ALLOCATING MEDICINE FAIRLY IN AN UNFAIR PANDEMIC

Govind Persad[*]

America's COVID-19 pandemic has both devastated and disparately harmed minority communities. How can the allocation of scarce treatments for COVID-19 and similar public health threats fairly and legally respond to these racial disparities? Some have proposed that members of racial groups who have been especially hard-hit by the pandemic should receive priority for scarce treatments. Others have worried that this prioritization misidentifies racial disparities as reflecting biological differences rather than structural racism, or that it will generate mistrust among groups who have previously been harmed by medical research. Still others complain that such prioritization would be fundamentally unjust. I argue that, to pass muster under current law, policymaking in this area must recognize a crucial distinction: prioritizing minority communities without regard to individual race is typically legal, but prioritizing individuals on the basis of their racial identity is likely not. I also explain how prioritization on the basis of Native American status is allowable and legally distinct from prioritization on the basis of race.

In Part II, I provide a brief overview of current and proposed COVID-19 treatments and identify documented or likely scarcities and disparities in access. In Part III, I argue that randomly allocating scarce medical interventions, as some propose, will not effectively address disparities: it both permits unnecessary deaths and concentrates those deaths among people who are more exposed to infection. In Part IV, I explain why using individual-level racial classifications in allocation is precluded by current Supreme Court precedent. Addressing disparities will require focusing on factors other than race, or potentially considering race at an aggregate rather

[*] Assistant Professor, University of Denver Sturm College of Law; Greenwall Foundation Faculty Scholar in Bioethics. JD, PhD, Stanford University. I am grateful to Greg Ablavsky, Stuart Benjamin, Jennifer Blumenthal-Barby, Alta Charo, Alan Chen, Jack Chin, Katie Eyer, Matthew Fletcher, Helene Gayle, Paul Gowder, Dan Ho, Adam Kern, Craig Konnoth, Sarah Krakoff, Benjamin Krohmal, Nancy Leong, Christopher Lewis, Toni Massaro, Amy McGuire, Barbara Noah, Kimani Paul-Emile, Jessica Roberts, Catherine Smith, and Aaron Tang for written comments on prior drafts and to Monica Peek, Michelle Mello, Harald Schmidt, Joseph Millum, David Wasserman, Parag Pathak, Utku Unver, Tayfun Sonmez, Robert Truog, Doug White, William Parker, Matthew Wynia, David Hoffman, RJ Leland, Lindsay Wiley, Dorit Reiss, Ruqaiijah Yearby, and audiences at the University of Chicago MacLean Center for Clinical Medical Ethics, UCSF/UC Hastings Consortium on Law, Science & Health Policy, DC Regional Bioethics Interest Group and the University of Denver Sturm College of Law Summer Faculty Workshop for helpful discussion. Thanks also to Marisa DeForest and Liza Sawyer for research assistance and to the editors at the *University of Illinois Law Review* for their hard work.

than individual level. I also argue that policies prioritizing members of Native American tribes can succeed legally even where policies based on race would not. In Part V, I examine two complementary strategies to narrow racial disparities. One would prioritize individuals who live in disadvantaged geographic areas or work in hard-hit occupations, potentially alongside race-sensitive aggregate metrics like neighborhood segregation. These approaches, like the policies school districts adopted after the Supreme Court rejected individualized racial classifications in education, would narrow disparities without classifying individuals by race. The other strategy would address the starkly disparate racial impact of deaths early in life by limiting the use of age-based exclusions from vaccine of treatment access that explicitly deprioritize the prevention of early deaths and so disparately exclude minorities, and by considering policies that prioritize the prevention of early deaths.

TABLE OF CONTENTS

I. INTRODUCTION

America's COVID-19 pandemic has both devastated and disparately harmed minority communities: 1 in 390 Native Americans and 1 in 555 Black

Americans have died of COVID-19, as opposed to 1 in 665 White Americans.[1] These deaths come not merely more often but also earlier: age-adjusted COVID-19 mortality rates in Latino and Pacific Islander communities are respectively around 2.4 and 2.6 times those in white communities, with other minority communities also currently experiencing disparately high mortality at earlier ages.[2] These disparities have been visible at the local level: at one point, approximately 70% of COVID-19 deaths in Chicago and in Louisiana occurred among Black patients—more than twice their representation in the local population.[3] During May 2020, the Navajo Nation experienced the third-highest per capita infection rate in the U.S. and had more deaths than thirteen states combined.[4]

This Article examines how the allocation of scarce medical treatments should respond to these disparities. Many commentators recognize that vaccine allocation happens against a backdrop of disparities.[5] Though not as widely discussed, novel treatments like remdesivir and monoclonal antibodies raise similar questions.[6] So do emergency interventions such as ventilators and ICU beds.[7] While increasing vaccine supply is slowly obviating the hardest tradeoffs, the challenge of prioritizing outreach among those eligible—even after everyone becomes eligible—will remain.

While the COVID-19 pandemic has deepened most health disparities, including disparities by economic status and education, I focus on racial disparities both because they have been extensively documented and because addressing them presents unique legal challenges.[8] Some have proposed that members of racial groups who have been especially hard-hit by the pandemic should receive priority for scarce treatments.[9] Others have worried that this prioritization misidentifies racial disparities as reflecting biological differences rather than structural racism, or that it will generate mistrust among groups who have previously

1. *The Color of Coronavirus: Covid-19 Deaths by Race and Ethnicity in the U.S.*, APM RESEARCH LAB, https://www.apmresearchlab.org/covid/deaths-by-race (Mar. 5, 2021) [https://perma.cc/6PSZ-FUZA].

2. *Id.* (observing that age-adjustment "results in even larger documented mortality disparities").

3. Rashawn Ray, *Why Are Blacks Dying at Higher Rates from COVID-19?*, BROOKINGS (Apr. 9, 2020), https://www.brookings.edu/blog/fixgov/2020/04/09/why-are-blacks-dying-at-higher-rates-from-covid-19/ [https://perma.cc/TK9G-7KAS].

4. Nina Lakhani, *Navajo Nation Reels Under Weight of Coronavirus – and History of Broken Promises,* GUARDIAN (May 8, 2020, 6:00 AM), https://www.theguardian.com/world/2020/may/08/navajo-nation-coronavirus [https://perma.cc/Y93D-8DPA].

5. *See* discussion *infra* Part II.

6. *E.g.*, Tom Wilemon, *New Data Offer Insights on COVID Treatments for People with Cancer*, VUMC REPORTER (Jul. 22, 2020, 1:39 PM), https://news.vumc.org/2020/07/22/new-data-offer-insights-on-covid-treatments-for-people-with-cancer/ [https://perma.cc/5B46-2Y3Z] ("Newly released data on treatment outcomes of people with cancer diagnosed with COVID-19 reveal a racial disparity in access to Remdesivir, an antiviral drug that has been shown to shorten hospital stays . . . .").

7. Douglas B. White & Bernard Lo, *A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic*, 323 JAMA 1773, 1773 (2020).

8. *See* discussion *infra* Part IV.

9. Megan Twohey, *Who Gets a Vaccine First? U.S. Considers Race in Coronavirus Plans,* N.Y. TIMES (Dec. 15, 2020), https://www.nytimes.com/2020/07/09/us/coronavirus-vaccine.html [https://perma.cc/NFD4-BQJM] (reporting endorsement of race-based prioritization by some commentators, including some members of governmental panels).

been harmed by medical research.[10] Still others complain that such prioritization is fundamentally unjust.[11]

In Part II, I provide a brief overview of current and proposed treatments for COVID-19 and identify documented or likely scarcities and disparities in access. In Part III, I explain why randomly allocating scarce medical interventions, as some have proposed, will not effectively address disparities: it both permits unnecessary deaths and concentrates those deaths among people who are more exposed to infection. In Part IV, I argue that using individual-level racial classifications in allocation policies—as several others have suggested—is precluded by current Supreme Court precedent. A more legally promising strategy would narrow racial disparities by focusing on factors other than race, or potentially by considering race at an aggregate, rather than individual, level. I also argue that policies prioritizing members of Native American tribes can succeed legally even where policies based on race would not. In Part V, I propose two complementary strategies to narrow racial disparities. One would prioritize individuals who live in disadvantaged geographic areas or work in hard-hit occupations, potentially alongside race-sensitive aggregate metrics like neighborhood segregation. These approaches, like the policies school districts adopted after the Supreme Court rejected individualized racial classifications in education,[12] would narrow disparities without classifying individual recipients by race. The other approach would address stark disparities in early deaths by limiting the use of policies that distribute preventative treatments like vaccines only to people older than a specified age, and by considering the use of policies for the allocation of critical care resources that prioritize the prevention of early deaths.

While this Article focuses on access to scarce treatments during the COVID-19 pandemic, similar disparities have existed for other scarce treatments and during other public health emergencies, from Hurricane Katrina back to

10. 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/PC88-NCH6] (reporting statement of Georges Benjamin, the executive director of the American Public Health Association, that "fast-tracking vaccine access solely by race and ethnicity could be 'stigmatizing' and might not result in the right groups being prioritized.").

11. *E.g.*, David E. Bernstein, *Two Decades Ago, the FDA and NIH Mandated the Use of Race to Categorize Subjects and Report Results in Medical and Scientific Research They Oversee. It Was a Huge Mistake*, YALE J. ON REGUL.: NOTICE & COMMENT (July 27, 2020), https://www.yalejreg.com/nc/two-decades-ago-the-fda-and-nih-mandated-the-use-of-race-to-categorize-subjects-and-report-results-in-medical-and-scientific-research-they-oversee-it-was-a-huge-mistake-by-david-e-bernstein/ [https://perma.cc/AB94-NVZ7] ("Distributing an essential medical product based on unscientific, arbitrary categories raises even more troubling questions than does the more general question of using race in medical research and clinical practice, and should be dismissed out of hand if for no other reason than the government has no scientific or other reasonable basis for determining who qualifies as African American or Hispanic/Latino"); Betsy McCaughey, *The Lunatic Drive for Racial Quotas for COVID-19 Vaccines*, N.Y. POST: OP. (July 16, 2020, 7:38 PM), https://nypost.com/2020/07/16/the-lunatic-drive-for-racial-quotas-for-covid-19-vaccines [https://perma.cc/4YZF-U35X].

12. Jennifer S. Hendricks, *Contingent Equal Protection: Reaching for Equality After Ricci and PICS*, 16 MICH. J. GENDER & L. 397, 414 (2010); *see* JODY FEDER, CONG. RSCH. SERV., RL30410, AFFIRMATIVE ACTION AND DIVERSITY IN PUBLIC EDUCATION: LEGAL DEVELOPMENTS 1 (2012).

smallpox epidemics in the 1860s and even earlier.[13] Realistically, without system-level efforts to address background inequity, these disparities are likely to characterize future pandemics and public health emergencies as well. Therefore, this Article is unfortunately likely to remain relevant beyond the COVID-19 pandemic, and indeed as long as the burden of pandemics remains unfairly borne.

II. PREVENTING AND TREATING COVID-19

In this Part, I briefly discuss five broad types of interventions for COVID-19: vaccines, therapeutics, tests, other drugs, and equipment and personnel. I explain that a vaccine or novel treatment is certain to be scarce initially, and that equipment, personnel, tests, and other drugs have been scarce at different times and in different locations throughout the pandemic. I also identify the connections between scarcity and disparities. Readers primarily interested in the broader legal and ethical issues presented by disparity reduction efforts for scarce treatments, rather than the COVID-19 pandemic in particular, should bypass this Part and continue to Part III.

A. Vaccines

The most widely discussed intervention for COVID-19 is a vaccine. As of March 2021, three vaccines have been approved in the United States, with others in clinical trials.[14] Even before these approvals, policymakers recognized that a vaccine is certain to be scarce initially.[15] For a vaccine to bring COVID-19 under control in the United States, it is estimated that more than more than 450 million doses might be needed.[16] This estimate is based on experts' assumption that two doses of a vaccine will be needed, and that stopping epidemic viral transmission will require at least 70% of individuals being vaccinated.[17]

Current vaccine scarcity has been accompanied by widespread and documented disparities.[18] While some of these disparities may reflect differential vaccine hesitancy, their magnitude goes beyond what can be explained by hesitancy alone.[19] Instead, it reflects both differential access to online signup processes and

13. *See* Jim Downs, *The Epidemics America Got Wrong,* ATL. (Mar. 22, 2020), https://www.theatlantic.com/ideas/archive/2020/03/role-apathy-epidemics/608527/ [https://perma.cc/Y3ND-XY6R]; Sandra Crouse Quinn, *Hurricane Katrina: A Social and Public Health Disaster*, 96 AM. J. PUB. HEALTH 204, 204 (2006).

14. *Different Vaccines*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 4, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html [https://perma.cc/XAW9-B8RP.]

15. Twohey, *supra* note 9.

16. TOPHER SPIRO & ZEKE EMANUEL, CTR. FOR AM. PROGRESS, A COMPREHENSIVE COVID-19 VACCINE PLAN 1 (2020).

17. *Id.*

18. Nambi Ndugga, Olivia Pham, Latoya Hill, Samantha Artiga & Salem Mengistu, *Early State Vaccination Data Raise Warning Flags for Racial Equity*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/policy-watch/early-state-vaccination-data-raise-warning-flags-racial-equity/ [https://perma.cc/8WB9-R3MR].

19. Tucker Doherty & Joanne Kenan, *Just 5 Percent of Vaccinations Have Gone to Black Americans Despite Equity Efforts*, POLITICO (Feb. 1, 2021, 7:55 PM), https://www.politico.com/news/2021/02/01/covid-vaccine-racial-disparities-464387 [https://perma.cc/ZM2N-URTB].

physical distribution sites, and prioritization rules that fail to address disparities and sometimes exacerbate them.[20]

B. Antibodies and Antiviral Drugs

A variety of antiviral treatments are under consideration as potential treatments for COVID-19.[21] Many were "re-purposed": they were initially developed for the treatment of another disease but have shown promise in treating COVID-19.[22] One effective antiviral, remdesivir, was initially in severe shortage, with doses being distributed to hospitals that could not use it effectively while areas with shortages went without the drug.[23] Several hospitals and health systems attempted to design protocols for fairly allocating remdesivir that take disadvantage into account.[24] Monoclonal antibody infusions, another authorized intervention for COVID-19 patients, have similarly been scarce, with some states making efforts to address disparities in distribution.[25]

C. Other Drugs

Other interventions prevent complications related to immune system overreaction or other issues, rather than directly targeting the virus.[26] The most prominently discussed treatment of this type is the steroid dexamethasone, which showed efficacy in severely ill COVID-19 patients in a large, randomized trial in the United Kingdom.[27] Concerns about scarcity have been raised for these interventions as well.[28]

20. *Id.*

21. *Coronavirus Treatment Acceleration Program (CTAP)*, U.S. FOOD & DRUG ADMIN., https://www.fda.gov/drugs/coronavirus-covid-19-drugs/coronavirus-treatment-acceleration-program-ctap (Dec. 31, 2020) [https://perma.cc/E9LF-SMK9].

22. Laura Riva et al., *Discovery of SARS-CoV-2 Antiviral Drugs Through Large-scale Compound Repurposing*, 102 NATURE 113, 113 (2020).

23. Yasmeen Abutaleb, Josh Dawsey, Lena H. Sun & Laurie McGinley, *Administration Initially Dispensed Scarce Covid-19 Drug to Some Hospitals That Didn't Need It*, WASH. POST (May 28, 2020, 4:46 PM), https://www.washingtonpost.com/health/2020/05/28/remdesivir-coronavirus-trump/ [https://perma.cc/7G32-48RH]; Zachary Brennan, *Frustrated Doctors Push Administration to Reveal which Hospitals Are Getting Remdesivir–And Why*, POLITICO (May 8, 2020, 12:03 PM), https://www.politico.com/news/2020/05/07/trump-administration-remdesivir-hospitals-243833 [https://perma.cc/B46X-VCXF].

24. Parker Crutchfield, Tyler S. Gibb, Michael J. Redinger & William Fales, *Ethical Allocation of Remdesivir*, 20 AM. J. BIOETHICS 84, 84–85 (2020); DOUGLAS B. WHITE ET AL., MODEL HOSPITAL POLICY FOR FAIR ALLOCATION OF SCARCE MEDICATIONS TO TREAT COVID-19, at 1 (2020).

25. Donald Berwick et al., *Rapid Expert Consultation on Allocating Covid-19 Monoclonal Antibody Therapies and Other Novel Therapeutics*, NAT'L ACAD. OF. SCI. 11 (2019), https://www.nap.edu/read/26063/chapter/1 [https://perma.cc/63NZ-E49R].

26. *Coronavirus Treatment Acceleration Program (CTAP)*, *supra* note 21 ("Immunomodulators . . . aimed at tamping down the body's own immune reaction to the virus, in cases where the body's reaction basically goes overboard and starts attacking the patient's own organs").

27. Dian Zhang, *Demand for Dexamethasone Rises After Study Finds COVID-19 Benefits, FDA Data Shows*, USA TODAY (July 2, 2020, 7:09 AM), https://www.usatoday.com/story/news/2020/07/02/coronavirus-drug-cheap-steroid-shortage-after-increased-demand/5355016002/ [https://perma.cc/JTP4-UWAW].

28. *Id.*; Heidi Ledford, *Dozens of Coronavirus Drugs Are in Development –What Happens Next?*, NATURE (May 14, 2020), https://www.nature.com/articles/d41586-020-01367-9 [https://perma.cc/B9C3-EA2G].

D. Testing

Access to COVID-19 testing is crucial because it can allow individuals to identify whether they are infected and enable them to seek treatment earlier or to quarantine to prevent infection. In the U.S., testing has been persistently scarce due to an inadequate federal response.[29] Racial disparities in testing are documented.[30]

E. Equipment and Personnel

Last, many prominent discussions around scarcity have focused on medical equipment for treating COVID-19, such as ventilators and ICU beds.[31] Scarcity is also possible for the personnel needed to provide technically complex intensive care and to operate ventilators.[32] Equipment needed to treat the complications of COVID-19, such as dialysis machines, has also been scarce.[33] While the need to ration emergency equipment has rarely been present, with supplies generally sufficient to meet needs, scarcity has occurred in COVID-19 hotspots at times during the pandemic.[34] This scarcity has not been equally distributed: the areas where scarcity has occurred, like Southern California, New York City, and the Rio Grande Valley in Texas, have frequently been ones with high proportions of minority residents.[35]

29. Sarah Mervosh & Manny Fernandez, *Months into Virus Crisis, U.S. Cities Still Lack Testing Capacity*, N.Y. TIMES (July 15, 2020), https://www.nytimes.com/2020/07/06/us/coronavirus-test-shortage.html [https://perma.cc/NQ9M-KFMN]; Michael D. Shear et al., *The Lost Month: How a Failure to Test Blinded the U.S. to Covid-19*, N.Y. TIMES (Apr. 1, 2020), https://www.nytimes.com/2020/03/28/us/testing-coronavirus-pandemic.html [https://perma.cc/65CS-RWFM]; Jennifer B. Nuzzo & Emily N. Pond, *Covid Vaccines Aren't Enough. We Need More Tests.*, N.Y. TIMES (Mar. 12, 2021), https://www.nytimes.com/2021/03/12/opinion/need-covid-tests.html [https://perma.cc/MF2X-MB4C].

30. Soo Rin Kim, Matthew Vann, Laura Bronner & Grace Manthey, *Which Cities Have the Biggest Racial Gaps in COVID-19 Testing Access*, ABCNEWS: FIVETHIRTYEIGHT (July 22, 2020), https://fivethirtyeight.com/features/white-neighborhoods-have-more-access-to-covid-19-testing-sites/ [https://perma.cc/G9SG-HRSV].

31. White & Lo, *supra* note 7, at 1; *see also* Ezekiel J. Emanuel et al., *Fair Allocation of Scarce Medical Resources in the Time of Covid-19*, 382 NEW ENG. J. MED. 2049, 2052–54 (2020).

32. Emanuel et al., *supra* note 31, at 2050 ("The limiting factor for ventilator use will most likely not be ventilators but healthy respiratory therapists and trained critical care staff to operate them safely over three shifts every day.").

33. Fred Mogul, *Shortage of Dialysis Equipment Leads to Difficult Decisions in New York ICUs*, NPR (Apr. 19, 2020, 6:54 PM), https://www.npr.org/sections/health-shots/2020/04/19/838103327/shortage-of-dialysis-equipment-leads-to-difficult-decisions-in-new-york-icus [https://perma.cc/AMG6-DRW5]; Leila Fadel, *'The Separate and Unequal Health System' Highlighted by COVID*-19, NPR (Jan. 21, 2021, 4:27PM).

34. Mogul, *supra* note 33; Tia Powell & Elizabeth Chuang, *COVID in NYC: What We Could Do Better*, 20 AM. J. BIOETHICS 62, 62–63 (2020).

