’”).

69. *Cf.* Shaina D. Massie, *Orange Is the New Equal Protection Violation: How Evidence-Based Sentencing Harms Male Offenders*, 24 WM. & MARY BILL RTS. J. 521, 543, 543 n.156 (2015) (analogizing a sex-based points system to the rigid point system struck down in *Gratz v. Bollinger*); *Roberts v. Bassett*, No. 22-CV-710, 2022 WL 785167, at *5 (E.D.N.Y. Mar. 15, 2022) (observing that the guidance at issue does not set “a threshold—or even target—number of points in order to obtain the Treatments”).

70. *UDOH Statement*, *supra* note 62.

71. Elizabeth J. Williamson et al., *Factors Associated with COVID-19-Related Death Using Open SAFELY*, 584 NATURE 430, 432 tbl.1 (2020).

72. Tuan Anh Nguyen v. INS, 533 U.S. 53, 64 (2001) (upholding gender distinction in part because “the use of gender specific terms takes into account a biological difference”); *Eline*, 452 F. Supp. 3d at 281 (concluding that “physical differences between men and women—as opposed to stereotypes about men or women—provide a constitutionally sound basis for laws which treat men and women differently”).

73. Heather Shattuck-Heidorn, Ann Caroline Danielsen, Annika Gompers, Joseph Dov Bruch, Helen Zhao, Marion Boulicault, Jamie Marsella & Sarah S. Richardson, *A Finding of Sex Similarities Rather Than Differences in COVID-19 Outcomes*, 597 NATURE E7, E8 (2021).

74. *Section 1557: Frequently Asked Questions*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html> [<https://perma.cc/6JS2-QV3A>] (May 18, 2017); *see also* 42 U.S.C. § 18116.

75. *See, e.g.*, *C.P. v. Blue Cross Blue Shield of Ill.*, 536 F. Supp. 3d 791, 793 (W.D. Wash. 2021); *Hammons v. Univ. of Md. Med. Sys. Corp.*, 551 F. Supp. 3d 567, 572, 591–592 (D. Md. 2021).

76. *Section 1557: Frequently Asked Questions*, *supra* note 74.

without discrimination on the basis of sex,”⁷⁷ which appears more demanding than intermediate scrutiny. Favoring the latter interpretation, some § 1557 cases have found—without conducting an intermediate scrutiny analysis—that an exclusion that prevents access to a “medically necessary treatment[.]” on the basis of sex “amounts to discrimination on the basis of sex in violation of the ACA.”⁷⁸ Though announced outside a scarcity context, this approach would appear on its face to bar the sex-based allocation of therapies. Greater protection against discrimination via statutory instead of constitutional equal protection is recognized in other contexts.⁷⁹

Beyond current federal law, some states apply strict rather than intermediate scrutiny to sex-based classifications.⁸⁰ Strict scrutiny would also apply if the Equal Rights Amendment were adopted.⁸¹ Under strict scrutiny, the use of sex-based therapy allocation would face the same obstacles that race-based allocation now does. Ultimately, while a well-designed use of sex as a priority factor is likelier to pass legal muster than prioritization based on race,⁸² its evaluation remains uncertain, particularly in the face of statutory rather than purely constitutional challenges.

IV. AGE

The odds of COVID-19 hospitalization and death after infection increase with age,⁸³ making its use in therapy allocation common. Federal recommendations and many state policies use ages sixty-five or seventy-five as eligibility cutoffs.⁸⁴ Like race and sex, chronological age is not a direct risk factor, but a proxy for a variety of medical and physiological risk factors. But the association between age and more severe outcomes is more likely to reflect physiological factors than similar associations with race or sex.

The use of age as a proxy for risk—unlike the use of race or sex—raises no constitutional problems. Constitutionally, age classifications face only rational

77. *Id.*

78. *Flack v. Wis. Dep’t of Health Servs.*, 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018); see also *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018).

