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

William A. Jacobson, on behalf of himself and others similarly situated, *Plaintiff*, v. **Mary T. Bassett**, in her official capacity as Acting Commissioner of the New York Department of Health, *Defendant*.	Civil Action No. 3:22-cv-00033-MAD-ML

BRIEF OF NATIONAL BIRTH EQUITY COLLABORATIVE, NATIONAL MEDICAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN PUBLIC HEALTH ASSOCIATION, COUNCIL OF MEDICAL SPECIALTY SOCIETIES, NEW YORK STATE ACADEMY OF FAMILY PHYSICIANS, COMMUNITY SERVICE SOCIETY OF NEW YORK, HOUSING WORKS, CALLEN-LORDE COMMUNITY HEALTH CENTER, PARTNERS IN HEALTH, AND MEDICAL AND HEALTH EQUITY PROFESSIONALS AND ACADEMICS AS *AMICI CURIAE* IN OPPOSITION TO PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION AND IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS

Rachel L. Fried (N.D (RCTD[(R)-3 (a)4 (cTd( )TjEMC /P ≠

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TABLE OF CONTENTS

N.Y. State Dep’t of Health,

COVID-19 patient's risk of progressing to severe illness.

ARGUMENT

I. Minoritized populations are at heightened vulnerability to severe illness and death from COVID-19.

For two years, the COVID-19 pandemic has wreaked havoc in communities across the country, upended the lives of countless families, and killed more than 68,000 New Yorkers.[3] Although the COVID-19 pandemic has taken a toll on all New Yorkers, it has disproportionately impacted minoritized populations. For example, Latinx populations have experienced higher rates of SARS-CoV-2 infection than white populations, and BIPOC populations have experienced higher rates of severe COVID-19 symptoms, serious illness requiring hospitalization, and death from COVID-19 than whites.

A. Minoritized populations have experienced disproportionately high rates of serious illness and death from COVID-19.

Minoritized populations have experienced disproportionately high rates of death from COVID-19.[4] Based on data collected through March 7, 2021, Black individuals have died from COVID-19 at 1.4 times the rate of white individuals.[5] One study found that, among individuals aged 25–54, the *Black and Latinx populations lost nearly 7 times, and the Indigenous population lost nearly 9 times, as many years of life before age 65 from COVID-19 as the white population*.[6] "[W]hile Asian Americans make up a small proportion of COVID-19 deaths in the USA, they

[3] N.Y. State Dep't of Health, *COVID-19 Fatalities Tracker*, on.ny.gov/3HlNh4j (last visited Feb. 23, 2022).

[4] *See, e.g.*, Zliea t on.ny.gov18r/O e.*RacalticDii(s)-1 p(ar)-1 (i)-2 (t)-2 (i)-2 (e)4(s)-1 (i)-2 (n3H)2 (8s)-1 p(o)-2 Micre*

experience significantly higher excess all-cause mortality (3.1 times higher), case fatality rate (as high as 53% higher), and percentage of deaths attributed to COVID-19 (2.1 times higher) compared to non-Hispanic Whites."[7] The disproportionately higher mortality rates for BIPOC people remain even after accounting for differences in level of education.[8] The inequity is stark:

> If all groups had experienced the same mortality rates as college-educated non-Hispanic White individuals, there would have been 48% fewer COVID-19 deaths among adults aged 25 years or older overall, including 71% fewer deaths among racial and ethnic minority populations and 89% fewer deaths among racial and ethnic minority populations aged 25 to 64 years.[9]

In New York State, according to a 2020 study, Black individuals comprised 16% of the population but made up 22% of COVID-19 deaths statewide;[10] Latinx individuals comprised 19% of state residents, but made up 24% of statewide COVID-19 deaths.[11] By contrast, whites comprised 55% of New York State's population, but made up 43% of statewide COVID-19 deaths.[12] According to recent data from New York State, the COVID-19 death rate for whites has been 155 per 100,000, whereas the death rates for Asian American, Black, and Latinx people has been 186, 349, and 269 per 100,000, respectively.[13] Outside of New York City, the age-adjusted death rate "is double or even quadruple for [Black], Latinx, and Asian New Yorkers" relative to