35. *See e.g.,* Powell & Chuang, *supra* note 34, at 63; Sarah R. Champagne, *Ten out of the 12 Hospitals in Texas' Rio Grande Valley Are Now Full*, TEX. TRIB. (July 4, 2020, 6:00 PM), https://www.texastribune.org/2020/07/04/texas-coronavirus-rio-grande-valley-hospitals/ [https://perma.cc/9UAY-PEXK]; Matthew Hildago, Jiyun Lim & Henry Kwang, *Opinion: The Pandemic Devastated the Rio Grande Valley. We Must Take Action Now Before Flu Season*, HOUS. CHRON. (Oct. 7, 2020, 3:00 PM), https://www.houstonchronicle.com/opinion/outlook/article/Opinion-The-pandemic-devastated-the-Rio-Grande-15626145.php [https://perma.cc/WMG8-8L8P] (noting that more than 90% of the Rio Grande Valley hospitals' patients are Hispanic); Leila Fadel, *supra* note 33 (discussing disparate impact of COVID-19 on low-income, minority COVID-19 patients).

III. THE NORMATIVE INADEQUACY OF RANDOM ALLOCATION

The combination of scarce resources and disparate outcomes has motivated substantial discussion about the fair allocation of interventions. In this Part, I consider how proposals to allocate scarce interventions randomly among individuals, without consideration of who is likely to benefit, would affect disparities. Some commentators have argued that random allocation is ethically required in order to avoid exacerbating disparities.[36] Others, including prominent legal academics, regard random allocation as reasonable, though not required.[37] Both staunch defenders of random allocation and those who regard it as a reasonable option believe that an allocation policy that treats everyone identically has the virtue of not exacerbating preexisting disadvantages.[38] In Section III.A, I explain that random allocation is both inconsistent with public health and unnecessary to disparity reduction. In Section III.B, I explain that random allocation is likely to be not only unnecessary but counterproductive to disparity reduction.

A. Random Allocation Costs Lives and Jeopardizes Public Health

Randomly allocating scarce treatments undermines a core value of the pandemic response: preventing deaths.[39] Pandemic response policies, such as closing schools or postponing elective medical procedures, uniformly reject a normative commitment that undergirds many defenses of random allocation: that we should be indifferent between preventing one death and preventing many more.[40] Instead, these policies aim to prevent more deaths rather than fewer, reflecting our commitment to the significance of each life.[41] Perhaps for this reason, community surveys generally reject purely random allocation.[42]

36. Diego S. Silva, *Ventilators by Lottery: The Least Unjust Form of Allocation in the Coronavirus Disease 2019 Pandemic*, 158 CHEST 890, 891 (2020); *see also* John Harris, *Why Kill the Cabin Boy?*, 30 CAMBRIDGE Q. OF HEALTHCARE ETHICS 4 (2020).

37. Samuel R. Bagenstos, *Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols*, 130 YALE L.J.F. 1, 18–20 (2020); Camara Phyllis Jones, *Coronavirus Disease Discriminates. Our Health Care Doesn't Have To*, NEWSWEEK MAG. (Apr. 7, 2020, 7:00 AM), https://www.newsweek.com/2020/04/24/coronavirus-disease-discriminates-our-health-care-doesnt-have-opinion-1496405.html [https://perma.cc/M2KA-9V4B]; Scott Hershovitz, *You Can Save One Person or Five. But Not All Six.*, N.Y. TIMES (May 7, 2020), https://www.nytimes.com/2020/05/07/opinion/coronavirus-rationing-dialysis-ventilator.html [https://perma.cc/82DZ-LVLU].

38. *See supra* notes 36–37.

39. *See* Govind Persad, *Disability Law and the Case for Evidence-Based Triage in a Pandemic*, 130 YALE L.J.F. 26, 44 (2020) (arguing that random allocation "not only leads to more deaths but concentrates those deaths among those likelier to contract COVID-19"); Hershovitz, *supra* note 37.

40. *See* Hershovitz, *supra* note 37 (summarizing the work of the philosopher John Taurek).

41. *See* David Wasserman, Govind Persad & Joseph Millum, *Setting Priorities Fairly in Response to Covid-19: Identifying Overlapping Consensus and Reasonable Disagreement*, 7 J.L. & BIOSCIENCES 1, 12 (2020).

42. Monica Schoch-Spana et al., *Influence of Community and Culture in the Ethical Allocation of Scarce Medical Resources in a Pandemic Situation: Deliberative Democracy Study*, 12 J. PARTICIPATORY MED. 1, 7–8 (2020); Simmy Grover, Alastair McClelland & Adrian Furnham, *Preferences for Scarce Medical Resource Allocation: Differences Between Experts and the General Public and Implications for the COVID-19 Pandemic*, 25 BRITISH J. HEALTH PSYCH. 889, 893 (2020).

Some have advocated allocation that, while not strictly random, ignores meaningful differences in prospect of benefit, even at the expense of letting more people die. Lynette Reid, for instance, claims that "differences in probabilities of survival must be substantial to override a fundamental commitment to human equality," and argues that "[w]e should modify critical care resource triage on the basis of considerations of justice, even at the cost of saving fewer lives."[43] Hannah McLane similarly argues that "There is nothing 'correct' about the 'save the most lives' argument; it is just one of many ethically defensible options and need not be followed rigidly."[44] Angela Ballantyne asserts that "[w]e can save more lives or . . . a more diverse group of lives."[45]

These proposals all acquiesce prematurely in the imagined trade-off between preventing deaths and reducing disparities. Disparity-reduction efforts in other contexts—such as education and employment—do not typically prioritize those disadvantaged individuals who are less likely to benefit from access to limited resources or opportunities, even if their lower likelihood of benefit stems from background injustice.[46] Instead, they prioritize disadvantaged individuals who are likely to benefit from those resources or opportunities.[47] By doing so, they reduce disparities while effectively using limited resources.

Importantly, those who can gain most from interventions—as opposed to those most likely to survive the hazards of the pandemic—are not typically the healthiest or most advantaged.[48] While Ballantyne claims that "[t]he easy lives to save will be those of people who already enjoy social privilege,"[49] even an allocation approach that emphasizes maximizing benefits would provide treatments where they can most improve outcomes, not provide them to people who, while likely to have good outcomes with treatment, would also have good outcomes without it.[50] The people who can gain most from access to treatment are likely to be those who are exposed to illness and infection by social disadvantage, rather than healthy people who can work from home. For instance, a vaccine or pre-exposure prophylactic is likely to have particular benefits for people who are

43. Lynette Reid, *Triage of Critical Care Resources In COVID-19: A Stronger Role for Justice*, 46 J. MED. ETHICS 526, 528–29 (2020) ("We should modify critical care resource triage on the basis of considerations of justice, even at the cost of saving fewer lives. . . . [D]ifferences in probabilities of survival must be substantial to override a fundamental commitment to human equality,"); *see also* Bagenstos, *supra* note 37, at 4.

44. Hannah McLane*, A Disturbing Medical Consensus Is Growing. Here's What It Could Mean for Black Patients with Coronavirus*, WHYY (Apr. 10, 2020), https://whyy.org/articles/a-disturbing-medical-consensus-is-growing-heres-what-it-could-mean-for-black-patients-with-coronavirus [https://perma.cc/GJ7X-BEQG]; *see also* Emily Cleveland Manchanda, Cheri Couillard & Karthik Sivashanker, *Inequity in Crisis Standards of Care*, 383 NEW ENG. J. MED. e16(1), e16(2) (2020).

45. Angela Ballantyne, *ICU Triage: How Many Lives or Whose Lives?*, J. MED. ETHICS: BLOG (Apr. 7, 2020), https://blogs.bmj.com/medical-ethics/2020/04/07/icu-triage-how-many-lives-or-whose-lives/ [https://perma.cc/UWE5-YCXT].

46. *See* Drew S. Days, III, *Reality*, 31 SAN DIEGO L. REV. 169, 192 (1994); Michel Rosenfeld, *Affirmative Action, Justice, and Equalities: A Philosophical and Constitutional Appraisal*, 46 OHIO ST. L.J. 845, 907 (1985).

47. Ballantyne, *supra* note 45.

48. *See id.*

49. *Id.*

50. Emanuel et al., *supra* note 31, at 2052 ("[P]eople who are sick but could recover if treated are given priority over those who are unlikely to recover even if treated and those who are likely to recover without treatment.").

likely to become more seriously ill if infected or who, for housing or occupational reasons, cannot avoid infection through social distancing.[51]

Proposals to distribute treatments without regard—or with limited regard—to their effects erroneously allow the superficially equitable distribution of medical treatment, a mere means, to take priority over the ultimate goal of equitably preventing illness and death.[52] An equitable response to a pandemic should not aim to symbolically provide scarce treatments to people who are disadvantaged irrespective of whether those treatments save lives, but to use those treatments to save lives in disadvantaged communities, which requires going beyond benefit-insensitive randomization. The flaws of randomization are especially clear for vaccines and pre-exposure prophylaxis, which, when effectively deployed, benefit individuals beyond immediate recipients by reducing disease transmission.[53]

B. Random Allocation Can Further Entrench Disparities

Random allocation is not only unnecessary for disparity reduction but also often further entrenches disparities, because it fails to respond to the nonrandom distribution of infection.[54] Randomly allocating vaccines or treatments therefore leaves the risk of death unjustly aligned with the risk of infection.[55] While random allocation achieves superficially equal treatment, it confuses sameness with equity.

Ultimately, while random allocation seductively promises to avoid legal entanglement by refusing to explicitly prioritize one patient over another,[56] it should be recognized as an unacceptable form of public health "defensive medicine" insofar as it pointlessly eschews opportunities to both save lives and reduce disparities.[57] An allocation policy that distributes scarce treatments randomly is, at the population level, like a physician who chooses random selection over individualized diagnosis. Perhaps reflecting this analogy, laypeople reject random allocation in part because it disregards the significance of the decision at hand.[58] This inadequacy of random allocation also makes it legally vulnerable because it fails to consider potential recipients as individuals.[59]

51. *See id.* at 2053.

52. *Cf.* Talha Syed, *Educational Accommodation and Distributive Equity: The Principle of Proportionate Progress*, 50 CONN. L. REV. 485, 546 (2018) (criticizing views that "'fetishiz[e]' generic external means independent of what they can actually do for specific persons").

53. Adrianna Rodriguez & Karen Weintraub, *'Really Exciting News': Pfizer Vaccine Appears Effective Against Asymptomatic COVID-19 Cases, Data from Israel Suggests,* USA TODAY (Mar. 12, 20201, 7:37 AM), https://www.usatoday.com/story/news/health/2021/03/12/pfizer-covid-vaccine-works-against-asymptomatic-spread-data-suggests/4645698001/ [https://perma.cc/SK62-EXYG].

54. *See* Harald Schmidt, *Vaccine Rationing and the Urgency of Social Justice in the Covid-19 Response*, 50 HASTINGS CTR. REP. 46, 47 (2020).

55. Persad, *supra* note 39, at 44.

56. Harris, *supra* note 36, at 4.

57. *See, e.g.*, Ballantyne, *supra* note 45.

58. Schoch-Spana et al., *supra* note 42, at 7 ("On a moral and religious aspect we'd be leaving everything to luck. Like, are you going to leave life to luck? Are we going to play bingo with my life?").

59. *See* Persad, *supra* note 39, at 32 n.25.

IV. THE LAW'S LIMITS ON RACIAL DISPARITY ALLEVIATION

Rather than ignoring race, as randomization advocates would, some have instead argued that race should be explicitly included in prioritization. These arguments have been advanced by legal scholars,[60] influential policy advocates,[61] ethicists,[62] and physicians and scientists.[63] Concretely, some have suggested assigning race-based "points" to individual patients as part of ventilator prioritization,[64] or lowering vaccine eligibility ages for individuals of specific races.[65] Others have suggested empowering physicians to preferentially allocate scarce resources to individual patients whom the physicians believe have experienced discrimination.[66] More recently, some commenters on the National Academies of Sciences, Engineering, and Medicine ("NASEM") draft COVID-19 vaccine allocation guidance, including prominent physicians and ethicists, argued for the use of individual race in allocation.[67] Despite these entreaties, NASEM's framework ultimately avoided allocation approaches that classified recipients by race,

60. Twohey, *supra* note 9 (reporting statement of legal scholar Dayna Bowen Matthew, who has consulted on vaccine allocation prioritization, that racial inequality "requires us to prioritize by race and ethnicity").

61. Jamie Ducharme, *Melinda Gates Lays Out Her Biggest Concern for the Next Phase of the COVID-19 Pandemic*, TIME (June 4, 2020, 11:30 AM), https://time.com/5847483/melinda-gates-covid-19/ [https://perma.cc/2JY9-F55G]; Helen Branswell, *Confusion Spreads Over System to Determine Priority Access to Covid-19 Vaccines*, STAT (July 22, 2020), https://www.statnews.com/2020/07/22/confusion-spreads-over-system-to-determine-priority-access-to-covid-19-vaccines/ [https://perma.cc/F7TU-QWA9] (reporting support by at least one member of CDC-designated committee for consideration of racial prioritization).

62. Nneka Sederstrom, *The "Give Back": Is There Room For It?*, BIOETHICS.NET (July 16, 2020, 4:33 PM), http://www.bioethics.net/2020/07/the-give-back-is-there-room-for-it/ [https://perma.cc/4D83-EGHT]; *see also* Katie Pearce, *Distributing a COVID-19 Vaccine Raises Complex Ethical Issues*, JOHNS HOPKINS UNIV.: HUB (July 1, 2020), https://hub.jhu.edu/2020/07/01/covid-vaccine-ethics-faden/ [https://perma.cc/5ZCR-BVMG] ("There is an important conversation to be had about whether, as a part of the much overdue racial reckoning in the U.S., we should consider putting people of color high on the list for vaccine priority in the early days.").

63. Twohey, *supra* note 9 (reporting statements by scientists Jose Romero and Sharon Frey); Manchanda et al., *supra* note 44, at e16(2) (advocating "[i]nclusion . . . of race- or ability-based adjustments"); Uché Blackstock & Oni Blackstock, *Opinion: White Americans are Being Vaccinated at Higher Rates than Black Americans. Such Inequity Cannot Stand,* WASH. POST. (Feb. 1, 2021, 4:15 PM), https://www.washingtonpost.com/opinions/2021/02/01/racial-inequality-covid-vaccine/ [https://perma.cc/85TR-AFG4] ("Black people must be explicitly prioritized for the covid-19 vaccine. Despite the disproportionate impact of the pandemic on Black Americans, the Centers for Disease Control and Prevention has not explicitly used race and ethnicity as a criterion to delineate vaccine priority groups").

64. Sederstrom, *supra* note 62; *see* Harald Schmidt, *The Way We Ration Ventilators Is Biased*, N.Y. TIMES: OP. (Apr. 15, 2020), https://www.nytimes.com/2020/04/15/opinion/covid-ventilator-rationing-blacks.html [https://perma.cc/GE37-A5SC].

65. Oni Blackstock & Uché Blackstock, *Opinion: Black Americans Should Face Lower Age Cutoffs to Qualify for a Vaccine*, WASH. POST. (Feb. 19, 2021, 4:51 PM), https://www.washingtonpost.com/opinions/black-americans-should-face-lower-age-cutoffs-to-qualify-for-a-vaccine/2021/02/19/3029d5de-72ec-11eb-b8a9-b9467510f0fe_story.html [https://perma.cc/M9CP-REZ2]

66. McLane, *supra* note 44 ("Our patient coming in needing a ventilator may have co-morbidities because she has already lived a life of deprivation and discrimination. It might be worth giving her more resources now, precisely because she has received less resources in the past. It is a form of affirmative action of medical resources, if you will. Physicians need to know that if they choose to give the ventilator to the Black woman–or if our guidelines provided to them reflect this value – there is an ethical argument to defend this choice.").

67. Tung Nguyen, Asian American Research Center on Health, *Comment to NAM Framework*, NAT'L ACADS. PRESS (Sept. 3, 2020, 1:36 AM), https://www.nap.edu/xvac/print.php?id=549 [https://perma.cc/4SX7-H3W7] (arguing that NASEM should "consider adding race/ethnicity as a qualifier in the determination of who

in part due to the concern that "such an allocation could be legally challenged."[68] An Oregon advisory committee similarly considered COVID-19 vaccine allocation based on individual race but rejected it for legal reasons.[69] Vermont's, Montana's, and Utah's criteria, however, still appear to contemplate using individual race,[70] and calls for similar approaches continue elsewhere.[71] And specific institutions have used individual race as an eligibility criterion for clinical trials of

gets the vaccine"); Denise Dudzinski, Chair of the Department of Bioethics & Humanities, UW School of Medicine (Seattle), *Comment to NAM Framework*, NAT'L ACADS. PRESS, (Sept. 4, 2020, 6:51 PM), https://www.nap.edu/xvac/print.php?id=1251 [https://perma.cc/9BFU-XVAH] ("Black, Hispanic, and [American Indian/Alaska Native] people, including [health care workers], should be prioritized over white [health care workers] and [first responders]"); Kristine McVea, *Comment to NAM Framework*, NAT'L ACADS. PRESS (Sept. 4, 2020. 4:47 PM), https://www.nap.edu/xvac/print.php?id=1165 [https://perma.cc/J4G6-6VVW] (asserting that it is "extremely important that racial and ethnic minorities be explicitly prioritized to receive the first waves of vaccine" and criticizing the NAM's draft for failing to "clearly state that race and ethnicity be considered for priority vaccination").

68. HELENE GAYLE, WILLIAM FOEGE, LISA BROWN & BENJAMIN KAHN, FRAMEWORK FOR EQUITABLE ALLOCATION OF COVID-19 VACCINE 133 (Nat'l Acads. Press 2020) [hereinafter NASEM Framework]; *see also* Sigal Samuel, *Should People of Color Get Access to the Covid-19 Vaccine Before Others?*, VOX (Oct. 28, 2020, 10:50 AM), https://www.vox.com/future-perfect/2020/10/2/21493933/covid-19-vaccine-black-latino-priority-access [https://perma.cc/M5AT-N4U8] (reporting statement of Helene Gayle, NASEM co-chair, that "[t]here's real concern about whether there would be legal challenges to something that is race-specific," and that "[i]n our laws, there are ways in which you can and cannot specifically address a racial group to give them preference. It could very well be challenged if we had a race-specific vaccine strategy. That could end up tying things up in legal considerations.").

69. Fedor Zarkhin, *Coronavirus Vaccine Equity Group Whittles Recommendations to About Half of Oregonians amid First Signs of Tension*, OREGONIAN, (Jan. 21, 2021), https://www.oregonlive.com/coronavirus/2021/01/coronavirus-vaccine-equity-group-whittles-recommendations-to-about-half-of-oregonians-amid-first-signs-of-tension.html [https://perma.cc/M86K-9U8A] (describing Oregon's plan); Galen Ettlin, *Oregon Vaccine Committee Adjusts Tentative Priority Recommendations*, OREGONIAN (Jan. 22, 2021, 6:46 PM), https://www.kgw.com/article/news/health/coronavirus/vaccine/oregon-vaccine-committee-adjusts-tentative-priority-recommendations/283-5e172387-5c01-4b84-87fe-764ffbf2d4b9 [https://perma.cc/Q8QX-N8LW] ("Some members raised the question of legality in designating certain races for vaccination priority. . . . the committee's tentative idea was submitted to the Department of Justice for legal review."); Fedor Zarkhin, *Legal and Practical Barriers Stymie Oregon Vaccine Equity Group Mission to Fight 'Structural Racism'*, OREGONLIVE (Jan. 28, 2021), https://www.oregonlive.com/coronavirus/2021/01/legal-and-practical-barriers-stymie-oregon-vaccine-equity-group-mission-to-fight-structural-racism.html [https://perma.cc/5GKW-VE4U] ("We're not able to prioritize services or make decisions based on services solely on somebody's race or ethnicity").

70. *Getting the COVID-19 Vaccine,* VT. DEP'T OF HEALTH (Apr. 5, 2021), https://www.healthvermont.gov/covid-19/vaccine/getting-covid-19-vaccine [https://perma.cc/5CVQ-JDEC] ("If you or anyone in your household identifies as Black, Indigenous, or a person of color (BIPOD), including anyone with Abenaki or other First Nations heritage, all household members who are 16 years or older can sign up to get a vaccine."); Marissa Perry & Jon Ebelt, *Governor Bullock Releases Updated COVID-19 Vaccination Distribution Plan*, MONT. DEP'T OF PUB. HEALTH & HUM. SERVS. (Dec. 30, 2020), https://dphhs.mt.gov/aboutus/news/2020/covid-19vaccinationdistributionplan [https://perma.cc/UH5G-ASGS]; *see also* 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/8KSZ-CZQX] ("Montana and Utah include people of color in their initial vaccine priority groups. With Montana vaccinating American Indians and people of color who may be at elevated risk for COVID-19 complications in Phase 1b, and Utah including people living in Tribal reservation communities and racial/ethnic groups at increased risk in Phase 1c.")