79. See *Glenn v. Brumby*, 663 F.3d 1312, 1321 (11th Cir. 2011); cf. Richard A. Primus, *The Future of Disparate Impact*, 108 MICH. L. REV. 1341, 1355 n.72 (2010) (providing an example).

80. E.g., *In re Marriage Cases*, 183 P.3d 384, 401 (Cal. 2008), *superseded on other grounds by constitutional amendment as stated in* *Hollingsworth v. Perry*, 570 U.S. 693, 701 (2013).

81. Kim Forde-Mazrui, *Why the Equal Rights Amendment Would Endanger Women’s Equality: Lessons from Colorblind Constitutionalism*, 16 DUKE J. CONST. L. & PUB. POL’Y. 1, 17 (2021).

82. *Contra* Hodge & Piatt, *supra* note 27.

83. Williamson et al., *supra* note 71, at 432 tbl.1.

84. E.g., *The COVID-19 Treatment Guidelines Panel’s Interim Statement on Patient Prioritization for Outpatient Anti-SARS-CoV-2 Therapies or Preventive Strategies When There Are Logistical or Supply Constraints*, NAT’L INST. OF HEALTH, <https://www.covid19treatmentguidelines.nih.gov/therapies/statement-on-patient-prioritization-for-outpatient-therapies/> [https://perma.cc/6ZSN-LJN7] (Mar. 24, 2022) [hereinafter *COVID-19 Treatment Guidelines*]; Molly Gamble & Gabrielle Masson, *COVID-19 Vaccine Eligibility, State by State: March 16*, BECKER’S HOSP. REV. (Mar. 16, 2021), <https://www.beckershospitalreview.com/public-health/covid-19-vaccine-eligibility-state-by-state-march-16.html> [https://perma.cc/8KK4-NH6H].

basis review,⁸⁵ and the association between age and risk clearly establishes a rational basis.

Statutes, regulations, and state laws introduce more complexity. Section 1557 of the ACA, as well as the Age Discrimination Act of 1975 (which the ACA incorporates), does limit age-based decisions.⁸⁶ Unlike other age discrimination statutes,⁸⁷ these are symmetrical, equally applying to policies that disadvantage the young and those that disadvantage the old. But its implementing regulations permit the use of all legislatively created age distinctions, as well as age distinctions that serve a program's normal operation or statutory objectives.⁸⁸ Most state allocation policies are not legislatively created, so they would have to satisfy the normal operation or statutory objective requirement. Their prospects here seem strong, given that age is a good proxy for post-infection risk. But regulatory guidance has sometimes appeared more limiting. For instance, federal guidance takes the position that age cannot be used as the only criterion for medical resource allocation.⁸⁹ And letters from the HHS Office of Civil Rights⁹⁰ have similarly been interpreted by some commentators as categorically disallowing the use of age to allocate scarce medical resources.⁹¹ Yet, the statutory and regulatory language itself suggests that considering age, especially as one factor, is legally acceptable. This should be true both for favoring older persons (as has been done in therapy and vaccine allocation), and favoring younger persons (as has been proposed, but debated, in critical care allocation).

Notably, however, the one-size-fits-all age cutoffs common in vaccine and therapy allocation policies will almost inevitably produce disparate racial impact because the racial groups most harmed by COVID-19 have been both younger on average and at higher risk earlier in life.⁹² But courts have so dramatically pared back disparate impact law for race discrimination claims that litigation on this basis will be challenging unless federal agencies decide to bring actions themselves.⁹³ And crafting a remedy for disparate impact itself presents the risk of violating the same legal strictures against race-based decision-making discussed in Part II.⁹⁴ As discussed next, disparate impact claims are easier to raise in disability law: age cutoffs at sixty-five or seventy-five may

85. *Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 83–84 (2000).

86. 42 U.S.C. § 18116; *see also Section 1557: Frequently Asked Questions*, *supra* note 74.