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[7] Brandon W. Yan, *Death Toll of COVID-19 on Asian-Americans: Disparities Revealed*, 36 J. Gen. Internal Med. 3547, 3545 (Aug. 4, 2021), doi.org/10.1007/s11606-021-07003-0.
[8] Justin M. Feldman & Mary T. Bassett, *Variation in COVID-19 Mortality in the US by Race and Ethnicity and Educational Attainment*, JAMA Network, Nov. 23, 2021, at 1, bit.ly/3sirmVs.
[9] *Id.*
[10] Laurens Holmes Jr. et al., *Black–White Risk Differentials in COVID-19 (SARS-COV2) Transmission, Mortality and Case Fatality in the United States: Translational Epidemiologic Perspective and Challenges*, 17 Int'l J. Env't Rsch. & Pub. Health 4322, 4328 (2020), doi.org/10.3390/ijerph17124322.
[11] *Id.*
[12] *Id.*
[13] COVID-19 Health Equity Interactive Dashboard, Emory University, *COVID-19 Outcomes in New York*, covid19.emory.edu/36 (last visited Feb. 23, 2022).

white New Yorkers.[14] In fact, after adjusting for age, *New York is the state with the highest COVID-19 mortality rate among its Black residents.*[15]

Indeed, from the earliest days of the COVID-19 pandemic, minoritized individuals have been disproportionately impacted. In New York City, the initial epicenter of the pandemic, the COVID-19 case rates in majority Black, Latinx, and other communities marginalized by systems and structures was between 24% and 110% higher than those in majority white communities[16] before leveling out, although Latinx communities still experience significantly higher infection rates than whites.[17]

More significantly, BIPOC people experience disproportionately higher rates of severe illness from COVID-19.[18] As of March 2021, the COVID-19 hospitalization rate of Asian Americans, Latinx, and Black New Yorkers was 2.5, 3.8, and 4.2 times that of white New Yorkers, respectively. [19] In fact, [illegible] experience higher rates of COVID-19 disease

severity upon admission to a hospital compared with whites, which increases the likelihood of needing intubation or ICU care, and death.[20]

B. Minoritized populations have disproportionately higher rates and severity of medical conditions that increase the risk of developing severe COVID-19 symptoms.

Heart disease and diabetes are two of the most common underlying medical conditions that the U.S. Centers for Disease Control and Prevention (CDC) has recognized place patients with COVID-19 at increased risk for severe illness or death,[21] and these diseases disproportionately affect BIPOC individuals, including in New York.[22] BIPOC people also experience higher rates of undiagnosed medical conditions (including diabetes),[23] thus increasing the likelihood of having a risk factor that goes undetected. And among people diagnosed with

related complications, and

and adolescents"—have occurred among Black or Latinx children.[29]

II. The higher rates of severe symptoms and death from COVID-19 experienced by minoritized people are tied to systemic racism and bias, and are not accounted for by other observable risk factors.

Extensive literature provides two well-supported explanations for the racial and ethnic inequities in COVID-19 case severity and mortality. First, the legacy of this country's long history of racist policies—such as segregation and persistent inequities in housing, employment, access to healthcare, health care, and other life opportunities—has led to adverse health outcomes for racial and ethnic groups historically marginalized by systems and structures.[30] Social factors, known as "social determinants of health," and systemic factors such as exposure to racism, are both "social drivers of health," which establish that societal conditions can—and do—affect an individual's health risk.[31] Second, racism and implicit bias within the medical system has resulted in lower quality healthcare for BIPOC individuals.[32] Crucially, these systemic inequities manifest in an increased risk of developing severe COVID-19 symptoms relative to whites—a risk that is not captured by other immediately observable information such as age, vaccination status, and presence of underlying medical conditions.[33]

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[29] CDC, *Disparities in Hospitalizations*, *supra* note 27.