71. *E.g.*, Press Release, Montgomery County Council, *Council Sends Letter to Governor Hogan Focused on the Racial Inequities in Vaccine Distribution and Pre-Registration* (Mar. 4, 2021), https://www2.montgomerycountymd.gov/mcgportalapps/Press_Detail.aspx?Item_ID=33847&Dept=1 [https://perma.cc/H5BL-YMB2] ("It is clear that our vaccine registration systems must immediately be revised to include a prioritization based on race and ethnicity"); Adrienne Robbins, *Urban League calls for State to Expedite COVID-19 Vaccines for*

COVID-19 treatments,[72] for COVID-19 vaccine receipt,[73] and for testing and priority access to COVID-19 vaccines.[74] As this Part will explain, these uses or planned uses of individual race in medical resource allocation are legally distinct from, and much more vulnerable than, policies aiming to increase vaccine access at the community level in minority communities through targeted outreach, delivery of additional doses, or geographic priority. The distinction concerns the difference between individual and community-based allocation, not—as commonly stated—the difference between "explicit" and subterranean priorities. Some states and organizations, however, have described disparity-alleviating aspects of their prioritization process ambiguously, increasing the prospect of legal challenges.

Any policy, of course, can be legally challenged. What matters is a question NASEM sidestepped: how would a legal challenge to race-based allocation policies be resolved? This Part examines how, under present jurisprudence, the Supreme Court and lower courts are likely to view race-based allocation policies for scarce treatments. Because this Part's focus is predictive—to understand how

Black Community (Feb. 23, 2021, 5:45 PM). https://www.nbc4i.com/community/health/coronavirus/urban-league-calls-for-state-to-expedite-covid-19-vaccines-for-black-community/ [https://perma.cc/GBP4-K7NF] (describing Ohio Council of Urban Leagues' request to Gov. Mike DeWine "to prioritize Black Ohioans, who have been disproportionately impacted by COVID-19 complications and deaths, for COVID-19 vaccination distribution" and to "[lower] the age required for African Americans to receive the vaccine to 50 years old"); Renee Baskerville, *We Should Prioritize Black, Brown, Indigenous People for Vaccines (Town Square),* MONTCLAIR LOCAL (Mar. 4, 2021), https://www.montclairlocal.news/2021/03/04/we-should-prioritize-black-brown-indigenous-people-for-vaccines-town-square/ [https://perma.cc/7ZRY-GE55] ("New Jersey and Montclair must recognize race and ethnicity as high-risk factors, and appropriately prioritize Black, brown and Indigenous people for vaccinations."); Katy Backes Kozhimannil, Mariana Tuttle & Carrie Henning-Smith, *The Heaviest COVID Burden Afflicts Rural People of Color*, STARTRIBUNE (Mar. 1, 2021, 5:13 PM), https://www.startribune.com/the-heaviest-covid-burden-afflicts-rural-people-of-color/600029098/?refresh=true [https://perma.cc/EC67-XGF7] ("We are disappointed, for example, to see that the recently released vaccination plan for Minnesota did not prioritize BIPOC individuals for COVID-19 vaccination. This is a missed opportunity, and could still be corrected using data and input from rural BIPOC Minnesotans").

72. *STOP COVID Trial*, Wash. Univ. Sch. of Med., https://stopcovidtrial.wustl.edu/ (last visited Mar. 23, 2021) [https://perma.cc/PG9V-E5PW] (stating that participants may be eligible if they have "at least one of the following risk factors for developing serious COVID-19," including being "African-American, Hispanic/Latino, Native American").

73. Ethan Bakuli, *Registration for Vermont BIPOC Vaccination Clinic Fills Within 24 Hours*, BURLINGTON FREE PRESS (Mar. 17, 2021, 11:17 AM), https://www.burlingtonfreepress.com/story/news/2021/03/17/vermont-begins-registration-bipoc-vaccination-clinics/4731828001/ [https://perma.cc/YDZ4-LVPT] ("Black, Indigenous and other people of color who fall within statewide vaccination eligibility guidelines can register for appointments at these clinics "); *COVID-19 Vaccination Event for BIPOC Community Members Living in North King County,* SHORELINE AREA NEWS (Mar. 2, 2021), https://www.shorelineareanews.com/2021/03/covid-19-vaccination-event-for-bipoc.html [https://perma.cc/QZ9L-KWWS] ("This COVID-19 vaccination event is focused only on BIPOC (Black, Indigenous, People of Color) communities that have been more impacted by the pandemic.").

74. *COVID-19 Vaccines*, OR. HEALTH & SCI. UNIV., https://www.ohsu.edu/health/covid-19-vaccines (last visited Feb. 7, 2021) [https://perma.cc/K66P-7G7B] (stating that, among "health care workers most at risk of being exposed to the coronavirus," the vaccination process is putting a high priority, among those workers, on, *inter alia*, "[t]hose who identify as part of the BIPOC (Black, Indigenous and people of color) community"); *OHSU Coronavirus (COVID-19) Response*, OR. HEALTH & SCI. UNIV., https://news.ohsu.edu/2021/01/15/preparing-for-the-novel-coronavirus-at-ohsu (Feb. 5, 2021) [https://perma.cc/3N8L-W49H] (stating that a person without symptoms can access COVID-19 testing if the person is "Black, African-American, Latinx, American Indian/Alaska Native, Asian, Asian-American or Pacific Islander").

courts, especially the Supreme Court, are likely to evaluate race-based allocation policies—it primarily analyzes case law and scholarship attempting to interpret or identify themes in existing doctrine, rather than pursuing a normative critique of American courts' treatment of race and equal protection.[75] It concludes that courts will almost certainly reject policies that allocate vaccines, therapeutics, or other scarce treatments on the basis of individual patients' race, regardless of whether the policies aim to address racial health disparities, to promote overall population health, or both. In contrast, policies that do not consider individuals' race, but do use facially race-neutral criteria and/or aggregate neighborhood-level racial data, have good prospects of success. So do policies that prioritize based on Native American status, either at an individual or group level.

A. Allocation Based on Individual Recipients' Race

Four broad categories of actors might implement scarce resource allocation policies: the federal government; state and local governments; federally funded institutions; and private actors not receiving federal funding. Each faces different, though often overlapping, legal prescriptions regarding the allowable use of race.[76] Although the Fourteenth Amendment's Equal Protection Clause only mentions states, current doctrine applies parallel equal protection requirements to the federal government as well.[77] Residual disagreement exists, however, regarding whether constitutional equal protection provisions grant the federal government a freer hand than state or local decisionmakers to reduce racial disparities.[78]

75. *See e.g.*, Ian Haney-López, *Intentional Blindness*, 87 N.Y.U. L. REV. 1779, 1876 (2012) ("We live today under a Fourteenth Amendment jurisprudence geared toward excluding evidence of the evolving mistreatment of non-Whites."); Mario L. Barnes & Erwin Chemerinsky, *The Once and Future Equal Protection Doctrine?*, 43 CONN. L. REV. 1059, 1076 (2011).

76. *See* Barnes & Chemerinsky, *supra* note 75, at 1079–80.

77. Adarand Constructors, Inc. v. Peña, 515 U.S. 200, 201 (1995) (collecting cases that which establish that Fourteenth Amendment equal protection analysis is also applicable to the federal government through the Fifth Amendment, and concluding that "any 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"); Grutter v. Bollinger, 539 U.S. 306, 326 (2003) (quoting Adarand) ("[A]ll racial classifications imposed by government 'must be analyzed by a reviewing court under strict scrutiny'"); United States v. Windsor, 570 U.S. 744, 774 (2013) ("The liberty protected by the Fifth Amendment's Due Process Clause contains within it the prohibition against denying to any person the equal protection of the laws.").

78. *See* Hampton v. Wong, 426 U.S. 88, 100 (1976) ("Although both [the Fifth and Fourteenth] Amendments require the same type of analysis . . . the two protections are not always coextensive."); City of Richmond v. J.A. Croson Co., 488 U.S. 469, 521–22 (1989) (Scalia, J., concurring) ("[I]t is one thing to permit racially based conduct by the Federal Government—whose legislative powers concerning matters of race were explicitly enhanced by the Fourteenth Amendment . . . and quite another to permit it by the precise entities against whose conduct in matters of race that Amendment was specifically directed"); Jana-Rock Const., Inc. v. N.Y. State Dep't of Econ. Dev., 438 F.3d 195, 209 (2d Cir. 2006) ("Congress and federal agencies have more leeway to make broader classifications—even after *Adarand* extended strict scrutiny to federal affirmative action programs—because the federal government must set policy on a national level."). *See generally* Adam Winkler, *The Federal Government as a Constitutional Niche in Affirmative Action Cases*, 54 UCLA L. REV. 1931, 1945–46 (2007).

Federally funded non-state actors using race-based classifications, meanwhile, are subject to Title VI of the Civil Rights Act of 1964.[79] Some courts have analyzed Title VI discrimination claims analogously to Equal Protection Clause claims, while others have repurposed the framework used for Title VII employment discrimination claims.[80] Federally funded health programs or facilities are also subject to Section 1557 of the Affordable Care Act, which applies Title VI's protections to these programs.[81]

In contrast, private actors receiving no governmental funding instead fall under the statutory regime laid out in 42 U.S.C. § 1981 to regulate racial discrimination in private contracts,[82] and private places of public accommodation—potentially including private hospitals—are also subject to Title II of the Civil Rights Act of 1964.[83] The Supreme Court has stated that "the prohibition against discrimination in § 1981 is co-extensive with the Equal Protection Clause."[84] This is so despite clear textual differences between the statute and the constitutional provision.[85] Several commentators have suggested that private actors who receive no federal funds are therefore, via § 1981, subject to the same limitations on the use of race that the Equal Protection Clause prescribes for governmental actors.[86] In a prominent, recent § 1981 case, however, the Ninth Circuit unanimously eschewed the Equal Protection Clause parallel: both the majority and

79. *See, e.g.*, Students for Fair Admissions, Inc. v. President & Fellows of Harv. Coll. (Harv. Corp.), 397 F. Supp. 3d 126, 189 (D. Mass. 2019); Katchur v. Thomas Jefferson Univ., 354 F. Supp. 3d 655, 668 (E.D. Pa. 2019).

80. *Compare* Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll. (Harvard Corp.), 397 F. Supp. 3d 126, 189 (D. Mass. 2019) ("[A]lthough Harvard is not a state actor, Harvard College is a component of Harvard University which receives federal funds and intentionally provides tips in its admissions process based on students' race . . . . Harvard College is therefore subject to the same standards that the Equal Protection Clause imposes upon state actors for the purposes of a Title VI claim."), *with* Davis v. Halpern, 768 F. Supp. 968, 974 (E.D.N.Y. 1991) (asserting that the "burdens of production and persuasion in a reverse discrimination case" under Title VI are analyzed using the same framework as used for Title VII).

81. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020). Whether Section 1557's protections extend beyond Title VI's remains disputed. *See, e.g.*, *id.* at 37,202 (explaining that the 2020 Final Rule, unlike prior interpretation, applies the existing enforcement mechanisms and implementing regulations for Title VI to Section 1557 race discrimination claims); *id.* at 37,203 (stating that the Department of Health and Human Services "no longer intends to take a position in its regulations on the issue of whether Section 1557 provides a private right of action"); *see also* Doe v. BlueCross BlueShield of Tenn., Inc., 926 F.3d 235, 240 (6th Cir. 2019) (concluding that, when enacting the Affordable Care Act, "Congress made plain that it prohibited discrimination in the provision of health care by incorporating and enforcing the substantive standards of liability" in statutes including Title VI, "not changing them").

82. *See, e.g.*, Doe v. Kamehameha Schs. Bernice Pauahi Bishop Est., 470 F.3d 827, 839 (9th Cir. 2006) (en banc) (explaining that Section 1981 applies to an affirmative action policy adopted by a private school that receives no federal funding).

83. *See* Crane v. Lifemark Hosp. of Fla., Inc., 149 So. 3d 718, 721 n.2 (Fla. Dist. Ct. App. 2014) (explaining that "courts are divided" as to whether hospitals are places of public accommodation for Title II purposes) (collecting cases).

84. Grutter v. Bollinger, 539 U.S. 306, 343 (2003).

85. *See* Gabriel J. Chin, *Illegal Entry as Crime, Deportation as Punishment: Immigration Status and the Criminal Process*, 58 UCLA L. REV. 1417, 1444 n.165 (2011) ("Notwithstanding its plain language . . . the Court has held that §1981 is coextensive with the Equal Protection Clause.").

86. Charles E. Daye, A. T. Panter, Walter R. Allen & Linda F. Wightman, *Does Race Matter in Educational Diversity? A Legal and Empirical Analysis*, 13 RUTGERS RACE & L. REV. *75-S, *82-S n.12 (2012) ("The

main dissent used a modified Title VII analysis, while another dissent rejected the Equal Protection Clause parallel without clearly presenting an alternative.[87] One judge also suggested that disparity reduction efforts through private philanthropy would sidestep the above federal limitations.[88] The Supreme Court, though, has not conclusively determined whether and how § 1981 constrains private decisionmakers who seek to address racial disparities.

In addition to the above federal enactments, some states have adopted legislation or constitutional amendments that restrict the use of racial classifications, typically with the aim of prohibiting disparity-alleviating affirmative action programs.[89] None of these enactments clearly apply to the allocation of vaccines or other treatments, since they only pertain to "public employment, public education, or public contracting," or are similarly restricted to education, employment, and/or contracts.[90] Treatment delivery would clearly not be education or employment, and likely would not constitute public contracting, particularly for vaccines or other interventions distributed free of charge. The adoption of explicitly race-based allocation policies might, however, risk prompting revisions to these enactments to broaden their scope. Some state courts have also interpreted their

Supreme Court has said that the constitutional constraints that apply only to public institutions would apply to any statutes that govern private institutions. Thus, regarding consideration of race, statutes such as . . . 42 U.S.C. § 1981 . . . would impose the same obligations on private institutions and parties that the Constitution imposes on public institutions."); Trina Jones, *The Diversity Rationale: A Problematic Solution*, 1 STAN. J.C.R. & C.L. 171, 211 (2005) (observing that while "under Title VII a private employer may have greater leeway to enact a race-conscious hiring policy than a public employer would under a constitutional law analysis," "private employers are also subject to 42 U.S.C. § 1981, which prohibits discrimination on the basis of race in the making of contracts," and interpreting Supreme Court precedent to require that "for all intents and purposes (at least when it comes to race) private and public employers are both subject to the same standards"); Symposium, *Doe v. Kamehameha Schools: The Undiscovered Opinion*, 30 U. HAW. L. REV. 355, 363 (2008) ("[B]y applying Title VII-type scrutiny instead of the strict scrutiny applicable to Title VI and the Fourteenth Amendment, the Court of Appeals construed § 1981 in a manner markedly different from the latter provisions, thereby contradicting Gratz, Grutter, and General Building Contractors.").

87. *See Doe*, 470 F.3d at 837, 840 ("Supreme Court precedent regarding § 1981 and Title VII suggests that the 'strict scrutiny' standard of equal protection does not apply to a wholly private school's race-based remedial admissions plan," and that "Title VII principles apply here."); *id.* at 858 (Bybee, J., dissenting) ("Like the majority, I agree that Title VII standards and not strict scrutiny must apply to § 1981 actions because to hold otherwise would effectively render the Title VII's provisions that expressly contemplate affirmative action plans nonsensical."); *id.* at 887 ("This case does not involve a public school or state action, so Grutter, Gratz, and the Equal Protection Clause do not come into the analysis."); *see also* Sharon Hsin-Yi Lee, *Justifying Affirmative Action in K-12 Private Schools*, 23 HARV. BLACKLETTER L.J. 107, 112 (2007) ("[E]very jurisdiction either explicitly or implicitly treats affirmative action policies identically under both Title VII and § 1981.") (collecting cases).

88. *Kamehameha Schs.*, 470 F.3d at 888 (Kozinski, J, dissenting) ("I don't believe section 1981 would apply at all if the schools were run entirely as a philanthropic enterprise and allowed students to attend for free.").

89. *See* Devon W. Carbado, *Intraracial Diversity*, 60 UCLA L. REV. 1130, 1141 nn.41–42 (2013) (discussing state proposals to limit or prohibit the use of race). Notably, a 2020 voter initiative to repeal California's constitutional amendment failed by 57%-43%, with polling suggesting that repeal failed to garner majority support among Latino or Asian/Pacific Islander voters. David Lauter, *Failure to Bridge Divides of Age, Race Doomed Affirmative Action Proposition,* L.A. TIMES (Nov. 24, 2020, 5:00 AM), https://www.latimes.com/politics/story/2020-11-24/age-race-divides-doomed-affirmative-action-proposition [perma.cc/B237-YAPH].

90. CAL. CONST. art. I, § 31; ARIZ. CONST. art. II, § 36; WASH. REV. CODE ANN. § 49.60.400 (West 2020); NEB. CONST. art. I, § 30; OKLA. CONST. art. II, § 36A; MICH. CONST. art. I, § 26; *see also* N.H. REV. STAT. ANN. § 21-I:52 (2019).

equal protection clauses to proscribe the use of race to remedy disparities,[91] but the role of state constitutional law in this area remains little explored.

Over the past half-century, the Supreme Court's view on when the Equal Protection Clause permits governmental actors to consider individual race for the purpose of disparity alleviation has increasingly come to reject even "benign" governmental racial categorizations.[92] During the 1960s, governments were permitted to treat individuals of different races differently in order to rectify racial disparities.[93] Since the 1970s, however, the Supreme Court has increasingly limited consideration of individuals' race even to combat racial disparities.[94] Currently, policies that treat individuals differently on the basis of race, even in order to address disparities, must satisfy "strict scrutiny": they must be narrowly tailored to satisfy a compelling governmental interest.[95] While some policies have satisfied this exacting test, the steep barrier strict scrutiny presents led it famously to be described as "strict in theory, fatal in fact."[96] Because courts often treat Title VI and Section 1981 claims parallel to Equal Protection claims, this shift has affected those areas as well.

The Supreme Court has not, however, directly considered the race-based allocation of scarce medical resources. While federal appellate courts have examined racial classifications in medicine, they have done so only outside scarcity.[97] Even for nonscarce treatments, however, courts have applied strict scrutiny, suggesting that the race-based allocation of scarce medical resources would similarly face strict scrutiny.[98]

In the absence of precedent directly concerning the race-based allocation of scarce medical resources, I begin in this Part by considering precedent on the allocation of scarce *nonmedical* resources. Some contexts where scarce benefits and burdens are distributed, such as prison policy and election law, are regarded as unique and so are unlikely to provide relevant precedent.[99] The most parallel precedent is *Parents Involved in Community Schools v. Seattle School District*

91. *E.g.,* Louisiana Associated Gen. Contractors v. Louisiana, 95-2105, p. 15 (La. 3/8/96); 669 So. 2d 1185, 1197; *see also* Sharp v. City of Lansing, 629 N.W.2d 873, 878–79 (Mich. 2001).

92. *See* Kimani Paul-Emile, *The Regulation of Race in Science*, 80 GEO. WASH. L. REV. 1115, 1148 (2012) ("The U.S. Supreme Court has struggled over the past forty years to determine the role race should play in government decision making, yet it has incrementally adopted colorblindness as its primary normative framework.").

93. *Id.*

94. *Id.* at 1148–49.

95. *Id.* at 1145.

96. *Id.* at 1146.

97. Mitchell v. Washington, 818 F.3d 436, 444 (9th Cir. 2016) (observing that "[t]he Supreme Court has never considered whether strict scrutiny applies to the use of race by a state actor in making a medical treatment decision," but concluding that strict scrutiny applies).

98. *Id.* at 445; *cf.* Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135, 157 (1998) ("[T]he recent political and judicial condemnation of affirmative action efforts suggests that health care policies designed to benefit minority groups may encounter substantial opposition.").

99. *See, e.g.*, Johnson v. California, 543 U.S. 499, 515 (2005) ("Prisons are dangerous places, and the special circumstances they present may justify racial classifications in some contexts."); Miller v. Johnson, 515 U.S. 900, 916 (1995) ("[T]he sensitive nature of redistricting and the presumption of good faith that must be accorded legislative enactments . . . requires courts to exercise extraordinary caution in adjudicating claims that a State has drawn district lines on the basis of race.").