87. *Kimel*, 528 U.S. at 67 (explaining that the Age Discrimination in Employment Act “covers individuals age 40 and over”).

88. *See Govind Persad, Evaluating the Legality of Age-Based Criteria in Health Care: From Nondiscrimination and Discretion to Distributive Justice*, 60 B.C. L. REV. 889, 899–900 (2019).

89. *Section 1557: Frequently Asked Questions*, *supra* note 74.

90. *Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19)*, OFF. FOR C.R., U.S. DEP'T OF HEALTH & HUM. SERVS. 1 (Mar. 28, 2020), <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf> [<https://perma.cc/T4SQ-VRZK>].

91. Samuel Bagenstos, *Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols*, 130 YALE L.J.F. 1, 16 & nn. 58–59 (2020) (observing that “even if many people agree that age is an appropriate criterion, not everyone does,” and asserting that “[a]mong those who do not are the HHS Office for Civil Rights”).

92. *See Persad*, *supra* note 5, at 1087.

93. *See Alexander v. Sandoval*, 532 U.S. 275, 293 (2001).

94. *See discussion supra* Part II; Primus, *supra* note 79, at 1346–47.

disproportionately exclude people with certain disabilities who either do not tend to live to those ages or face higher COVID-19 risks earlier in life.

V. HEALTH STATUS AND DISABILITY

Complaints that therapy allocation discriminates based on disability are likely to be comparatively rare because therapy allocation typically facially prioritizes, rather than excludes, on the basis of medical conditions that constitute legally protected disabilities.⁹⁵ No cases have held that disability-based classifications require intermediate or strict scrutiny.

Because disability law allows for disparate impact liability,⁹⁶ however, therapy allocation rules might be challenged as disparately impacting individuals with certain disabilities. For instance, people with early-onset medical conditions that typically cause death by one's twenties may be disproportionately excluded by allocation criteria that prioritize individuals who are older or have certain later-onset medical conditions that themselves constitute disabilities. This presents a familiar challenge for the application of disability law to medical decision-making: since disabilities are often closely connected to medical conditions, even medical decisions that are not based on stereotyping or inaccuracy might be challenged as having disparate impact. Though agencies have sometimes taken more expansive positions,⁹⁷ courts have typically confined their review to inaccuracy or stereotyping,⁹⁸ and some have interpreted medical decision-making as altogether exempt.⁹⁹ This challenge is intertwined with debates over the relative importance, in disability discrimination analysis, of a policy's effect on an individual or group with a specific disability compared to its effect on individuals with other disabilities or the overall population of persons with disabilities.¹⁰⁰ Under scarcity, almost any prioritization rule—including rules that prioritize access for people with certain disabilities—will tend to screen out individuals whose disabilities are negatively correlated with the prioritization criteria, even if it improves access for those with other disabilities or for the population of all individuals with disabilities.

VI. VACCINATION STATUS

Some states have recently made vaccine refusal, or vaccination status, a

95. *E.g.*, *COVID-19 Treatment Guidelines*, *supra* note 84.

96. *Raytheon Co. v. Hernandez*, 540 U.S. 44, 53 (2003).

97. *E.g.*, *Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19)*, *supra* note 90, at 1.

98. *E.g.*, *Bragdon v. Abbott*, 524 U.S. 624, 648–50 (1998).

99. *E.g.*, *Burger v. Bloomberg*, 418 F.3d 882, 883 (8th Cir. 2005).

100. This issue remains unsettled. *See* Nicole Buonocore Porter, *Mixed Signals: What Can We Expect from the Supreme Court in This Post-ADA Amendments Act Era?*, 35 *TOURO L. REV.* 435, 443 (2019); *cf.* *Moddero v. King*, 82 F.3d 1059, 1062 (D.C. Cir. 1996) (concluding that disability law permits a reimbursement limit applicable to only certain types of medical care that leaves “the disabled as a class — mentally and physically disabled individuals in the aggregate . . . better off” that would “across-the-board limits on coverage”).