[30] *See, e.g.*, CDC, *Health Equity Considerations and Racial and Ethnic Minority Groups*, bit.ly/3giQc1z (last updated Jan. 25, 2022); Paula Braveman et al., *What is Health Equity?*, Robert Wood Johnson Found. (May 1, 2017), rwjf.ws/3Gkedjx; Rima A. Afifi et al., *'Most at risk' for COVID19? The imperative to expand the definition from biological to social factors for equity*, 139 Preventive Med. 106229 (2020), bit.ly/3oYJPFx.

[31] *See* CDC, *Social Determinants of Health: Know What Affects Health*, bit.ly/3IWQXd3 (last reviewed Sept. 30, 2021).

[32] *See* Kevin B. O'Reilly, *AMA: Racism is a threat to public health*, Am. Med. Ass'n (AMA) (Nov. 16, 2020), bit.ly/35xEoGE.

[33] *See* Rima A. Afifi et al., *supra* note 30, at 2 ("Fundamental social causes of disease mobilize pathways to morbidity and mortality that . . . exacerbate consequences of COVID19 . . . ."); Benjamin Seligman et al., *Social determinants of mortality from COVID-19: A simulation study using NHANES*, PLOS Med., Jan. 11, 2021, bit.ly/3ITbxek; *see also infra* note 84.

A. Social drivers of health caused the COVID-19 pandemic to disproportionately harm minoritized populations.

The COVID-19 pandemic's disparate impact is neither novel nor a coincidence. Racial and ethnic disparities in health outcomes are well documented. For example, Black individuals "are three times as likely as whites to develop cardiovascular disease and are twice as likely to die from it."[34] In 2017, the rate of asthma deaths among adults aged 65 and older was significantly higher for Black Americans, Asian Americans, and Pacific Islander Americans than for whites.[35] And Black women are nearly three times as likely as white women to die from pregnancy-related complications.[36] Inequities in health outcomes persist "even when access-related factors, such as patients' insurance status and income, are controlled."[37] To illustrate, a study found that "[t]he PRMR [pregnancy-related mortality ratio] among black women with a completed college education or higher was 1.6 times that of white women with less than a high school diploma."[38] It is crucial to note that "these disparities do not arise from bad individual choices or biological differences between races but the social factors that shape people's lives every day . . . . We as a society have created them."[39]

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[34] *Just Medicine*, *supra* note 24, at 57; *see also Inequality and African-American Health*, *supra* note 24, at 11.

[35] Off. Disease Prevention & Health Promotion, *Asthma deaths among adults (per million population, 65+ years) By Race/Ethnicity*, https://bit.ly/3geCooT (last updated Feb. 6, 2022).

[36] CDC, *Pregnancy Mortality Surveillance System*, bit.ly/3ohnWB5 (last reviewed Nov. 25, 2020).

[37] Inst. of Med., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 1 (2003), doi.org/10.17226/10260 [hereinafter Unequal Treatment]; *see also Inequality and African-American Health*, *supra* note 24, at 22.

[38] Emily E. Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, 68 MMWR 762, 763 (2019), https://bit.ly/3BD2UCs.

[39] COVID-19 Policy Playbook, *supra* note 22, at 7; *see also* Yin Paradies, *A systematic review of empirical research on self-reported racism and health*, 35 Int'l J. Epidemiology 888, 888 (2006), bit.ly/3IX87qS ("The manifestations of racism vary considerably across time and place but in general ensue from societal systems that produce an unequal distribution of power (and hence resources) in societies based on the notion of 'race', where race is a social rather than a biological construct related to the notion of essentialized innate phenotypical, ancestral, and/or cultural