No. 1, a case concerning scarce educational resources, which struck down Seattle's use of "racial classification . . . to allocate slots in oversubscribed high schools" as violating the Equal Protection Clause.[100]

Like proposals to allocate scarce treatments by race, the policy struck down in *Parents Involved* aimed to rectify disparities.[101] A majority of the Court concluded that such policies must satisfy strict scrutiny.[102] Relevant for the allocation of other scarce resources, a majority also regarded the use of race to allocate high school places as less supportable than its use in higher education and described higher education as a "unique context."[103] And a majority also judged the schools' plans unacceptable because they "failed to show that they considered methods other than explicit racial classifications to achieve their stated goals."[104]

While a majority agreed that Seattle's schools got it wrong, the Court provided only fractured guidance on how to get it right. In a plurality opinion joined by Justices Alito, Thomas, and Scalia, Justice Roberts sweepingly asserted that "[t]he way to stop discrimination on the basis of race is to stop discriminating on the basis of race."[105] In contrast, Justice Kennedy's concurrence took the narrower position that "it is permissible to consider the racial makeup of schools and to adopt general policies to encourage a diverse student body, one aspect of which is its racial composition," and that schools "are free to devise race-conscious measures to address the problem in a general way and without treating each student in different fashion solely on the basis of a systematic, individual typing by race."[106] In Justice Kennedy's view, these race-conscious measures would not prompt the application of strict judicial scrutiny.[107] In contrast, individualized race-based classifications would only be permitted as a "last resort."[108] Ultimately, Justice Kennedy would have permitted both "facially race-neutral" approaches and "if necessary, a more nuanced, individual evaluation of school needs and student characteristics that might include race as a component."[109]

Parents Involved prompted major changes in school assignment policies. These included the invalidation of policies that classify teachers by race[110] and

100. Parents Involved Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701, 710 (2007).
101. *Id.* at 713.
102. *Id.* at 720.
103. *Id.* at 724.
104. *Id.* at 704 (quoting Grutter v. Bollinger, 539 U.S. 306, 339 (2003)).
105. *Id.* at 748.
106. *Id.* at 788–89 (Kennedy, J., concurring).
107. *Id.* at 789 ("These mechanisms are race conscious but do not lead to different treatment based on a classification that tells each student he or she is to be defined by race, so it is unlikely any of them would demand strict scrutiny to be found permissible.").
108. *Id.* at 790.
109. *Id.* at 789–90 (quoting Adarand Constructors, Inc. v. Pena, 515 U.S. 200, 213 (1995)); *see also* Kimberly Jenkins Robinson, *The Constitutional Future of Race-Neutral Efforts to Achieve Diversity and Avoid Racial Isolation in Elementary and Secondary Schools*, 50 B.C. L. REV. 277, 280 (2009) ("Justice Kennedy's opinion, which has been described as the opinion that will determine the future of school integration, affirms that the Equal Protection Clause does not necessarily preclude elementary and secondary schools from considering race as one factor among many when assigning students to schools.").
110. *See, e.g.*, Perrea v. Cincinnati Pub. Sch., 709 F. Supp. 2d 628, 644 (S.D. Ohio 2010).

the abandonment of policies that classify students by race.[111] While Justice Kennedy's concurrence may permit the use of explicit, individual racial classifications "as a component" if facially race-neutral measures prove inadequate to address disparities, school districts have shifted toward policies that may consider aggregate racial disparities but that avoid individual racial classifications.[112] Some districts completely eschew explicit consideration of neighborhood-level racial demographics and rely only on socioeconomic factors, although they may retrospectively review racial disparities.[113] Others explicitly consider neighborhood racial demographics without basing assignments on individual students' race.[114]

Parents Involved, while not about the allocation of scarce medical resources, strongly suggests that allocating scarce medical interventions based on individual patients' race would not pass legal muster. Notably, even the four dissenting Justices observed that school assignment "is not a context that involves the use of race to decide who will receive goods or services that are normally distributed on the basis of merit and which are in short supply," and "is not one in which race-conscious limits stigmatize or exclude; the limits at issue do not pit the races against each other or otherwise significantly exacerbate racial tensions."[115] While scarce treatments are not typically distributed on the basis of merit as traditionally conceived, they are often distributed on the basis of where they can do the most good, and sometimes on the basis of reciprocity for activities like organ donation or participation in vaccine trials. In addition, allocating a clearly limited supply of potentially lifesaving medical interventions on the basis of individual patients' race might well be thought to "pit the races against each other or . . . exacerbate racial tensions."[116] These aspects of scarce medical treatments make it even likelier that their individualized, race-based allocation

111. *E.g.*, N.N. *ex rel.* S.S. v. Madison Metro. Sch. Dist., 670 F. Supp. 2d 927, 932 (W.D. Wis. 2009).

112. Laura Petty, *The Way Forward: Permissible and Effective Race-Conscious Strategies for Avoiding Racial Segregation in Diverse School Districts*, 47 FORDHAM URB. L.J. 659, 682 (2020) ("Many academics and practitioners have observed that Justice Kennedy's concurrence in *Parents Involved* left such a seemingly narrow opening for race-based school assignment policies that courts and school districts have avoided it."); Robinson, *supra* note 109, at 279 ("[R]ecent evidence indicates that, although some districts abandoned efforts to promote diversity after the *Parents Involved* decision, many school districts continue to pursue diversity but have adjusted their approach to doing so.").

113. Petty, *supra* note 112, at 690–91.

114. Michelle Adams, *Racial Inclusion, Exclusion and Segregation in Constitutional Law*, 28 *Const. Comment.* 1, 33 (2012) ("Even after *Parents Involved*, school districts may take overtly race-conscious steps—short of classifying individual students by race—to ameliorate the harms of segregation for which they are not legally responsible."); Petty, *supra* note 112, at 692–712 (reviewing the approaches adopted in Berkeley, CA; Nashville, TN; Montclair, NJ; Tampa, FL; and Louisville, KY).

115. Parents Involved Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701, 834–35 (2005) (Breyer, J., dissenting).

116. *Id.*; *see* Carla K. Johnson, *U.S. Panel Tackles Race, Poverty in Virus Vaccine Priorities*, PBS (Oct. 2, 2020, 1:29 PM), https://www.pbs.org/newshour/health/u-s-panel-tackles-race-poverty-in-virus-vaccine-priorities [https://perma.cc/RJ3U-VGDB] ("'The country's already divided,' said Gary Puckrein of the National Minority Quality Forum, a nonprofit advocacy group. 'Are we going to prioritize African Americans and Hispanics over whites to give them the vaccine because they have a higher risk?'").

by governmental actors would be viewed as unconstitutional.[117] Significantly, the Department of Veterans Affairs, after suggesting that individual race and ethnicity could potentially be incorporated into risk-based prioritization, has removed discussion of race from their prioritization framework.[118]

Courts' willingness to uphold public health restrictions during the pandemic, along with empirical data showing the outsized risk racial minorities have faced, might seem to suggest the opposite view: that the use of individual recipients' race to allocate scarce medical resources in a life-threatening emergency like the COVID-19 pandemic would be viewed more favorably than the use of race to allocate scarce but not life-saving goods like educational places.[119] This argument faces three problems. First, strict scrutiny applies to the use of racial classifications even in emergency contexts,[120] a point courts have reaffirmed during the COVID-19 pandemic, including when evaluating mandatory COVID-19 testing policies that were alleged to consider race.[121] Second, it is unclear

117. *See* Johnson, *supra* note 116 ("Using race to prioritize vaccines 'could end up in the Supreme Court,' said Larry Gostin, a professor at Georgetown University who has advised Republican and Democratic administrations on public health issues. 'With a strong conservative majority, the Court might well strike down any racial preference'").

118. *See* Nikki Wentling, *Minority Veterans to Receive Priority for Coronavirus Vaccines*, STARS & STRIPES (Dec. 10, 2020), https://www.stripes.com/news/us/minority-veterans-to-receive-priority-for-coronavirus-vaccines-1.654624 [https://perma.cc/U8E2-8SWG]. *Compare COVID-19 Vaccines at VA,* U.S. DEP'T VETERANS AFFS., https://www.va.gov/health-care/covid-19-vaccine/ (Jan. 22, 2021) [https://perma.cc/H6TK-8BRC], *with COVID-19 Vaccines at VA,* U.S. DEP'T VETERANS AFFS., http://web.archive.org/web/20201211013217/https://www.va.gov/health-care/covid-19-vaccine/ (Dec. 10, 2020) [https://perma.cc/QET3-DS2W]. The proposal was quickly criticized. *See* Eugene Volokh, *Civil Rights Commissioners Gail Heriot & Peter Kirsanow on the VA's Planned Race-Based Vaccine Distribution*, REASON: 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/2MHH-YQKQ]; Eugene Volokh, *Vaccination by Race, and Why It's Unconstitutional*, REASON: 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/3WH3-GK7H].

119. *See* Galen Ettlin, *Oregon Vaccine Committee Adjusts Tentative Priority Recommendations*, KGW (Jan. 22, 2021, 6:46 PM) https://www.kgw.com/article/news/health/coronavirus/vaccine/oregon-vaccine-committee-adjusts-tentative-priority-recommendations/283-5e172387-5c01-4b84-87fe-764ffbf2d4b9 [https://perma.cc/K6Y4-P2J6] ("We're not picking BIPOC communities . . . because they're ethnic, Black or Latino," but "because we've been impacted so severely by COVID . . . . To me, whatever we do is driven by data."); *see also* Christopher Ogolla, *Triaging Public Health Services Based on Race: What Are The Legal Challenges?*, RACE & THE 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/9GJU-N56Q] (suggesting the argument that "During a pandemic, there is more urgency and a race neutral alternative might not be as equally effective. For example, vulnerable populations might slip through the cracks while waiting for their priority groups. One can conclude that race-based policies have the greatest chance of passing strict scrutiny during pandemics"). Ogolla, however, ultimately predicts—in agreement with this Article--that "focusing on vulnerable populations in vaccine distribution is likely to succeed only if it doesn't explicitly use racial categories." *Id.*

120. *E.g.*, Johnson v. California, 543 U.S. 499, 512 (2005) ("The 'necessities of prison security and discipline' . . . are a compelling government interest justifying only those uses of race that are narrowly tailored to address those necessities.") (internal citation omitted); *see also* Tiwari v. Mattis, 363 F. Supp. 3d 1154, 1162 (W.D. Wash. 2019), *appeal dismissed sub nom*. Tiwari v. Shanahan, No. 19-35293, 2019 WL 3047272 (9th Cir. Apr. 26, 2019) (explaining Department of Defense security clearance procedures that classified individuals based on national origin were subject to strict scrutiny).

121. *E.g.*, Castillo v. Whitmer, No. 1:20-CV-751, 2020 WL 4810950, at *2 (W.D. Mich. Aug. 14, 2020) (explaining that strict scrutiny applies to "state actions that differentiate on the basis of race," but declining to

whether courts would regard racial disparity reduction as a sufficiently compelling governmental purpose on its own to satisfy strict scrutiny. Third, even if the justification for using individual race were understood solely or primarily as improving population health by reducing *total* deaths, hospitalizations, or infections rather than addressing racial disparities in those outcomes, any use of individual racial classifications would still have to be narrowly tailored to achieving that goal. As explained below, that showing will likely require evidence that facially race-neutral means were tried and proved ineffective; merely showing that minority populations have faced a higher burden of disease and death is insufficient under current precedent to justify the use of individual race as an allocation criterion. Even if using individual race as an eligibility or prioritization factor would improve the predictive power of an allocation framework and so save more lives,[122] it would be unlikely to pass strict scrutiny if used as a first, as opposed to last, resort.

Might other precedents on the constitutionality of considering individual race be friendlier to race-based allocation of medical interventions than *Parents Involved*? The requirement that all policies treating individuals differently on the basis of their race, even in order to address disparities, surmount the challenging hurdle of strict scrutiny was established a decade before *Parents Involved* in *Adarand Constructors v. Peña*, which held that "all racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny," and rejected "holding 'benign' state and federal racial classifications to different standards."[123] Justice Stevens vigorously dissented, criticizing the majority's approach for equating "a law that made black citizens ineligible for military service with a program aimed at recruiting black soldiers," and would have distinguished race-conscious policies that burden minorities from those that benefit them.[124] Justice Stevens' proposed approach in *Adarand*, which would permit without strict scrutiny the use of individual race when that use accompanies other factors that expose individuals to disadvantage,[125] has considerable merit, but this is "one of those instances in which the dissent clearly tells us what the law is not . . . it is not as if the proposition had not occurred to the majority of the Court."[126] Thus, even in 1995, the use of individual race was already highly circumscribed.[127]

apply strict scrutiny because "Plaintiffs have not demonstrated that the Emergency Order constitutes a race-based government action subject to strict scrutiny"); *cf.* Bannister v. Ige, No. CV 20-00305, 2020 WL 4209225, at *7 (D. Haw. July 22, 2020) (explaining that the public health restrictions at issue "do not implicate any fundamental rights or suspect classifications" and so applying a rational relationship test).

122. *Cf.* Luisa N. Borrell et al., *Race and Genetic Ancestry in Medicine–A Time for Reckoning with Racism*, NEW ENG. J. MED., 384, 474 (Feb. 4, 2021), https://www.nejm.org/doi/full/10.1056/NEJMms2029562 [https://perma.cc/7XUK-8KDA] (arguing that "scientists and clinicians should continue to use racial/ethnic categories to address and eliminate health inequities until better predictors are available").

123. Adarand Constructors, Inc. v. Peña, 515 U.S. 200, 227 (1995).

124. *Id*. at 245 (Stevens, J., dissenting).

125. *Id.*

126. Kobach v. U.S. Election Assistance Comm'n, 772 F.3d 1183, 1188 (10th Cir. 2014).

127. One context where individual race continues to be used after *Adarand*, with strict scrutiny unmentioned, is racial identification of criminal suspects. As Paul-Emile observes, "when presented with a challenge to the use of a race-based suspect description," courts have "consistently evaded the issue by concluding that the

The parallel that might appear friendliest, though I conclude even it would not succeed, is the use of hiring and promotion policies that consider race in order to address disparities. Such policies have frequently been upheld by appellate courts, most recently in 2015 by the D.C. Circuit in *Shea v. Kerry,* concerning a preference for minority Foreign Service officers.[128] They have survived even as other efforts to address racial disparities have been steadily curtailed or subject to heightened scrutiny.[129]

For case-specific procedural reasons, *Shea*—even though it concerned government action—focused on whether a federal hiring policy satisfied Title VII of the Civil Rights Act of 1964, rather than whether it satisfied the Equal Protection Clause.[130] As discussed above, Title VII frameworks have been borrowed to analyze policies adopted by private actors who receive no federal funds and so are subject only to Section 1981, making them potentially relevant to vaccine allocation.[131] In contrast, a governmental allocation policy challenged on constitutional rather than statutory grounds would be analyzed under strict scrutiny.[132]

Shea considered several factors that would apply to the assessment of scarce medical resource allocation policies. First, following the Supreme Court's approach in employment discrimination cases, it analyzed whether the preference responded to a "manifest imbalance in a traditionally segregated job category."[133] While this language is particular to employment contexts, it suggests the relevance both of substantial present disparities and of historic disparities attributable to past segregation. COVID-19 has both disparately affected minority communities and reinforced traditional patterns of disparity. *Shea* also observes that considering race only when allocating a future opportunity, as hiring policies do, is preferable to disrupting expectations by using race as a factor in layoff decisions.[134] Similarly, the allocation of novel medical interventions for a

official use of racial categories in this context is appropriate." Paul-Emile, *supra* note 92, at 1157. While I agree with Paul-Emile's assessment, I doubt that courts would be willing to sidestep strict scrutiny in the context of medical resource allocation. Interpreted generously, the survival of race-based suspect identification might reflect a desire not to overturn established jurisprudence; more realistically, the criminal law exceptionalism that likely underpins the survival of suspect identification would be unlikely to extend to other contexts.

128. Shea v. Kerry, 796 F.3d 42, 61 (D.C. Cir. 2015).

129. *See, e.g.*, Ricci v. DeStefano, 557 U.S. 557, 564 (2009).

130. *Shea*, 796 F.3d at 49 (explaining Equal Protection claims were not at issue because they were not timely filed).

131. *Cf.* Doe v. Kamehameha Schs., 470 F.3d 827, 839 (9th Cir. 2006) ("Defendant is a purely private entity that receives no federal funds. The Supreme Court has never applied strict scrutiny to the actions of a purely private entity.").

132. *See, e.g.*, Bennett v. Arrington (*In re* Birmingham Reverse Discrimination Emp. Litig.), 20 F.3d 1525, 1536 (11th Cir. 1994) ("[T]he obligations of a public employer under Title VII and the Constitution are not identical."); Airth v. City of Pomona, No. 96-56491, 2000 WL 425006, at *1 (9th Cir. Apr. 19, 2000).

133. *Shea*, 796 F.3d at 57. This standard is less demanding than the standard used in Equal Protection cases, which is typically interpreted to require a governmental employer to show evidence of its *own* past discriminatory conduct before using race-based factors in hiring to address disparities. *E.g.*, Cotter v. City of Bos., 323 F.3d 160, 169 (1st Cir. 2003) ("There must be evidence of discrimination specific to the governmental agency seeking to use racial preference; 'societal' discrimination, on its own, will not support affirmative action."); Taxman v. Bd. of Educ., 91 F.3d 1547, 1560 (3d Cir. 1996) ("[U]nder the Constitution a public employer's remedial affirmative action initiatives are valid only if crafted to remedy its own past or present discrimination . . . .").

134. *Shea*, 796 F.3d at 61.

pandemic disease like COVID-19 would not disrupt established entitlements. And *Shea* observes that a hiring plan that identifies beneficiaries based on race is more acceptable when it does not provide access for "unqualified beneficiaries" or impose an "absolute bar . . . to the advancement of non-beneficiaries."[135] A scarce treatment allocation policy that considers individual race as one factor would not absolutely bar members of any race from access and need not provide access for people who are unlikely to benefit.

Nevertheless, the other factors *Shea* used to assess "whether an affirmative action plan unnecessarily trammels the rights of non-beneficiaries"[136] sharply cut against the use of individual patients' race in scarce treatment allocation. Most importantly, the race-based policy *Shea* upheld was instituted after "a number of previous attempts to correct the identified imbalances without resort to explicit racial preference."[137] For multiple years, the State Department had striven to increase minority enrollment in courses relevant to hiring criteria, to encourage applications from minority candidates, and to place Foreign Service Officers at minority-serving institutions to encourage interest.[138] The importance of first considering "race-neutral alternatives" has been underscored by the Supreme Court elsewhere.[139] A policy that began at the outset by using individual recipients' race to allocate scarce, novel medical interventions would fail to meet the requirement that race-neutral alternatives be seriously attempted.[140] Further, the affirmative action plan examined in *Shea* was a short-term plan with only a modest effect on the makeup of eligible employees—only sixteen minority employees were hired through the plan out of more than 2,000, making the plan's impact on any nonbeneficiary minimal.[141] In contrast, the use of race in vaccine allocation would likely affect many more people. The stakes of allocating scarce medical interventions—which are frequently the only option for prevention or cure—are also higher compared to hiring, where those not hired remain eligible for a plethora of other jobs.

An even more serious practical problem is that that the Court's composition and ideological commitments have shifted sharply since the last cases that forthrightly endorsed private employers' use of affirmative action under Title VII.[142] Perhaps for this reason, advocacy organizations have been wary of relying on this line of cases at the Supreme Court, settling one case after certiorari was

135. *Id.* at 61–62.

136. *Id.* at 61. The "unnecessarily trammels" language derives originally from United Steelworkers v. Weber, 443 U.S. 193, 208 (1979).

137. *Shea*, 796 F.3d at 64.

138. *Id.*

139. *See* Fisher v. Univ. of Tex. at Austin, 136 S. Ct. 2198, 2213 (2016); City of Richmond v. J.A. Croson Co., 488 U.S. 469, 507 (1989).

140. *See* Regents of Univ. of Cal. v. Bakke, 438 U.S. 265, 357 (1978).

141. *Shea*, 796 F.3d at 64.

142. Cynthia L. Estlund, *Putting Grutter to Work: Diversity, Integration, and Affirmative Action in the Workplace*, 26 BERKELEY J. EMP. & LAB. L. 1, 3–4 (2005) ("[T]he more permissive reading of Johnson has been strained by the passage of time, the changing composition of the Court, and the subsequent decisions in Croson and Adarand which struck down minority contractor set-asides under the Constitution.").

granted.[143] The vitality of the Supreme Court's "few and aging Title VII precedents" concerning affirmative action, which undergird cases like *Shea*, was doubtful even in 2015,[144] and is even more doubtful given post-2015 changes to the Court's composition.

B. Race-Conscious Alternatives to Individual Classification

In this Section, I consider the likely fate of vaccine or treatment allocation policies that recognize the importance of addressing racial disparities without explicitly classifying individuals by race. I argue that these pass muster under current doctrine, but that their success will require care in both planning and drafting.

Policies that address racial disparities, either as a fundamental objective or in order to achieve other societal goals such as effective pandemic response, are likelier to pass legal muster when they avoid explicitly classifying individuals by race. Justice Kennedy's *Parents Involved* concurrence highlights the difference between individual classifications and other policy measures:

> If it is legitimate for school authorities to work to avoid racial isolation in their schools, must they do so only by indirection and general policies? Does the Constitution mandate this inefficient result?. . . . The argument ignores the dangers presented by individual classifications, dangers that are not as pressing when the same ends are achieved by more indirect means. When the government classifies an individual by race, it must first define what it means to be of a race. Who exactly is white and who is nonwhite? To be forced to live under a state-mandated racial label is inconsistent with the dignity of individuals in our society. And it is a label that an individual is powerless to change. Governmental classifications that command people to march in different directions based on racial typologies can cause a new divisiveness. The practice can lead to corrosive discourse, where race serves not as an element of our diverse heritage but instead as a bargaining chip in the political process. On the other hand race-conscious measures that do not rely on differential treatment based on individual classifications present these problems to a lesser degree.[145]

143. *Id.* at 13 ("When the Supreme Court granted certiorari, civil rights advocates intervened to help settle the case, averting what they feared might be a disastrous result and leaving Johnson standing for another day."). *See generally* Lisa Estrada, *Buying the Status Quo on Affirmative Action: The Piscataway Settlement and Its Lessons About Interest Group Path Manipulation,* 9 GEO. MASON U. C.R. L.J. 207 (1999) (examining the involvement of civil rights groups in the *Piscataway* settlement decision).