Numerous social drivers of health have historically prevented people of color, and Black individual

regardless of community income."[53] In New York, numerous policies over the past several decades have resulted in underfunded and under-resourced hospital systems in communities of color.[54] For example, when the state "cut thousands of hospital beds" in 2016, a disproportionate number were

documented racial and ethnic inequities in COVID-19 mAb treatment, including "systemic factors such as limited access to testing and care because of availability constraints, inadequate insurance coverage, and transportation challenges; lack of a primary care provider to recommend treatment; variations in treatment supply and distribution; potential biases in prescribing practices; and limited penetration of messaging in some communities about mAb availability and effectiveness to prevent disease progression."[65]

iii. *Working conditions as a social driver of health.*

Racial and ethnic inequities in employ Tw 12 016 (s he)43 of-4 2251.6 336.5]TJ01as a socitv-5 (ter)-1 (e

determinants of health, including lack of paid time off and lack of insurance, as barriers to COVID-19 vaccine access and accommodations.[70]

iv. Exposure to racism as a social driver of health.

Exposure to racial and ethnic discrimination in daily life is a significant social driver of health. Extensive research has documented that racism itself negatively impacts health over time through a process called weathering.[71] A review of 138 empirical studies on the health effects of racism showed a clear link between racism and ill health for oppressed racial groups, even after adjustment for confounding factors.[72] Another meta-analysis of 293 studies concluded that "racism is significantly related to poorer health."[73] In a 2011 study, more than 90% of Black individuals reported having experienced racial discrimination.[74] Racial discrimination can cause chronic

be intended: "[e]vidence has revealed that unconscious bias in interpersonal interactions is strong, widespread and deeply rooted, and could potentially take a heavy toll on health."[76]

v. *Incarceration and homelessness as social drivers of health.*

Incarceration and homelessness are two additional social determinants of health that disproportionately impact people of color. Black individuals have higher rates of incarceration than white individuals who commit the same offense.[77] In New York, Black individuals are imprisoned at a rate that is over three times their percentage of the state's population.[78] Imprisoned people are exposed to more infectious diseases and to significant stress, yet prisons rarely "provide much beyond the most basic medical care."[79] The increased likelihood of having disease while imprisoned does not end upon release; a history of incarceration also "strongly increases the chances of severe health limitations after release."[80] Prisons have been epicenters of COVID-19 outbreaks since the beginning of the pandemic.[81] Additionally, people experiencing homelessness in New York experienced higher rates of death from COVID-19 in both congregate shelter and unsheltered settings.[82] Minoritized people are disproportionately represented among homeless

effects of social-

more severe forms of, medical conditions such as heart disease, thereby compounding the risk of getting severely ill or dying from COVID-19 in a way that is not captured by consideration of the presence of heart disease alone.

"many white medical students and residents"—73% of the study sample—"hold beliefs about biological differences between blacks and whites, many of which are false and fantastical in nature, and that these false beliefs are related to racial bias in pain perception."[101] Another study found that among children who visited emergency departments, Black and Latinx children were less likely to "have their care needs classified as immediate/emergent" and "experienced significantly longer wait times and overall visits as compared to whites."[102] The researchers concluded the "difference could not be fully explained by possible confounding factors available in the dataset, such as demographic, socioeconomic, or clinical variables."[103] Additionally, "Black newborns have significantly lower mortality if they're cared for by Black doctors rather than white ones."[104] Another study of 495 largely white, male physicians found that they were less likely to prescribe an aggressive HIV treatment to Black men than white men due to negative racial bias.[105]

In 2007, researchers produced "the first evidence of unconscious (implicit) race bias among physicians, its dissociation from conscious (explicit) bias, and its predictive validity."[106] The researchers concluded that physicians' implicit bias contributed to racial and ethnic disparities in the use of medical procedures such as thrombolysis for myocardial infarction.[107] The study also