144. *See* Deborah C. Malamud, *The Strange Persistence of Affirmative Action Under Title VII*, 118 W. VA. L. REV. 1, 23 (2015); *see also* Roberto L. Corrada, *Ricci's Dicta: Signaling A New Standard for Affirmative Action Under Title VII?*, 46 WAKE FOREST L. REV. 241, 257 (2011) (observing that *Johnson* and *Weber* "are now dated and likely do not reflect the current thinking of the Court in these matters").

145. Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701, 796–97 (2007) (Kennedy, J., concurring).

Justice Kennedy adopted a similar approach when authoring two later majority opinions for the Court.[146] This approach, which permits race to be considered at an aggregate level but prohibits individual racial classifications, builds on older opinions by Justice O'Connor that permit race-neutral measures to address disparities such as lower rates of minority business participation.[147]

Justice Kennedy's approach of criticizing individual racial classifications while permitting other race-conscious policies has drawn fire from two diametrically opposed quarters: those who would permit disparity-reducing uses of individual racial classifications, paralleling Justice Stevens' *Adarand* dissent, and from those who reject the legitimacy of addressing racial disparities regardless of the means used to address them.[148] Justice Ginsburg's dissent in *Fisher v. University of Texas at Austin*, for instance, argues that policies that "candidly disclose their consideration of race [are] preferable to those that conceal it," and that "only an ostrich could regard the supposedly neutral alternatives as race unconscious,"[149] echoing an earlier dissent by Justice Souter.[150] When Justice Kennedy more recently endorsed a university admissions plan that explicitly classified applicants by race, he himself deployed a similar criticism against a facially race-neutral alternative, arguing that the plan, "though facially neutral, cannot be understood apart from its basic purpose, which is to boost minority enrollment."[151] Meanwhile, Justice Breyer's *Parents Involved* dissent contended that facially race-neutral measures will be ineffective in addressing racial disparities.[152]

The scholarly literature exploring the constitutionality of facially race-neutral policies that are adopted for race-conscious purposes such as disparity reduction has identified three broad possibilities.[153] Many believe such policies are

146. Texas Dep't of Hous. & Cmty. Affs v. Inclusive Cmtys. Project, Inc., 576 U.S. 519, 545 (2015) ("When setting their larger goals, local housing authorities may choose to foster diversity and combat racial isolation with race-neutral tools, and mere awareness of race in attempting to solve the problems facing inner cities does not doom that endeavor at the outset."); Fisher v. Univ. of Tex. at Austin, 136 S. Ct. 2198, 2208 (2016).

147. *E.g.*, Bush v. Vera, 517 U.S. 952, 958 (1996) (plurality opinion) (O'Connor, J.) ("Electoral district lines are 'facially race neutral,' so a more searching inquiry is necessary before strict scrutiny can be found applicable in redistricting cases than in cases of 'classifications based explicitly on race.'"); City of Richmond v. J.A. Croson Co., 488 U.S. 469, 507 (1989) (requiring consideration of "the use of race-neutral means to increase minority business participation"); Grutter v. Bollinger, 539 U.S. 306, 343 (2003) ("We take the Law School at its word that it would 'like nothing better than to find a race-neutral admissions formula' and will terminate its race-conscious admissions program as soon as practicable.").

148. *See* Richard Primus, *The Future of Disparate Impact*, 108 MICH. L. REV. 1341, 1345 (2010) ("Many people to both the left and the right of the Supreme Court may consider this distinction unprincipled. If race-conscious decision making is objectionable . . . it is objectionable whether its allocative effects are visible or not. Conversely, if some race-conscious decision making is permissible, its permissibility should not depend on its being kept secret.").

149. Fisher v. Univ. of Texas, 570 U.S. 297, 335–36 (2013) (Ginsburg, J., dissenting).

150. Gratz v. Bollinger, 539 U.S. 244, 298 (2003) (Souter, J., dissenting) (arguing that facially race-neutral schemes to address racial disparities face the "disadvantage of deliberate obfuscation" and arguing that "[e]qual protection cannot become an exercise in which the winners are the ones who hide the ball").

151. Fisher v. Univ. of Texas at Austin, 136 S. Ct. 2198, 2213 (2016).

152. Parents Involved in Cmty Schs v. Seattle Sch. Dist. No.1, 551 U.S. 701, 851–52 (2007) (Breyer, J., dissenting).

153. Stephen M. Rich, *Inferred Classifications*, 99 VA. L. REV. 1525, 1527–28 (2013) ("Some have argued that racially egalitarian facially neutral measures such as race neutral affirmative action are constitutional because

subject only to rational basis review.[154] Others believe strict scrutiny would apply, but believe such policies typically pass strict scrutiny because they use race-neutral means to pursue a laudable rather than an invidious purpose.[155] Last, some propose that such plans both ought to be subject to strict scrutiny and will generally fail.[156]

Any prediction must also recognize that the Justices who most praised facially race-neutral policies that aim to address racial disparities, Justices Kennedy and O'Connor, are no longer on the Court. Some of Justice Thomas's statements, including his view that "race-based government decisionmaking is categorically prohibited unless narrowly tailored to serve a compelling interest[,]"[157] and that government "demeans" Americans when it "makes race relevant to the provision of burdens or benefits"[158] suggests openness not only to applying heightened scrutiny to facially race-neutral plans, but to striking them down. Justice Thomas has, however, applied lesser scrutiny to some formally race-neutral policies that implicate race, such as the continuation of historically black colleges.[159] It remains less clear whether Justices Roberts and Alito—who have not joined Justice Kennedy's praise of race-neutral disparity reduction approaches—or the Court's newest Justices, Kavanaugh, Gorsuch, and Barrett,

egalitarian purposes are distinguishable from discriminatory purposes. Others have argued that such measures are unconstitutional, or at least deserve strict scrutiny, because equal protection holds all race conscious purposes equally suspect.").

154. Michelle Adams, *Is Integration A Discriminatory Purpose?*, 96 IOWA L. REV. 837, 854 (2011) ("[Under] Justice Kennedy's approach . . . the government may pursue the race-conscious objective of integration without even triggering strict-scrutiny review."); Rich, *supra* note 153, at 1573 (reading caselaw to imply that "strict scrutiny would not constrain facially neutral attempts to pursue . . . race conscious objectives"); *cf.* Daniel Kiel, *Accepting Justice Kennedy's Dare: The Future of Integration in A Post-PICS World*, 78 FORDHAM L. REV. 2873, 2903–04 (2010) (arguing that strict scrutiny should not apply to a plan that uses race at a neighborhood but not individual level, but that such a plan would in any event satisfy strict scrutiny).

155. Kim Forde-Mazrui, *The Constitutional Implications of Race-Neutral Affirmative Action*, 88 GEO. L.J. 2331, 2376 (2000) ("Strict scrutiny should be satisfied . . . by the compelling interest of remedying societal discrimination tailored through race-neutral means."); Jennifer S. Hendricks, *Contingent Equal Protection: Reaching for Equality After* Ricci *and* PICS, 16 MICH. J. GENDER & L. 397, 402 (2010) (rejecting the view that "race-neutral policies meant to promote racial equality could somehow avoid strict scrutiny entirely," but arguing the "better route is to recognize the state's compelling interest in reducing structural inequality and to evaluate it using the developing form of strict scrutiny that is not fatal in fact").

156. Some defend this view as both doctrinally plausible and normatively correct. *See* Brian T. Fitzpatrick, *Can Michigan Universities Use Proxies for Race After the Ban on Racial Preferences?*, 13 MICH. J. RACE & L. 277, 307 (2007) ("[The] Equal Protection Clause strictly scrutinizes not only explicit racial classifications, but also the use of racial proxies designed to evade its prohibition on explicit classifications."); Kenneth L. Marcus, *The War Between Disparate Impact and Equal Protection*, 2009 CATO SUP. CT. REV. 53, 72 (2009) ("[R]acially neutral governmental actions with a predominant racial motive trigger both strict scrutiny and disparate-treatment analysis."). Others regard it as a possible but normatively troubling future for equal protection jurisprudence. *See, e.g.*, Reva B. Siegel, *From Colorblindness to Antibalkanization: An Emerging Ground of Decision in Race Equality Cases*, 120 YALE L.J. 1278, 1313 (2011) (discussing the possibility that "race conservatives might object and advance colorblindness objections to race-conscious, facially neutral practices whose constitutionality they have long sanctioned").

157. *Parents Involved*, 551 U.S. at 752 (Thomas, J., concurring).

158. Grutter v. Bollinger, 539 U.S. 306, 353 (2003) (Thomas, J., dissenting in part).

159. *See* United States v. Fordice, 505 U.S. 717, 748–49 (1992) (Thomas, J., concurring) (stating that governments may legitimately "operate a diverse assortment of institutions-including historically black institutions-open to all on a race-neutral basis, but with established traditions and programs that might disproportionately appeal to one race or another").

would apply strict scrutiny to facially neutral policies that narrow racial disparities, or would strike down some or all such policies as failing strict scrutiny.[160]

Before Justice Kennedy's departure, commentators generally concluded that the Court is unlikely to apply heightened scrutiny to facially race-neutral disparity reduction policies.[161] Lower courts have agreed, including when plans incorporate aggregate data on the racial makeup of neighborhoods.[162] But litigation over medical resource allocation could prompt a doctrinal shift or a context-specific distinction, given both the Court's changing composition and the education-specific distinctions drawn in Justice Breyer's *Parents Involved* dissent.[163] Because the delivery of scarce treatment, unlike the delivery of education, is not a process of sustained intergroup interaction and dialogue, the state's interest in narrowing racial health disparities would not be able to draw on the diversity rationale undergirding race-conscious higher education admissions,[164] a rationale the *Parents Involved* dissenters believed should extend to primary and secondary schools as well.[165] The absence of support from a diversity rationale would be particularly salient if the case for individual racial priorities in vaccination were

160. *Parents Involved*, 551 U.S. at 745 (plurality opinion) (arguing that "other means for achieving greater racial diversity in schools," such as "where to construct new schools, how to allocate resources among schools, and which academic offerings to provide to attract students to certain schools," "implicate different considerations than the explicit racial classifications at issue," and stating that "we express no opinion on their validity—not even in dicta"); *cf.* Deborah Hellman, *Two Concepts of Discrimination*, 102 VA. L. REV. 895, 925 (2016) (considering "whether an intent to reduce racial disparities is . . . illegitimate and especially whether this intention, when operationalized in a facially neutral form, calls for strict scrutiny," and suggesting that "[t]he first strong hint that this may be so is found in Chief Justice Roberts's opinion in [*Parents Involved*]"); Siegel, *supra* note 156, at 1314 n.107 (describing *Parents Involved* as leaving it "unsettled . . . whether Chief Justice Roberts would allow the traditional forms of race-conscious, facially neutral state action, such as drawing school district lines with attention to their effects on integration, that Justice Kennedy's concurring opinion expressly affirms").

161. *See, e.g.*, Katie Eyer, *Constitutional Colorblindness and the Family*, 162 U. PA. L. REV. 537, 599 (2014) ("[A]lthough there have been hints across a number of domains that the Court has begun to problematize racial practices that have long remained effectively unscrutinized, it has so far shown itself far from willing to fully embrace the implications of a truly colorblind race law regime.").

162. Lewis v. Ascension Par. Sch. Bd., 806 F.3d 344, 358 (5th Cir. 2015) (arguing that even if a plan "incorporated . . . demographic data and projections" that included race, "this does not establish that the plan explicitly classified students by race," and "does not bring the plan within the ambit of Parents Involved, as that case addressed individualized student assignments that took into account the student's race"); Spurlock v. Fox, 716 F.3d 383, 394 (6th Cir. 2013) ("If consideration of racial data were alone sufficient to trigger strict scrutiny, then legislators and other policymakers would be required to blind themselves to the demographic realities of their jurisdictions and the potential demographic consequences of their decisions."); Doe *ex rel.* Doe v. Lower Merion Sch. Dist., 665 F.3d 524, 548 (3d Cir. 2011) ("Designing a policy 'with racial factors in mind' does not constitute a racial classification if the policy is facially neutral and is administered in a race-neutral fashion.").

163. *Parents Involved*, 551 U.S. at 834–35 (Breyer, J., dissenting) (arguing that the school assignment context in *Parents Involved* "is not a context that involves the use of race to decide who will receive goods or services that are normally distributed on the basis of merit and which are in short supply," and "is not one in which race-conscious limits stigmatize or exclude; the limits at issue do not pit the races against each other or otherwise significantly exacerbate racial tensions").

164. *See id.* at 791 (Kennedy, J., concurring); *id.* at 724 (plurality opinion); *cf.* Fisher v. Univ. of Texas at Austin., 136 S. Ct. 2198, 2210 (2016) (concluding that race-conscious admissions policies are justified because student body diversity "promotes cross-racial understanding, helps to break down racial stereotypes, and enables students to better understand persons of different races") (internal citation omitted); Estlund, *supra* note 142, at 14 (describing the Court's view of permissible affirmative action as "instrumental and forward-looking; it is decidedly *not* a remedial argument") (emphasis added).

165. *Parents Involved,* 551 U.S. at 842 (Breyer, J., dissenting).

understood in remedial terms, as amelioration of historical injustice.[166] Meanwhile, the Court's belief that race-based policies cause social division might loom larger, given the scarcity of treatments and the potentially life-or-death stakes of prioritization.[167]

The risk that allocation policies aimed at narrowing racial disparities face heightened scrutiny even if they employ facially race-neutral means suggests an alternative Kim Forde-Mazrui and Stephen Rich have proposed: policies pursuing only race-neutral goals by race-neutral means unquestionably avoid heightened scrutiny.[168] For instance, policies could be designed to prioritize localities or occupations that have been hard-hit, and could explicitly describe the prioritization of hard-hit workers or places as an independently desirable goal and/or as a means to the unquestionably valued goal of reducing hospitalizations and infections. Policies justified by race-neutral goals that involve no individual racial classifications are effectively insulated from equal protection concerns even if they also narrow racial disparities.[169]

Treatment allocation policies that focus only on the alleviation of non-racial disparities and/or the maximization of benefits without considering even neighborhood-level racial data, however, will likely reduce racial disparities less and may also save fewer lives.[170] In contrast, treatment allocation policies modeled on post-*Parents Involved* educational policies[171] that consider neighborhood-level geographic and economic factors while recognizing racial disparity reduction as a relevant aim, or that add consideration of neighborhood-level racial composition but not individual race, might more effectively reduce disparities and save lives while remaining legally compliant. These approaches, however, are at more risk from doctrinal change.[172]

Ultimately, any neighborhood-based strategy has not only legal but also ethical and practical advantages for allocating scarce resources in a pandemic over a system that assigns points based on individual race. Such a points system, apart from its legal vulnerability, risks providing insufficient priority to effectively address disparities and missing the most vulnerable members of groups subject to racism by overlooking cross-cutting vulnerabilities. It would also likely struggle to prioritize multiracial individuals, to recognize disparate risks

166. Dan Ming, *This Doctor Says Black Americans Should be Prioritized for COVID Vaccines*, VICENEWS (Feb. 17, 2021, 1:23 PM), https://www.vice.com/en/article/epd7ya/this-doctor-says-black-americans-should-be-prioritized-for-covid-vaccines [https://perma.cc/6EU4-JND8] (stating that "you can think of the vaccine almost as medical reparations" and that "we really should be giving this vaccine preferentially to people of color, I do believe").

167. *Cf. id.* at 834–35 (Breyer, J., dissenting).

168. Forde-Mazrui, *supra* note 155, at 2376; Rich, *supra* note 153, at 1527; *see also* Hendricks, *supra* note 155, at 410–11.

169. Forde-Mazrui, *supra* note 155, at 2381; Hendricks, *supra* note 155, at 410–11.

170. *See* Petty, *supra* note 112, at 691.

171. *See id.* at 695–709.

172. *See id.* at 709–11.

within broad racial categories,[173] and to set comparative priorities among individuals with different racial identities.[174] In addition, basing prioritization on individual self-identification would likely track the social and structural drivers of racial health disparities more poorly than basing it on factors like neighborhood-level segregation.[175]

C. The Unique Case of Native American Preference

An important caveat to the above discussion involves the prioritization of Native American tribes and tribal members for scarce medical treatments.[176] During the COVID-19 pandemic, Native Americans have experienced exceptionally stark racial disparities. Courts have found federal legislation that preferentially allocates benefits based on tribal membership to require less judicial scrutiny than legislation allocating benefits based on racial identity.[177] Many statutes preferentially allocate benefits to tribes and their members, in recognition of

173. For instance, while the Asian American census category nationwide has not faced outsized COVID-19 burden, Filipino Americans in California have. *See* Tiffany Wong, *Ailments, Job Hazards Raise Risks for Filipinos; COVID-19 Death Rates Are Higher Than for Asian Americans at Large*, L.A. TIMES (Jul. 23, 2020), https://enewspaper.latimes.com/infinity/article_share.aspx?guid=38cb2678-0dc9-4812-bc26-322e63e44930 [https://perma.cc/K5FD-ZSBP] (documenting disparately high death rates among Filipino Californians and reporting statement of an expert that using "'Asian American' as an overarching label obscures a lot of the inequalities within and among communities").

174. As an example, a suggestion from the chair of the University of Washington's bioethics department that Black, Hispanic, and Native Americans be prioritized over white health care workers and first responders did not explain how to prioritize among these groups, nor mention Asian Americans, Native Hawaiians, and/or Pacific Islanders. *See* Dudzinski, *supra* note 67. Yet Asian Americans are the largest minority group in Seattle, where the University of Washington is located, and Washington State has the third highest number of Native Hawaiian and Pacific Islander residents. *See* Office of Planning & Development, *Race & Ethnicity Quick Statistics, About Seattle*, CITY OF SEATTLE, https://www.seattle.gov/opcd/population-and-demographics/about-seattle#raceethnicity (last visited Mar. 23, 2021) [https://perma.cc/6LVB-QYWP]; *see also Profile: Native Hawaiians/Pacific Islanders*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF MINORITY HEALTH, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=65 (last visited Mar. 23, 2021) [https://perma.cc/VR72-FSBZ]. Pacific Islanders' age-adjusted death rate has been 2.7 times that of white Americans. *See The Color of Coronavirus: Covid-19 Deaths by Race and Ethnicity in the U.S.*, *supra* note 1.

175. *Cf.* Christopher Lewis, *Latinos and the Principles of Racial Demography,* 16 DU BOIS REV. 63, 66 (2019) (explaining that "antidiscrimination law is primarily a safeguard against people being mistreated on the basis of how they are racially perceived," rather than being mistreated on the basis of their racial self-identification); *Social Media*, VT. DEP'T OF HEALTH (Apr. 2, 2021), https://www.healthvermont.gov/media/social [https://perma.cc/V76B-R79E] ("If you identify as BIPIC, then you qualify."). *But cf. OHSU COVID-19 Vaccine FAQ*, *supra* note 74 (proposing to preferentially distribute COVID-19 vaccines to employees "who identify as part of the BIPOC (Black, Indigenous and people of color) community").

176. I primarily use "Native American" here, recognizing that many cases and scholars use other terminology, such as "Indian" or "Indigenous."

177. Washington v. Confederated Bands & Tribes of Yakima Indian Nation, 439 U.S. 463, 500–01 (1979) ("It is settled that 'the unique legal status of Indian tribes under federal law' permits the Federal Government to enact legislation singling out tribal Indians, legislation that might otherwise be constitutionally offensive."); Delaware Tribal Bus. Comm. v. Weeks, 430 U.S. 73, 85 (1977) ("[A] legislative judgment should not be disturbed '(a)s long as the special treatment can be tied rationally to the fulfillment of Congress' unique obligation toward the Indians . . . .'"); Morton v. Mancari, 417 U.S. 535, 553 & n.24 (1974) (observing that an explicit employment preference for members of federally recognized tribes "does not constitute 'racial discrimination,'" and "is not even a 'racial' preference"); United States v. Eagleboy, 200 F.3d 1137, 1140 (8th Cir. 1999) (endorsing the "longstanding principle that special treatment for Indians based on our government's historic trust obligations is not race discrimination").

tribes' status as sovereign entities.[178] This parallels policies in Canada and Australia that also prioritize indigenous groups.[179] Encouragingly, many tribal systems have been able to distribute COVID-19 vaccines more rapidly and broadly than other entities.[180]

Under current precedent, a federal allocation policy that explicitly prioritizes members of federally recognized tribes would receive only rational basis review.[181] State or local governmental policies allocating vaccines or treatments preferentially to tribal members, however, might only receive rational basis review if acting pursuant to federal law or the fulfillment of federal obligations to tribes,[182] or pursuant to a compact between a state and a tribe.[183] The question of what level of scrutiny applies to nonfederal laws concerning tribes remains unsettled,[184] and can be important for allocation policies when federal action, especially at the legislative level, is delayed. Notably, Washington's statutory limitation on affirmative action in public education explicitly permits schools that are

178. Rice v. Cayetano, 528 U.S. 495, 519 (2000) (collecting cases).

179. *Priority Groups for COVID-19 Vaccination Program: Phase 1B*, AUS. GOV. (Mar. 18, 2021), https://www.health.gov.au/sites/default/files/documents/2021/03/priority-groups-for-covid-19-vaccination-program-phase-1b_1.pdf [https://perma.cc/YA6U-FF5D]; *Guidance on the Prioritization of Initial Doses of COVID-19 Vaccine(s),* GOV. CAN., https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/guidance-prioritization-initial-doses-covid-19-vaccines.html (last visited Mar. 23, 2021) [https://perma.cc/QQ26-3SM6].

180. Zac Hollander, *Tribal Health Groups Are Vaccinating Teens and Healthy Adults Against COVID-19, Which Hits Alaska Native People at Disproportionate Rates*, ANCHORAGE DAILY NEWS (Jan. 15, 2021), https://www.adn.com/alaska-news/2021/01/15/tribal-health-groups-are-already-vaccinating-teens-and-healthy-adults-for-covid-19-a-virus-that-sickens-alaska-native-people-at-disproportionate-rates/ [https://perma.cc/DTP5-56TL]; Harmeet Kaur, *Anyone in Oklahoma can now get the COVID-19 Vaccine, Thanks to Several Native Tribes*, CNN (Mar. 16, 2021, 3:08 PM), https://www.cnn.com/2021/03/16/us/oklahoma-tribes-offers-vaccine-to-all-trnd/index.html; Hannah Furfaro, *Teachers Crying Tears of Gratitude as Washington Tribes Help Speed COVID-19 Vaccines to Them*, SEATTLE TIMES: EDUC. LAB (Mar. 18, 2021, 9:39 AM), https://www.seattletimes.com/education-lab/tribal-governments-in-washington-help-speed-teacher-vaccination-effort/ [https://perma.cc/KYP2-5RDM].

181. *See* Am. Fed'n of Gov't Emps., AFL-CIO v. United States, 330 F.3d 513, 522–23 (D.C. Cir. 2003); Krueth v. Indep. Sch. Dist. No. 38, 496 N.W.2d 829, 836 (Minn. Ct. App. 1993); *cf.* Means v. Navajo Nation, 432 F.3d 924, 933 (9th Cir. 2005) (upholding federal law that applied to "enrolled or de facto members of tribes, not all ethnic Indians").

182. *Compare* Greene v. Comm'r of Minn. Dep't of Hum. Servs., 755 N.W.2d 713, 727 (Minn. 2008) (observing that "courts have applied rational basis review to state laws that promote tribal self-governance" and "benefit tribal members" as well as those that "implement or reflect federal laws," and upholding a state law whose purpose "is to further the congressional policy of tribal self-governance"), *and* State v. McBride, 955 P.2d 133, 139 (Kan. App. 1998) ("The importation of the federal trust responsibility into the realm of state-tribal relations by the State of Kansas is by no means improper and has been sanctioned by other courts."), *with* KG Urban Enterprises, LLC v. Patrick, 693 F.3d 1, 20 (1st Cir. 2012) ("[I]t is quite doubtful that *Mancari's* language can be extended to apply to preferential *state* classifications based on tribal status."), *and* Tafoya v. City of Albuquerque, 751 F. Supp. 1527, 1531 (D.N.M. 1990) ("The Albuquerque City Council has considerably less power than the United States Congress to pass law discriminating in favor of members of federally recognized Indian tribes.").

183. *See* United States v. Garrett, 122 F. App'x 628, 633 (4th Cir. 2005).

184. Akina v. Hawaii, 141 F. Supp. 3d 1106, 1131 (D. Haw. 2015) (recognizing the difficulty of determining the appropriate level of scrutiny for state laws concerning tribes). *See generally* Washington v. Confederated Bands & Tribes of Yakima Indian Nation, 439 U.S. 463, 500 (1979) (explaining that "States do not enjoy this same unique relationship with Indians" as exists between the Federal Government and tribes but upholding a state statute because it was enacted "under explicit authority granted by Congress.").

part of a state-tribe education compact to implement "a policy of Indian preference in employment" and prioritize "the admission of tribal members where capacity of the school's programs or facilities is not as large as demand."[185]

More complicated issues arise if an allocation policy prioritizes members of non-recognized tribes or prioritizes Native Americans regardless of their tribal membership. As Matthew Fletcher observes, doctrinal approaches to policies favoring Native Americans fall along a spectrum from less to more restrictive.[186] The approach Fletcher endorses, which would be most favorable to a broad priority for Native Americans, would conclude that if "Congress has decided to provide government services to Indians, and defines eligible Indians by blood quantum, then the courts may only inquire as to whether those services and that eligibility determination are rationally related to the duty of protection."[187] Fletcher's preferred approach is neither foreclosed nor clearly endorsed by current precedent, which instead typically rests on the idea that tribal preferences are "granted to Indians not as a discrete racial group, but, rather, as members of quasi-sovereign tribal entities."[188] This current approach would support preferential allocation of vaccines and treatments to members of tribal entities—potentially including unrecognized tribes[189]—but is silent on how an allocation approach that favored Native Americans apart from tribal connection would be viewed. A third, more restrictive approach interprets current doctrine to support rational basis review only when the allocation prefers members of formally recognized tribes, but to subject other forms of Native American preference to strict scrutiny.[190]

185. WASH. REV. CODE § 49.60.400(7) (2019).

186. Matthew L.M. Fletcher, *Politics, Indian Law, and the Constitution*, 108 CALIF. L. REV. 495, 502 (2020).

187. *Id.* at 519; *see also* Gregory Ablavsky, *"With the Indian Tribes": Race, Citizenship, and Original Constitutional Meanings*, 70 STAN. L. REV. 1025, 1074 (2018) ("[W]ith respect to those people labeled 'Indians,' the Constitution itself authorizes distinctions based on ancestry."); Addie C. Rolnick, *The Promise of* Mancari*: Indian Political Rights As Racial Remedy*, 86 N.Y.U. L. REV. 958, 995 (2011) ("Because federal treaties and the Constitution recognized Indians as unique and politically distinct bodies long before passage of the Fourteenth Amendment—and indeed because the Fourteenth Amendment itself excludes Indians—federal legislation singling out Indians is arguably exempt from the strict scrutiny regime developed out of the Fourteenth Amendment, even if it does draw on racial classifications.").

188. Morton v. Mancari, 417 U.S. 535, 554 (1974); *see also* Ablavsky, *supra* note 177, at 1069 (endorsing this position as doctrinally defensible but characterizing it as "at least in part a legal fiction reliant on a partial and formalist perspective").

189. L. Scott Gould, *Mixing Bodies and Beliefs: The Predicament of Tribes*, 101 COLUM. L. REV. 702, 726 (2001) ("*Mancari*'s text is broader, implying that preferences may be upheld for individuals as long as they are identified with tribal groups."); United States v. Bruce, 394 F.3d 1215, 1224 (9th Cir. 2005) ("Tribal enrollment is 'the common evidentiary means of establishing Indian status, but it is not the only means nor is it necessarily determinative.'").

190. United States v. Zepeda, 792 F.3d 1103, 1119 (9th Cir. 2015) (Kozinski, J. concurring) (stating that because "[a]n unrecognized tribe is not a quasi-sovereign political entity for the purposes of federal law, and has no political relationship whatsoever with the United States," permitting "a federal statute to turn solely on a racial connection to an unrecognized tribe has no basis in the justification for disparate treatment articulated in *Mancari*"); *see also* Stuart Minor Benjamin, *Equal Protection and the Special Relationship: The Case of Native Hawaiians*, 106 YALE L.J. 537, 571 (1996) ("[O]nly some American Indians are members of tribes, and only legislation limited to them is considered under rational basis review.").

Some courts and advocates have proffered approaches that would much more substantially limit preference even for members of federally recognized tribes. As Fletcher notes, a few courts have suggested that only tribal preferences concerning "uniquely Indian interests" pass muster and disapproved at least indirectly of legislation that "provides a preference in an industry that is not uniquely native" and "in no way relates to native land, tribal or communal status, or culture."[191] As Fletcher and others describe, some advocacy has pressed yet further describing legislation preferring tribes and their members as objectionably racially classificatory[192] and contemplating the imposition of strict scrutiny on all such legislation.[193]

Which of the above legal approaches ultimately prevails has important implications for recent COVID-19 vaccine allocation proposals. For instance, California's proposal to consider "historical and contemporary injustices" as a vaccine allocation factor would likely be acceptable under most prevailing approaches if framed as "a chance for the government to mend its relationship with Indigenous Americans,"[194] in line with federal treaty and protection obligations, but not if expanded to prioritize members of other racial groups on the basis of individual race—notwithstanding those other groups exposure to other forms of historical injustice. Similarly, Montana's plan to include "American Indians and other people of color who may be at elevated risk for COVID-19" would likely pass legal muster regarding Native Americans, but not other minority groups.[195]

Trying to predict how the current Supreme Court would evaluate an explicit preference in medical treatment allocation for tribal members, or for Native Americans more generally, is complex. In *Adoptive Couple v. Baby Girl*, Justices Thomas, Roberts, Kennedy, and Breyer joined an opinion by Justice Alito suggesting in dicta that a legislative enactment that would "put certain vulnerable children at a great disadvantage solely because an ancestor—even a remote one—was an Indian" would raise equal protection concerns.[196] Justice Sotomayor dissented strenuously on this point, joined by Justices Scalia, Ginsburg,

191. Williams v. Babbitt, 115 F.3d 657, 664–65 (9th Cir. 1997) (applying constitutional avoidance canon); *cf.* In re Santos Y., 112 Cal. Rptr. 2d 692, 730 (Cal. Ct. App. 2001).

192. *See* Matthew L.M. Fletcher, *The Original Understanding of the Political Status of Indian Tribes*, 82 ST. JOHN'S L. REV. 153, 162 (2008) ("Opponents of treaty rights and legislation benefiting Indians and Indian tribes suggest that these 'Indian preferences' are nothing more than race discrimination, disguised in the form of preferences and set asides."); Sarah Krakoff, *They Were Here First: American Indian Tribes, Race, and the Constitutional Minimum,* 69 STAN. L. REV. 491, 505 (2017) (describing the "latest wave of attacks" on tribal preference, which "are in the nature of anti-affirmative action claims").

193. *See* Fletcher, *supra* note 186, at 501–02; *cf. Williams*, 115 F.3d at 666 n.8 (describing as "unwarranted" the "dire prediction" that "subjecting laws favoring Indians to strict scrutiny 'would effectively gut Title 25 of the U.S. Code.'").

194. April Dembosky, *In California, Health Workers Will Get COVID-19 Vaccine 1st. Who's Next?*, KQED (Dec. 10, 2020; 5:09 AM), https://www.wvpublic.org/2020-12-10/in-california-health-workers-will-get-vaccine-1st-who-should-be-next [https://perma.cc/5WGS-LEWL].

195. Marissa Perry & Jon Ebelt, *Governor Bullock Releases Updated COVID-19 Vaccination Distribution Plan,* DPHHS (Dec. 30, 2020), https://dphhs.mt.gov/aboutus/news/2020/covid-19vaccinationdistributionplan [https://perma.cc/YRC8-MENR].

196. Adoptive Couple v. Baby Girl, 570 U.S. 637, 655 (2013).

and Kagan.[197] Since *Adoptive Couple* was decided, Justices Kennedy, Scalia, and Ginsburg have been replaced by Justices Gorsuch, Kavanaugh, and Barrett. *Adoptive Couple* provides reason to believe that Justice Alito in particular might be friendly to an effort to weaken tribal preference by assimilating it to racial preference; other cases suggest that Justice Thomas is no firm friend of the precedent distinguishing tribal from racial classifications;[198] and Justice Kavanaugh's pre-confirmation writings indicate a willingness to at least limit preference to formally recognized tribes only.[199] But there is also reason to doubt that Justice Breyer would oppose a data-driven allocation policy that benefits members of tribes (as opposed to a jurisdictional statute like the one at issue in *Adoptive Couple*), and also reason to believe that Justice Gorsuch might follow his predecessor, Justice Scalia, in distinguishing tribal preference from affirmative action more generally.[200] The case for an allocation policy that considers tribal membership would seem particularly compelling if an allocation policy identified specific tribes, such as the Navajo Nation, who have suffered extraordinary burdens from COVID-19.[201]

V. CONSIDERING DISADVANTAGE LEGALLY AND FAIRLY

Part III demonstrated that random selection will not effectively address disparities. Part IV showed that the explicit, individual-level consideration of race some have advocated is foreclosed by Supreme Court precedent, but that facially neutral, race-conscious policies could pass muster, as could policies that prioritize tribal members. Part V will suggest two complementary ways that scarce resource allocation policies could address disparities: (1) using place-based policies that avoid individual racial classifications, modeled on school districts' post-*Parents Involved* policies, and (2) adopting policies that work to prevent the distinctive and disparately suffered harm of death early in life. Other efforts, like effective engagement with hesitancy, are also relevant for certain interventions like vaccines.[202] But the approaches discussed in this Part are particularly promising because they can help reduce disparities in access and outcomes, both with respect to the COVID-19 pandemic and with respect to other public health

197. *Id.* at 690 (Sotomayor, J., dissenting).

198. Fletcher, *supra* note 192, at 500.

199. Brett Kavanaugh, *Are Hawaiians Indians? The Justice Department Thinks So*, WALL ST. J., Sep. 27, 1999, at A35, https://turtletalk.files.wordpress.com/2018/07/are_hawaiians_indians_the_jus.pdf [https://perma.cc/AZC7-SW8K].

200. *See* McGirt v. Oklahoma, 140 S. Ct. 2452, 2477 (2020) ("[H]owever enlightened the State may think it was for territorial law to apply to all persons irrespective of race, some Tribe members may see things differently, given that the same policy entailed the forcible closure of tribal courts in defiance of treaty terms."); *see also* Greene v. Impson, 530 F. App'x 777, 780 (10th Cir. 2013) ("[C]lassifications based on Indians and non-Indians do not offend the Due Process Clause because such classifications '[are] not based upon impermissible racial classifications' but instead are 'rooted in the unique status of Indians as . . . once-sovereign political communities.'").

201. Lakhani, *supra* note 4; Russell Contreras, *Biden Gives Navajo Nation a Disaster Declaration Over COVID-19*, AXIOS (Feb. 3, 2021), https://www.axios.com/biden-navajo-nation-disaster-declaration-covid-19-3b5c7d05-1d7b-477c-b615-ea2f9d1d97b8.html [https://perma.cc/F6MH-RBMM].

202. *See infra* Part V.

threats.[203] Because COVID-19 burdens have fallen more severely on minority populations, reducing disparities in the allocation of vaccines and other preventive interventions will not only promote equity but also prevent deaths, hospitalizations, and COVID-19 spread.[204]

A. Place-Based, Disparity-Sensitive Policies Without Individual Racial Classifications

Like school assignment policies adopted after *Parents Involved*, an allocation policy for vaccines or treatments could be designed to combine neighborhood- or occupation-level information about socioeconomic disadvantage with information about neighborhood or occupational racial composition, while avoiding individual racial classifications.[205] Such policies in educational settings have so far avoided invalidation, even in states like California that stringently restrict the use of individual-level racial data. As one court stated, a policy that "does not consider an individual student's race when assigning the student to a school," but instead "considers the average household income in the neighborhood, the average education level of adults residing in the neighborhood, and the racial composition of the neighborhood as a whole" while ensuring that "[e]very student within a given neighborhood receives the same treatment, regardless of his or her individual race" does not violate explicit state constitutional strictures against race-based preferential treatment.[206] Alternatively, similar to school assignment policies used in other cities, allocation policies could exclude even aggregate racial factors while nonetheless understanding disparity reduction as a

203. *See infra* Part V.

204. This point belies the well-meaning rhetoric offered by some states. Massachusetts, for instance, claims that "[f]actors that have no bearing on the likelihood or magnitude of immunization benefit, include but are not limited to, race, disability, gender, sexual orientation, gender identity, ethnicity, ability to pay or insurance status, socioeconomic status, English language proficiency, perceived social worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources." *COVID-19 Vaccine Frequently Asked Questions–Vaccine Providers*, MASS.GOV,https://www.mass.gov/info-details/covid-19-vaccine-frequently-asked-questions-vaccine-providers#vaccine-administration (Mar. 15, 2021) [https://perma.cc/CXS4-NZRD]. But immunization benefit is *higher* for people who are more vulnerable to contracting, spreading, or becoming seriously ill from COVID-19—which includes people from minority communities, people with certain disabilities, and people who are incarcerated, homeless, or in poverty. Prioritizing access for these groups is not only a matter of fairness, but also of maximizing benefits.

205. *See* Petty, *supra* note 112, at 661–62. A place- or occupation-based approach to disparity reduction also obviates concerns that individual classifications may be inaccurate or divisive. *E.g.*, Bernstein, *supra* note 11 ("I can't imagine anyone seriously wants the government deciding for the purpose of early vaccination whether a fair-skinned biracial woman qualifies as African-American, or whether an individual with one mixed-race Mexican, one Italian-Argentine, and two European grandparents counts as Hispanic."); *cf.* Gillian Flaccus, *Role of Race in US Vaccine Rollout Gets Put to the Test*, A.P. NEWS (Jan. 28, 2021), https://apnews.com/article/public-health-race-and-ethnicity-coronavirus-pandemic-oregon-coronavirus-vaccine-418205f28faed79f9a569ea3c6002dc3 [https://perma.cc/6NZL-XTD2] (reporting statement by Rachael Banks, public health division director at the Oregon Health Authority, that the use of a social vulnerability index rather than individual racial classifications "gets beyond an individual perspective and to more of a community perspective" and is better than asking a person to prove "how they fit into any demographic").

206. Am. C.R. Found. v. Berkeley Unified Sch. Dist., 90 Cal. Rptr. 3d 789, 792, 801 (2009).

relevant policy goal and collecting information on whether allocation is affecting aggregate-level racial disparities.[207]

Both these approaches could strengthen their legality by making clear that addressing racial disparities is not the sole or predominant justification for the policy.[208] Some commentators have framed place-based policies as solely motivated by racial disparity reduction or as mere proxies for individual racial classification,[209] an approach that is both strategically mistaken and factually inverted. Rather than place being a proxy for race, place and race are both factors that expose people to differential societal treatment.[210] Nevertheless, while framing may exact political costs,[211] its legal effects are unclear. The Supreme Court's most recent jurisprudence could consistently be read to suggest that statements suggestive of improper motivation by public officials would not compel the legal invalidation of a place-based policy that realizes constitutionally unimpeachable governmental interests (such as alleviating economic and geographic disparities and improving overall public health) and does not classify individual recipients by race.[212] But state officials would be ill advised to assume their incautious

207. *See* Toni M. Massaro & Ellen Elizabeth Brooks, *Flint of Outrage*, 93 NOTRE DAME L. REV. 155, 202 (2017).

208. *Cf.* Miller v. Johnson, 515 U.S. 900, 920 (1995) (applying strict scrutiny where race was the "predominant" factor in a geographically based policy); Doe *ex rel.* Doe v. Lower Merion Sch. Dist., 665 F.3d 524, 556 (3d Cir. 2011) (upholding school district's assignment plan where "race was not the predominant factor motivating the decision").

209. *See, e.g.*, Melissa Healy, *Injecting Race into Plans to Dispense Vaccines; People of Color Face Higher COVID Risk, but Prioritizing Them Is a Fraught Challenge*, L.A. TIMES (Jan. 1, 2021), https://enewspaper.latimes.com/infinity/article_share.aspx?guid=98181e08-1fc2-4a82-bb6f-65f775c7c04a [https://perma.cc/JZN2-T4J6] (reporting statement by Dr. Eric C. Schneider, vice president of the Commonwealth Fund and an expert on vaccine allocation, that distribution of vaccines "according to race and ethnicity would probably spark legal challenges, such as those that have targeted affirmative-action programs for college admissions and employment" and that "[i]nstead," "state and local authorities will need 'workarounds' that focus on specific disadvantages such as housing, occupational hazards and access to medical care," which are "a tricky exercise"); Samuel, *supra* note 68 (stating that geographic and other "factors are a good way of getting at race without actually using race as the explicit criterion" and reporting statement of Dr. Kirsten Bibbins-Domingo, an epidemiology and biostatistics professor at the University of California San Francisco who specializes in health disparities, that "the history of segregation and redlining means that, frankly, place is not a bad proxy for race").