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[101] Kelly M. Hoffman, *supra* note 92, at 4299.
[102] Xingyu Zhang et al., *Racial and Ethnic Disparities in Emergency Department Care and Health Outcomes Among Children in the United States*, Frontiers in Pediatrics, Dec. 19, 2019, at 1, doi.org/10.3389/fped.2019.00525.
[103] *Id*. at 5.
[104] Akilah Johnson & Nina5co1 Tf09Tc 0.032 (t)-2 (bis)-1]TJ-0.01 Twka.Tj/TT40720 (ki)-2 (l)-2 (a)4 (h Jya

showed that as physicians' IAT (implicit bias) scores increased, their likelihood of treating Black patients with thrombolysis decreased. A 2015 systematic review of 15 studies measuring implicit bias and health outcomes confirmed that healthcare professionals hold the same level of implicit bias against Black, Latinx, and dark-skinned people as the general population, and that "implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes."[108] A 2017 systematic review of 37 studies confirmed the substantial evidence of "pro-White or light-skin/anti-Black, Hispanic, American Indian or dark-skin bias among a variety of [healthcare professionals] across multiple levels of training and disciplines."[109]

Research has shown that a person can "hold strongly negative implicit biases" even where they express no explicit bias and believe themselves to be race-neutral.[110] Studies show that implicit bias influences behavior more directly than conscious bias does.[111] The evidence reveals that "implicit race biases are as prevalent among professionals in the health care industry as they are among the American public generally."[112] Most healthcare professionals, like most whites, "are low in explicit and high in implicit" bias.[113] In other words, many healthcare professionals unconsciously hold negative biases against BIPOC groups, and these negative biases may cause them to provide—entirely unintentionally—a lower quality of care to their BIPOC patients than

[108] William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 Am. J. Pub. Health e60, e60 (2015), http:doi.org/10.2105/AJPH.2015.302903.
[109] Ivy W. Maina et al., *A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test*, 199 Soc. Sci. & Med. 219, 219 (2018), bit.ly/3rXSGJy.
[110] *Just Medicine*, *supra* note 24, at 46.
[111] *Id.* at 39.
[112] *Id.* at 41.
[113] Michelle van Ryn et al., *The Impact of Racism on Clinician Cognition, Behavior, and Clinical Decision Making*, 8 Du Bois Rev. 199, 204 (2011), doi.org/10.1017/S1742058X11000191.

BIPOC individuals' conditions tend to be less well-treated, deadlier, and more severe than white individuals'.[44] BIPOC COVID-19 patients thus are at an increased risk of developing severe symptoms that the Prioritization Guidance's remaining risk factors, such as age and presence of underlying medical conditions alone, do not account for.

To illustrate, suppose a Black individual with heart disease and high blood pressure is eligible for one or more of the COVID-19 treatments during a time of low supply. The ind hugg (ur)3

consider “Black race (as a proxy for underlying racism)” a risk factor.[126] However, it is important to reiterate that race is a social construct, rather than an inherent biological trait, and when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.

Because racism and implicit racial and ethnic biases are known to inform medical care, thereby contributing to healthcare disparities

outcomes will alleviate the crisis of hospital overcrowding and demands on our healthcare system.[130]

Indeed, if medical professionals fail to consider BIPOC individuals' increased risk of getting severely ill or dying from COVID-19, along with other relevant factors, in prioritizing COVID-19 treatments during times of low supply, that would likely result in BIPOC COVID-19 patients continuing to get severely ill and to die from COVID-19 at disproportionately higher rates relative to white patients; in effect, their risk would be underappreciated. Only by accounting for the increased risk of severe illness from COVID-19 that BIPOC individuals face will their assigned risk group accurately reflect their level of risk.[131]

CONCLUSION

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

Respectfully submitted,

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[130] *See* Sharon Otterman & Joseph Goldstein, *More P.-4(ee)TJ 1.33 (on r/31.19 Td(J)-1 9.6B)3 (w7n15.92 0*

CERTIFICATE OF SERVICE

I hereby certify that on February 23, 2022, a[on]