210. *See* Jagannathan, *supra* note 10 (reporting statements by Dr. Monica Peek, a University of Chicago associate professor of medicine who researches health disparities, that race "is just a proxy for the social conditions and the structural racism and interpersonal racism that puts people at increased risk for the coronavirus," and by Dr. Georges Benjamin, executive director of the American Public Health Association and former secretary of the Maryland Department of Health and Mental Hygiene, that people are at risk not because of skin color, but "because they have public-facing jobs, chronic diseases, and other social determinants that put them at risk"); *see also* Letter from Or. BIPOC Caucus to Vaccine Advisory Comm. (Jan. 25, 2021), https://www.opb.org/pdf/Letter%20to%20VAC%20from%20BIPOC%20Caucus%20(1)_1611619115514.pdf [https://perma.cc/8746-ZSGJ] (criticizing Vaccine Advisory Committee for potentially prioritizing "Black, Indigenous, and People of Color (BIPOC) communities" regardless of other vulnerability above "frontline workers, adults in custody, and people in low-income senior housing and other congregate care facilities," and arguing that the committee should instead "base its decisions on the data of who is most vulnerable because of their occupation or living situation").

211. *See* Healy, *supra* note 201 (describing backlash against advocates of race-based vaccine prioritization).

212. *Cf.* Dep't of Homeland Sec. v. Regents of Univ. of Cal., 140 S. Ct. 1891, 1916 (2019) (concluding that Presidential statements "fail to raise a plausible inference" that a decision "was motivated by animus"). *But see Regents of Univ. of Cal.*, 140 S. Ct. at 1917–18 (Sotomayor, J., dissenting in part and concurring in part) (declining to "so readily dismiss the allegation that an executive decision disproportionately harms the same racial group that the President branded as less desirable mere months earlier").

statements will be granted the same generous leeway that the President's frank bigotry received.[213] And, in any event, established precedent suggests that enactments supported in fact by racially discriminatory purposes are invalid even if supportable in principle by permissible justifications.[214] Whether and when racial disparity reduction is a discriminatory purpose, however, remains uncertain.[215]

Notably, the Sixth Circuit, in *Castillo v. Whitmer*, recently upheld a Michigan COVID-19 testing requirement for migrant workers against a challenge that it discriminated against Latinos, concluding that despite official statements recognizing racial disparity reduction as one goal of state COVID-19 policy, plaintiffs "could not disprove all possible permissible justifications for the Order, including Defendants' assertion that the Order is motivated by the State's rational desire to protect migrant workers, their families, their communities, and the food supply chain."[216] While *Castillo* does not establish that racial disparity reduction is sufficient alone to justify a policy, it supports the view that facially race-neutral policies that address public health needs or non-racial disparities will not be invalidated merely because racial disparity reduction is also a motivation. The *Castillo* panel also observes, citing established law, that "facially race-neutral

213. *See Regents of Univ. of Cal.*, 140 S. Ct. at 1917–18 (Sotomayor, J., dissenting in part and concurring in part) (discussing statements "comparing undocumented immigrants to 'animals' responsible for "the drugs, the gangs, the cartels, the crisis of smuggling and trafficking").

214. Vill. of Arlington Heights v. Metro. Hous. Dev. Corp., 429 U.S. 252, 265–66 (1977) ("When there is a proof that a discriminatory purpose has been a motivating factor in the decision this judicial deference is no longer justified."); *see also* Richard A. Primus, *Equal Protection and Disparate Impact: Round Three*, 117 HARV. L. REV. 493, 545 (2003) ("[T]here must be constitutional limits on government's license to act for the purpose of reallocating goods from historically advantaged racial groups to historically disadvantaged ones, even when the means for pursuing those motives are themselves unobjectionable."). The tension between established case law and the Court's approach in *Regents* has been recognized elsewhere. *See Fifth Amendment –Due Process Clause –Equal Protection –Department of Homeland Security v. Regents of the University of California*, 134 HARV. L. REV. 510, 519 (2020) (observing that the "Court's latest effort to avoid acknowledging the administration's real reasons may create unnecessary obstacles for future claims of discriminatory intent").

215. *Compare* Ricci v. DeStefano, 557 U.S. 557, 594–95 (2009) (Scalia, J., concurring) (arguing that requirements that employers "evaluate the racial outcomes of their policies, and to make decisions based on (because of) those racial outcomes" are discriminatory, even if the response to these outcomes involves facially race-neutral, non-individualized efforts), *with* Primus, *supra* note 215, at 548 ("[T]he motive behind disparate impact doctrine could avoid triggering strict scrutiny, even if that doctrine aims to eliminate de facto racial hierarchy in the workplace by reallocating positions from some racial groups to others."); Br. of Worker Advocates, Unions, Community Organizations, and Health Experts as Amici Curiae in Support of Defendants-Appellees at 12, Castillo v. Whitmer, 823 F. App'x. 413 (6th Cir. 2020) (No. 20-1815) ("*Spurlock*, *Parents Involved*, and *Inclusive Communities* make clear that a state does not intentionally discriminate when it takes facially neutral action to avoid disparate impacts on a particular race."); Br. of Professor Richard Primus in Support of Neither Party at 7, Castillo v. Whitmer, 479 F. Supp. 3d 545 (2020) (No. 1:20-cv-751) ("To whatever extent the Order in the present case was motivated by a desire to reduce the adverse impact of COVID-19 on Latinos, it uses race-neutral means to pursue that end.").

216. Castillo v. Whitmer, 823 F. App'x. 413, 416–17 (6th Cir. 2020) (explaining that "considering the effects of government action on various racial groups is not evidence of improper purpose"); *see also* Castillo v. Whitmer, No. 1:20-CV-751, 2020 WL 5029586, at *1 (W.D. Mich. Aug. 21, 2020) (explaining that a requirement that "migrant agricultural workers, seasonal agricultural workers, and residents of migrant housing camps must be tested for COVID-19" did not constitute "racial discrimination against Latinos" because "a facially-neutral government program designed to protect and improve the working and living conditions of a group is not reviewed under strict scrutiny"). The Sixth Circuit three-judge panel included two recent Republican appointees. *Castillo*, 823 F. App'x at 414.

actions are . . . unconstitutional when they disproportionately affect a racial minority and can be traced to a discriminatory purpose," and that improper purpose requires a showing that a policy was adopted "at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group."[217] This language has promising implications for place-based, disparity-reducing policies for the allocation of scarce treatments: such policies are likelier to be adopted "in spite of," rather than "because of," any adverse effects on those in more advantaged locales, and those adverse effects are less likely to disproportionately affect minority groups. It does, however, suggest that scarce resource allocation policies that aim, even in part, to divest historically advantaged groups of undeserved privileges—rather than to assist disadvantaged groups—are likelier to be invalidated as discriminatory.[218]

While inartful drafting or legally infirm motivations may not necessarily doom an allocation policy, these missteps not only expose policies to invalidation but also risk creating precedent that imperils longstanding efforts at disparity reduction. Experienced advocates for disparity reduction in other areas have recognized that bad facts will make bad law and have organized—and even settled cases—to avoid unfavorable factual presentation in decisions likely to generate important precedent.[219] And, as always, decisionmakers should be aware that litigation challenging a poorly drafted policy can expose them to a discovery process that may uncover legally or politically problematic internal communications, even before any ruling on the policy's merits.

Current doctrine offers one clear takeaway: all decisions based on individual racial classifications (in contrast to other classifications like tribal preference) must satisfy strict scrutiny. And despite Justice Kennedy's suggestion in *Parents Involved* that individualized use of "race as a component" might pass muster under strict scrutiny "if necessary," public health policymakers would be wise to follow education policymakers in declining that invitation.[220] While Justice Roberts has shown some sympathy for group-level disparity reduction,[221] he has not shown the same sympathy for individualized classifications—and, in any event, merely persuading one member of the *Parents Involved* plurality would not be enough.

217. *Castillo*, 823 F. App'x at 415–16 (citing Pers. Adm'r of Mass. v. Feeney, 442 U.S. 256, 272, 279 (1979)).

218. *Cf.* Primus, supra note 215, at 545 ("[A] decision to raise taxes in Beverly Hills and lower them in South Central Los Angeles would probably be invalid if it were based on simple racial animus toward whites.").

219. *See supra* notes 2–14; *cf.* Douglas NeJaime, *Winning Through Losing*, 96 IOWA L. REV. 941, 973 (2011) (describing civil rights organizations that "coordinate litigation strategies and go to great lengths to avoid unfavorable precedent").

220. *See supra* note 4 and accompanying text.

221. *See* Siegel, *supra* note 156, at 1315 (observing that "[i]n oral argument in Ricci, Chief Justice Roberts seemed in fact to suggest that he had accepted as constitutional race-conscious school siting decisions in Parents Involved" and quoting Justice Roberts' statement that "I thought both the plurality and the concurrence in Parents Involved accepted the fact that race conscious action such as school siting or drawing district lines is--is okay, but discriminating in particular assignments is not.").

Given current precedent, while asserting that a policy is "not about race" but "about race and disadvantage"[222] is preferable to describing racial disparity reduction as a policy's sole purpose, policymakers should be careful to avoid using individual race even as one factor among many, lest their policy be invalidated under strict legal scrutiny. While ensuring that a policy aims to address population-level disadvantage as well as racial disparity is helpful, and perhaps even necessary, considering other forms of disadvantage will not excuse a policy that considers *individual* race from strict scrutiny. For instance, a policy that "[i]f you're healthy, just the fact you're African American doesn't mean that you ought to get to the front of the line," whereas you would move to the front "[i]f you're African American, and you're a bus driver, and you have chronic diseases," has public health merit but would face strict scrutiny under present law because it considers individual race.[223] Such a policy would have escaped strict scrutiny under Justice Stevens' *Adarand* dissent, but not under controlling precedent. In contrast, a policy that prioritized bus drivers (of any race) with chronic diseases who live in a poor, segregated community is legally unproblematic.[224] Likewise, current doctrine prohibits not only basing eligibility and prioritization decisions "solely on somebody's race or ethnicity," but also basing such decisions, unless they can satisfy strict scrutiny, on individual race or ethnicity *at all.*[225] Meanwhile, it is equally clear—despite confused statements by officials who profess "fear that singling out neighborhoods for priority access could invite lawsuits alleging race preference"[226]—that decisions neither based on individual racial classifications nor motivated by racial disparity reduction raise no legal concerns, even when they serve to substantially reduce disparities.[227]

The greatest areas of remaining unclarity and potential doctrinal change center on two other questions, one involving racial data in implementation and another involving disparity reduction as an allowable aim (Table 1). First, while current doctrine appears to permit the use of population-level racial data without strict scrutiny, it is unclear whether avoiding the use of such data nevertheless buttresses the legal safety of a policy, as some officials and scholars believe.[228]

222. Flaccus, *supra* note 205.

223. Nicholas St. Fleur, *Health Experts Want to Prioritize People of Color for a Covid-19 Vaccine. But How Should It Be Done?*, STAT NEWS (Nov. 9, 2020), https://www.statnews.com/2020/11/09/health-experts-want-to-prioritize-people-of-color-for-covid19-vaccine-but-how-should-it-be-done/ [https://perma.cc/LW4D-HG7Q].

224. *Cf.* Am. C.R. Found. v. Berkeley Unified Sch. Dist., 90 Cal. Rptr. 3d 789, 792 (2009) (holding that categorization by neighborhood demographics is not discriminatory because it does not use individual racial classifications).

225. *See* Flaccus, *supra* note 205.

226. Abby Goodnough & Jan Hoffman, *The Wealthy Are Getting More Vaccinations, Even in Poorer Neighborhoods*, N.Y. TIMES (Mar. 4, 2021), https://www.nytimes.com/2021/02/02/health/white-people-covid-vaccines-minorities.html [https://perma.cc/KF6C-3U4K].

227. *See Am. C.R. Found.*, 90 Cal. Rptr. 3d at 792.

228. *See* Paul M. Ong & Jonathan D. Ong, *Assessing Vulnerability Indicators and Race/Ethnicity*, UCLA CTR. FOR NEIGHBORHOOD KNOWLEDGE 12 (Jan. 18, 2021), https://knowledge.luskin.ucla.edu/wp-content/uploads/2021/01/Assessing-Vulnerabilities-V2.pdf [https://perma.cc/MP9G-AP34] ("Base[d] on a strict interpretation of Proposition 209, the SVI [Social Vulnerability Index] indicator could be considered not a viable option because one of its input variables is based on race.").

Second, it remains unclear whether ensuring that racial disparity reduction is not a policy's sole or preeminent aim protects a policy against allegations of improper purpose, though some courts have indicated that it does.[229]

1. Public Health and Environmental Justice

Commented [WK1]: Should be a third-level heading

As some commentators have proposed, and California and other jurisdictions have implemented,[230] individuals from vulnerable neighborhoods or geographic areas could be given priority access to a defined portion of the pool of available treatments.[231] This approach would parallel approaches used by school districts after *Parents Involved*.[232] It would also parallel longstanding efforts in public health to direct interventions to at-risk communities. For instance, two states, Virginia and Rhode Island, "analyzed race and ethnicity data and targeted interventions to specific geographic locations."[233] Virginia used geographic and other data to collect a multi-level spatial analysis that identified factors associated with infant mortality, including the racial breakdown of a census tract, percentage of children by race in poor neighborhoods, and health professional shortage areas.[234] They then identified that "inequities exist in birth outcomes mostly in communities where there is low education attainment, a significant African American population, and high poverty rates," and recommended that resources be directed to those communities.[235] Similarly, Rhode Island used a place-based method to identify areas with high prevalence of access to tobacco products, based on findings that ethnic and racial minorities were suffering disparately from tobacco-related illnesses, and to direct smoking cessation efforts to those

229. *See* Doe *ex rel*. Doe v. Lower Merion Sch. Dist., 665 F.3d 524, 556–57 (3d Cir. 2011).

230. Janie Har & Kathleen Ronayne, *California to Give 40% of Vaccine to Latino, High-Risk Areas,* AP (Mar. 4, 2021), https://apnews.com/article/us-news-gavin-newsom-california-coronavirus-pandemic-d4896b54205b67af3bf607cb632155bf [https://perma.cc/F6QZ-XCS9]; *Striving Toward Equity*, UTAH.GOV (Mar. 2021), https://coronavirus-download.utah.gov/Health/Vaccine_Equity_Roadmap.pdf [https://perma.cc/3WBT-LL8T] ("Prioritize vaccine distribution to ZIP codes that have been most severely affected by COVID-19 or that have other social or economic factors that put people at higher risk."); Ellen Hine, *COVID-19 Vaccine: Equity Still Concern for Hamilton County Despite Improvement*, ENQUIRER (Mar. 10, 2021), https://www.cincinnati.com/story/news/2021/03/10/covid-19-hamilton-county-ohio-details-ways-aims-get-more-vaccines-blacks/6937826002/ [https://perma.cc/TKN8-GCS9] ("[T]he county health department has been setting aside 20% of the county's vaccine supply for pop-up clinics in suburban areas with greater disparity").

231. Parag A. Pathak, Tayfun Sönmez, M. Utku Unver & M. Bumin Yenmez, *Leaving No Ethical Value Behind: Triage Protocol Design for Pandemic Rationing* 12 (Nat'l Bureau of Econ. Rsch., Working Paper No. 26951, 2020), https://www.nber.org/system/files/working_papers/w26951/w26951.pdf [https://perma.cc/D96G-AK28].

232. *Id.* at 6 (discussing the use of similar approaches by school districts). These approaches can still face political headwinds. *See* Kathryn A. McDermott, Erica Frankenberg & Sarah Diem, *The "Post-Racial" Politics of Race: Changing Student Assignment Policy in Three School Districts*, 29 EDUC. POL'Y 504, 512–13 (2015).

233. Denise Osborn, Larry Hinkle & Jill Rosenthal, *Using Geographic Information to Target Health Disparities: State Experience*, HEALTHCARE COST AND UTILIZATION PROJECT (HCUP) (Sept. 20, 2011), https://www.hcup-us.ahrq.gov/reports/race/GeographicInfoIB.jsp [https://perma.cc/A2KD-E277].

234. *Id.*

235. *Id.*

communities.[236] It also used mapping to more efficiently use "scarce state resources" to combat lead poisoning among vulnerable populations, including refugees.[237]

A place-based approach could likewise be used to direct interventions to areas or occupations where the risk of deaths among minority patients is particularly high.[238] Such approaches, including the use of the Social Vulnerability Index developed by the Centers for Disease Control (CDC), have been proposed for vaccine allocation.[239] And several states and localities have incorporated place-based outreach to vulnerable communities into their COVID-19 response strategy.[240] Addressing racial disparities would not need to be the only, or even the primary, goal of such a policy. Instead, disparity reduction could be combined with other important policy goals that may overlap or even run counter to it, such as protecting people at high risk of poor outcomes, vaccinating people who are more likely to contract or spread the virus, or vaccinating health workers.

Place-based approaches could also be combined with individual prioritization. Socioeconomic status is not a legally protected identity, limiting "reverse discrimination" claims by people who are economically or socially better off.[241] Accordingly, states could prioritize people who are economically disadvantaged. Despite the greater burden of COVID-19 in poorer communities, few states have taken this approach. Minnesota, notably, has done so by prioritizing individuals who are dually eligible for Medicare and Medicaid.[242]

The greatest obstacles to place-based policies have stemmed not from law, but from politics—and especially from politicians motivated to view public health through a "culture war" lens. In Michigan, Republican state legislators passed an amendment that would prohibit use of the Social Vulnerability Index—

236. *Id.*

237. *Id.*

238. Evan Watson, *VDH Will Give More Vaccine Doses to Minority Communities; 'Mobile Clinics' Part of Expansion*, 13NEWSNOW (Feb. 25, 2021, 6:04 PM), https://www.13newsnow.com/article/news/health/coronavirus/vaccine/vdh-will-give-more-vaccine-doses-to-minority-communities-mobile-clinics-part-of-expanded-access/291-02ddd561-b74e-44dd-81e2-ca3b3abbdbf8 [https://perma.cc/R6K7-UP56].

239. NAT'L ACAD. OF MED., FRAMEWORK FOR EQUITABLE ALLOCATION OF COVID-19 VACCINE 8–9 (Helene Gayle, William Foege, Lisa Brown & Benjamin Kahn, eds., 2020), https://www.nap.edu/read/25914/chapter/1 [https://perma.cc/EEF3-JXNP]. Others have proposed using a similar index, the Area Deprivation Index. *See* Schmidt, *supra* note 64.

240. *E.g.*, Jared Brey, *A Tiny Public Housing Authority Offered Residents the Vaccine. Could Others Follow Suit?*, NEXT CITY (Jan. 21, 2021), https://nextcity.org/daily/entry/a-tiny-public-housing-authority-offered-residents-the-vaccine [https://perma.cc/267H-E57G].

241. *See, e.g.*, Petrella v. Brownback, 787 F.3d 1242, 1263 (10th Cir. 2015) (rejecting claim that plaintiffs are "intentionally discriminated against on the basis of their wealth"); *cf.* Massaro & Brooks, *supra* note 207, at 202 ("The shelter of zip code—or even race and poverty—government classifications may be necessary in order to effectively redress environmental injustice that travels along zip code, race, and poverty lines. Strict scrutiny of such measures may do more harm than good. . . .").

242. *Minnesota Guidance for Allocating and Prioritizing COVID-19 Vaccine–Phases 1b, 1c, 2,* MINNESOTA DEPT. OF HEALTH (Mar. 10, 2021), https://www.health.state.mn.us/diseases/coronavirus/vaccine/phase1b1c2.pdf [https://perma.cc/U4DS-NWNV] (recommending "that vaccinators prioritize people 65 years of age and older who are dual eligible for Medicare/Medicaid and younger people who participate in Minnesota Health Care Programs as they become eligible in later phases" and explaining that "people who are dual eligible for Medicare and Medicaid suffer a disparate burden of severe illness due to COVID-19").

an index endorsed by NASEM's expert panel—in vaccine allocation, criticizing the index as "social engineering" while refusing to engage with the public health evidence that social vulnerability predicts COVID-19 risk.[243] Notably, to the extent that these state legislators' preference to ignore place-based and other differential sources of risk would vanish if racial *majorities* were facing greater place-based risk (or greater risk at earlier ages, as described in Part V.B), their decisions should be legally vulnerable under a "but for" standard of discrimination liability.[244] Whether courts would engage in such review, though, remains uncertain. Other political activists have similarly attacked the use of place-based approaches.[245]

Notably, place-based policies have been used without legal incident to pursue environmental justice goals. As Sheila Foster observes, the Comprehensive Environmental Response, Compensation, and Liability Act is in part "motivated by a desire to lessen adverse impacts on minority communities," and "leaves open the possibility of using race-neutral means such as health indicators or other quantitative data to identify health or environmental impacts on a specific population and to reduce those impacts."[246] Foster also provides the example of the

> Environmental Protection Agency's (EPA's) decision to revise its methodology for setting water quality standards to incorporate a higher default fish consumption rate, [which was facially] race-neutral, . . . even though revisiting its risk assessment and standard-setting was motivated at least in part by evidence that Native American subsistence populations tend to consume far greater quantities of self-caught fish than the general population and, thus, were disproportionately harmed by the existing standard.[247]

Another commentator has focused on the issue of individual racial classifications versus aggregate consideration of race, and argued that "because equal protection applies to individuals, and strict scrutiny applies to individual racial classifications, use of race to inform decisions regarding what geographic areas or communities receive environmental attention does not raise an equal protection issue that would trigger strict scrutiny."[248] These examples suggest further support for

243. Sarah Cwiek, *The Social Vulnerability Index, COVID-19 Vaccines, and Why It Makes Some Republicans Mad* (Feb. 26, 2021), https://www.michiganradio.org/post/social-vulnerability-index-covid-19-vaccines-and-why-it-makes-some-republicans-mad [https://perma.cc/8C3Y-Y52X].

244. See Katie Eyer, *The But-For Theory of Anti-Discrimination Law*, 107 VA. L. REV. (forthcoming Dec. 8, 2021). Eyer's approach has a textualist grounding and builds on similar ideas adopted in recent Supreme Court caselaw, making its application particularly plausible. *Id.*

245. *Black, Latino Seniors in Virginia Get COVID-19 Vaccine Priority as White 85-Year-Olds Wait*, JUD. WATCH (Feb. 23, 2021), https://www.judicialwatch.org/corruption-chronicles/black-latino-seniors-in-virginia-get-covid-19-vaccine-priority-as-white-85-year-olds-wait/ [https://perma.cc/A3XC-G5DN].

246. Sheila R. Foster, *Environmental Justice and the Constitution*, 39 ENV'T L. REP. NEWS & ANALYSIS 10347, 10350 (2009); *cf.* 42 U.S.C. § 9604(k)(6)(C)(x) (using as a criterion "the extent to which a grant would address or facilitate the identification and reduction of threats to the health or welfare of . . . minority or low-income communities, or other sensitive populations").

247. Foster, *supra* note 246, at 10,350–51.

248. David F. Coursen, *Equal Protection, Strict Scrutiny, and Actions to Promote Environmental Justice*, 39 ENV'T. L. REP. NEWS & ANALYSIS 10201, 10206 (2009).

the legality of a place-based approach to treatment allocation, even if that approach recognizes reducing racial disparities as an important goal or explicitly considers aggregate racial data.

2. Scarce Medical Resources

Commented [WK2]: Should be a third-level heading

Some have argued that disparity-sensitive allocation, whatever its merits elsewhere, should not be used for scarce medical resources, which should instead be allocated according to narrow medical criteria rather than broader social criteria. The legal academic Scott Hershovitz, for instance, argues:

> I don't think we should ask doctors to remedy past discrimination. They can't do it, except haphazardly. And it's not their job. A doctor ought to consider a patient's present medical needs and nothing else: not her sex, not her race, not her long-term disabilities, not whether her mother loves her, not any fact about her, save as relevant to her medical condition.[249]

Other commentators make similar claims.[250]

The argument that doctors should ignore broader social impacts and focus only on individual patients is dubious even in the context of ordinary medical care.[251] But, more importantly, this objection misunderstands recommendations for the allocation of scarce medical resources, including not only COVID-19 treatments but other interventions such as transplantable organs. For predictably scarce treatments, allocation policies are developed at an institutional or societal level rather than left to bedside physicians.[252] Incorporating disparity reduction into scarce resource allocation policies would not ask doctors to remedy past discrimination, nor "expect . . . healthcare workers—under extreme duress of caring for patients in the ICU during a pandemic—[to] also attempt to redress the social determinants of ill health during a pandemic,"[253] but would relieve front-line health workers of the burdens of making these determinations and reduce the risk of biased, *ad hoc* decisions.

Such disparity-aware institutional or governmental policies for allocating scarce pandemic interventions would parallel federal policies for organ allocation developed by the Organ Procurement and Transplantation Network and the

249. Hershovitz, *supra* note 37, at 20.

250. *E.g.*, Silva, *supra* note 36, at 891; Reid, *supra* note 43, at 528–29 ("[T]he objection that access to medical care should be based on medical, not social, criteria."); Rosamond Rhodes, *Justice and Vaccination Priority: A Response to CDC and NASEM Proposals*, BIOETHICS.NET (Dec. 3, 2020, 1:10 PM), http://www.bioethics.net/2020/12/justice-and-vaccination-priority-a-response-to-cdc-and-nasem-proposals/ [https://perma.cc/EM4F-NEQM] ("Although the Committee correctly notes that 'the COVID-19 pandemic has highlighted long-standing, systemic health and social inequities,' . . . that serious social problem is best addressed by creating dedicated programs aimed at ameliorating such disparities. . . . Whereas reducing health and other disparities should be addressed, vaccination priority is not the means for achieving that important, but different, goal.").

251. Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 719–20 (1994); Richard S. Saver, *In Tepid Defense of Population Health: Physicians and Antibiotic Resistance*, 34 AM. J.L. & MED. 431, 477 (2008).

252. Emanuel et al., *supra* note 31, at 2051–53 (reviewing allocation proposals from U.S. and other national health systems).

253. Silva, *supra* note 36, at 891.

United Network for Organ Sharing ("UNOS"), which have long recognized reducing disparities as legitimate and important.[254] Numerous facially race-neutral changes to organ allocation policies that recognize the importance of narrowing racial disparities have been proposed or implemented without legal incident. These include changes to kidney allocation policies that allow patients with type B blood to receive certain type A kidneys,[255] the design of kidney donation "chains,"[256] and the factors used in calculating the kidney allocation score.[257] They also include changes to policies for the allocation of other organs.[258] UNOS' Minority Affairs Committee also often examines how specific policies, such as allowing multiple-organ transplants or "chains" of directed organ donation, will affect minority transplant candidates.[259] While organ allocation policy recognizes the importance of disparity reduction, it rejects the use of individual racial classifications in allocation.[260] This rejection aligns with legal commentators' predictions that organs could not legally be allocated based on individual

254. *See infra* notes 238–41.

255. *E.g.*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK /UNITED NETWORK FOR ORGAN SHARING (OPTN/UNOS), GUIDANCE FOR TRANSPLANT PROGRAM PARTICIPATION IN THE TRANSPLANTATION OF NON-A_1/NON-A_1B (A_2/A_2B) DONOR KIDNEYS INTO BLOOD GROUP B CANDIDATES 1–2, 6 (2017), https://optn.transplant.hrsa.gov/media/2347/mac_guidance_201712.pdf [https://perma.cc/3FMH-BHSM] (stating that a primary goal of kidney allocation policy "is to broaden patient access for historically disadvantaged kidney transplant candidates, which includes blood group B candidates, who have experienced greater waiting times compared to other blood groups," and that "this disparity affects minority populations most of all").

256. *See e.g.*, Chelsea Rock Haynes & Ruthanna Leishman, *Allowing Deceased Donor-Initiated Kidney Paired Donation (KPD) Chains* 2, 4 (Organ Procurement and Transplantation Network Kidney Transplant Committee, Concept Paper, 2017), https://optn.transplant.hrsa.gov/media/2219/kidney_pcconcepts_201707.pdf [https://perma.cc/GA3S-LHR4] (asking how policies for kidney paired donation chains can "be developed so as to protect vulnerable or disadvantaged populations," including "minority populations," and discussing the risk of "[u]nequal distribution across ethnic minority groups").

257. *See e.g.*, Meeting Summary from the OPTN/UNOS Minority Affairs Committee 3 (July 8, 2014), https://optn.transplant.hrsa.gov/media/1660/mac_meetingsummary_20140708.pdf [https://perma.cc/5GRU-42Z5] (discussing "four significant policy initiatives to improve access to transplantation for minority populations," including changes to the role of waiting type and antigen matching); Press Release, OPTN/UNOS Board of Directors, Board Revises Kidney Policy to Boost Minority Transplants (Nov. 14, 2002), https://optn.transplant.hrsa.gov/news/board-revises-kidney-policy-to-boost-minority-transplants/ [https://perma.cc/9A2V-D4QW].

258. *See e.g.*, OPTN/UNOS PANCREAS TRANSPLANTATION COMMITTEE, PROPOSAL TO CHANGE WAITING TIME CRITERIA FOR KIDNEY-PANCREAS CANDIDATES 11, 13 (2018), https://optn.transplant.hrsa.gov/media/2387/pancreas_publiccomment_20180122.pdf [https://perma.cc/JRE7-GBN5] (observing that a change to waiting time criteria for kidney-pancreas transplants would "increase access for minority populations" and "improve equity in access to transplant by ethnicity").

259. *See e.g.*, Meeting Summary from the OPTN/UNOS Minority Affairs Committee Meeting 2 (Sept. 18, 2017), https://optn.transplant.hrsa.gov/media/2288/mac_meetingsummary_20170918.pdf [https://perma.cc/AK2L-M3L6] (raising concerns about whether paired kidney donation chains initiated by deceased donors "may hurt minority access," and observing that "[i]t is important to see models of how these options may impact minority candidates"); *see also* Noah, *supra* note 98, at 174–75 ("The UNOS Committee on Minority Affairs regularly monitors and evaluates the impact of race on access to transplantation at all stages, on registration at the transplantation center, on the allocation process, and on the ultimate success rates of each type of procedure.").

260. U.S. DEP'T OF HEALTH & HUM. SERVS., ETHICAL PRINCIPLES IN THE ALLOCATION OF HUMAN ORGANS (2010), https://optn.transplant.hrsa.gov/resources/ethics/ethical-principles-in-the-allocation-of-human-organs/ [https://perma.cc/9HWB-GEGH] (rejecting race-based allocation of organs).

recipients' race.[261] The legal and ethical acceptance of facially race-neutral disparity reduction policies in organ allocation is a potentially promising sign for the viability of similar proposals for allocating scarce vaccines and therapeutics.

Beyond the scarcity context, disparity reduction is similarly recognized as important. Federal public health and health policy statutes recognize not only the importance of improving overall health, but also the importance of addressing racial health disparities,[262] and the federal government has referenced the importance of addressing racial disparities as a justification for asking Census respondents their race.[263] Numerous state statutes likewise explicitly reference racial disparities and assert a commitment to addressing them in a variety of areas,

261. *E.g.*, Larry J. Pittman, *A Thirteenth Amendment Challenge to Both Racial Disparities in Medical Treatments and Improper Physicians' Informed Consent Disclosures*, 48 ST. LOUIS U. L.J. 131, 181 (2003) ("[I]t is doubtful that a physician's explicit use of race to ration kidneys would satisfy the 'narrowly tailored' requirement.").

262. *See, e.g.*, 42 U.S.C. § 300u-6(a) ("The Office of Minority Health . . . shall retain and strengthen authorities . . . for the purpose of improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities."); 42 U.S.C. § 300u-13(c)(2)(B)(vi) (proposing to award grants "to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health . . ."); 42 U.S.C. § 300ff-121(a) (appropriating funds "to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders) . . ."); 42 U.S.C. § 1320b-9a(b)(2)(B) (requiring that "measures developed under the pediatric quality measures program . . ." be "designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care . . .").

263. Morales v. Daley, 116 F. Supp. 2d 801, 813 (S.D. Tex. 2000) (reporting and agreeing with Census Bureau's argument that data on race is "needed to assess racial disparities in health and environmental risks").

including immunization, maternal and child health, and women's health.[264] Reducing COVID-19 racial disparities has similarly been recognized as important at both federal and state levels.[265]

B. Preventing Early Deaths

Commented [WK3]: Should should be changged to B (since heading above got moved in)

Beyond the use of place-based policies and other policies that consider aggregate information to reduce disparities, a strategy for fair allocation of scarce

264. *E.g.*, ARK. CODE ANN. § 20-2-103(a)(7)(A) (West 2019) (directing the Arkansas Minority Health Commission to "[d]evelop, implement, maintain, and disseminate a comprehensive survey of racial and ethnic minority disparities in health and health care"); CONN. GEN. STAT. ANN. § 17b-306(a) (West 2015) (recognizing the reduction of "racial and ethnic health disparities among children" as a goal of preventative health services); FLA. STAT. ANN. § 381.7355(3)(a) (West 2019) (prioritizing "areas with the greatest documented racial and ethnic health status disparities" for access to public health grants to address disparities); 410 ILL. COMP. STAT. ANN. 100/5(c) (West 2006) (stating that it is the "intent of the General Assembly to provide funds within Illinois counties . . . to stimulate the development of community-based and neighborhood-based projects that will improve the health outcomes of racial and ethnic populations"); LA. STAT. ANN. § 40:2018.5(B)(1)-(2) (2018) (creating "Healthy Moms, Healthy Babies Advisory Council" that, *inter alia*, "shall address racial and ethnic disparities in maternal health outcomes"); MD. CODE ANN., Health-Gen. § 20-1004(7) (West 2018) (directing Office of Minority Health and Health Disparities to "support ongoing community-based programs that are designed to reduce or eliminate racial and ethnic health disparities in the State"); MASS. GEN. LAWS ANN. ch. 118E, § 13B (West 2012) (making hospital rate increases conditional on "reduction of racial and ethnic disparities in the provision of health care"); MICH. COMP. LAWS ANN. § 333.2227(a) (West 2020) (directing the development and implementation of "an effective statewide strategic plan for the reduction of racial and ethnic health disparities"); MINN. STAT. ANN. § 145.928 subdiv. 1 (West 2019) ("It is the goal of the state to decrease the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites"); MISS. CODE. ANN. § 41-3-61(1)(e) (West 2020) (legislatively finding "that when minorities have a medical home, racial and ethnic disparities in terms of medical access disappear and the costs of health care decrease"); N.J. STAT. ANN. § 26:2-162.1(a)(2)-(3) (West 2020) (directing New Jersey Office on Minority and Multicultural Health to "review the extent to which the effects of racial and ethnic disparities on the sexual and reproductive health of African-American women in a geographic area indicate the need to increase access to health care services among racial and ethnic populations in that area" and "identify ways to reduce or eliminate racial and ethnic disparities that affect the sexual and reproductive health of African-American women"); OR. REV. STAT. ANN. § 414.572(1)(f) (West 2020) (requiring coordinated care organizations to address "regional, cultural, socioeconomic and racial disparities in health care"); 23 R.I. GEN. LAWS ANN. § 23-64.1-6(a)(2) (West 2020) (committing to "[e]valuate the state's progress toward eliminating or reducing racial and ethnic health disparities").

265. *E.g.*, *FY 2020 Funding Opportunity Announcement*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF MINORITY HEALTH, https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=97 (last visited Mar. 23, 2021) [https://perma.cc/3FHU-D4C3] (funding a project whose aim is to decrease "disparities in COVID-19 testing and vaccination rates among racial and ethnic minority populations in highly impacted geographic areas"); *Michigan Coronavirus Task Force on Racial Disparities*, MICH. DEP'T OF HEALTH & HUM. SERVS., https://www.michigan.gov/mdhhs/0,5885,7-339-71551_5460_99929—-,00.html (last visited Mar. 23, 2021) [https://perma.cc/RH78-L4P7] (observing that "[t]he COVID-19 pandemic has disproportionately impacted communities of color in Michigan" and creating a task force to "study the causes of racial disparities and recommend actions to address . . . historical and systemic inequities"); Press Release, N.C. Gov. Roy Cooper, NCDHHS Announces Upcoming No-Cost COVID-19 Community Testing Event (Aug. 24, 2020), https://governor.nc.gov/news/ncdhhs-announces-upcoming-no-cost-covid-19-community-testing-event [https://perma.cc/Z9VQ-886T] (discussing an "initiative to increase access to no-cost COVID-19 testing, particularly for African American, LatinX/Hispanic and American Indian communities that currently have limited testing sites"); Press Release, Ill. Dep't Hum. Servs., The Illinois Department of Human Services Launches Targeted COVID-19 Prevention Campaign to Help Support African American Communities in Chicago (Nov. 4, 2020), https://www2.illinois.gov/Pages/news-item.aspx?ReleaseID=22302 [https://perma.cc/V5DD-Q99S] ("While COVID-19 public health and economic crisis has affected everyone across the board, there are particular and unique needs and circumstances impacting the Black community.").

treatments could further reduce disparities by addressing the outsized burden of early deaths in minority communities. COVID-19 death rates for Black persons ages twenty-five to fifty-four have been up to seven times higher than for white persons, and only slightly less disparate among same-age Hispanic and Native American populations; among Asian/Pacific Islander persons, they were more than two times higher.[266] More than a third of Hispanic patients and nearly a third of all non-white patients who have died of COVID-19 died before 65, in contrast to only 13.2% of white decedents.[267] Because of these disparities in early deaths, more total years of life before sixty-five have been lost among Black people than white people, despite the far smaller size of the Black population; the same is true when Hispanic and white populations are compared.[268] These racial disparities are especially troubling because early deaths are not only disproportionately inflicted on minority populations but are also an especially bad outcome in themselves.[269]

As an initial step in addressing these disparities, allocation policies should avoid relying solely or primarily on one-size-fits-all age cutoffs—like those that the World Health Organization and the CDC's Advisory Committee on Immunization Practices have proposed, and several states have adopted—that categorically assign patients under a specific age, such as sixty-five or seventy-five, lower priority access to scarce vaccines, regardless of other risk factors.[270] The emergency use authorizations for some therapeutics similarly use age sixty-five as an eligibility criterion for patients without specified serious comorbidities.[271] Some states, like Maine and Connecticut, have gone further to use age as the only criterion for vaccine access.[272] Such one-size-fits-all exclusions unjustifiably prioritize, for instance, a healthy sixty-six-year-old over a sixty-four-year-old essential worker who faces high exposure risk at work and has a high-risk medical condition. They also likely worsen health disparities that track economic

266. Mary T. Bassett, Jarvis T. Chen & Nancy Krieger, *Variation in Racial/Ethnic Disparities in COVID-19 Mortality by Age in the United States: A Cross-Sectional Study*, 17 PLOS MED. 1, 5 (2020).

267. Jonathan M. Wortham et al., *Characteristics of Persons Who Died with COVID-19—United States, February 12-May 18, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 923, 924 (2020).

268. Bassett, Chen & Krieger, *supra* note 266, at 2; *see also* Akilah Johnson & Nina Martin, *How COVID-19 Hollowed Out a Generation of Young Black Men*, PROPUBLICA (Dec. 22, 2020, 5:30 AM), https://www.propublica.org/article/how-covid-19-hollowed-out-a-generation-of-young-black-men [https://perma.cc/LPS8-8E6L].

269. *See* Ryan M. Antiel et al., *Should Pediatric Patients Be Prioritized When Rationing Life-Saving Treatments During the COVID-19 Pandemic*, 146 PEDIATRICS, Sept. 2020, at 2; 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, 927 (2019); *see also* White & Lo, *supra* note 7.

270. *See* Jon Cohen, *The Line Is Forming for a COVID-19 Vaccine. Who Should Be at the Front?*, SCI. (June 29, 2020, 5:30 PM), https://www.sciencemag.org/news/2020/06/line-forming-covid-19-vaccine-who-should-be-front [https://perma.cc/S5N2-AXXL].

271. *Frequently Asked Questions on the Emergency Use Authorization for Bamlanivimab*, U.S. FOOD & DRUG ADMIN., https://www.fda.gov/media/143605/download (Jan. 29, 2021) [https://perma.cc/EY59-QM2Z].

272. Govind Persad, Emily A. Largent & Ezekiel J. Emanuel, *Opinion: Age-Based Vaccine Distribution Is not only Unethical. It's Also Bad Health Policy.*, WASH. POST. (Mar. 9, 2021), https://www.washingtonpost.com/opinions/2021/03/09/age-based-covid-vaccine-distribution-unethical/ [https://perma.cc/CGL6-K8BB].

and health inequality, because early death is correlated with economic disadvantage and with certain disabilities and medical conditions.[273] And, particularly relevant for these purposes, they also worsen racial disparities. For example, COVID-19 associated death rates among American Indian and Alaska Native ("AIAN") patients age fifty to fifty-nine were approximately 1.8 times higher than death rates among white patients a decade older (sixty to sixty-nine), and rates among AIAN patients sixty to sixty-nine were slightly higher than death rates among white patients ages seventy to seventy-nine.[274] This indicates that defining eligibility using a one-size-fits-all age cutoff inequitably assigns higher-risk minority patients less priority than lower-risk non-minority patients, and permits unnecessary harm compared to a policy that considers sources of risk other than age.[275]

Instead of using age alone to define eligibility, policymakers would do better to use age as one among multiple factors. For instance, they could follow CDC Director Robert Redfield's suggestion to "prioritize the elderly (>70 yo) who reside in multi-generation households," a proposal made on the bases that "[o]ften our Hispanic, Black and Tribal Nations families care for their elderly in multigenerational households and they are also at significant risk" and that prioritizing multi-generational households "will ensure a more equitable distribution to those most at risk for hospitalizations and fatalities."[276] The state of Washington has prioritized older residents of multigenerational households.[277] Or states could combine age with place-based approaches; the City of Dallas initially proposed to prioritize people over 65 in hard-hit areas, though their plan

273. Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States, 2001-2014*, 315 JAMA 1750, 1756 (2016); Antonio Scalfari et al., *Mortality in Patients with Multiple Sclerosis*, 81 NEUROLOGY 184, 184–92 (2013); Carsten Hjorthøj, Anne Emile Stürup, John J. McGrath & Merete Nordentoft, *Years of Potential Life Lost and Life Expectancy in Schizophrenia: A Systematic Review and Meta-Analysis*, 4 LANCET PSYCHIATRY 295, 295–301 (2017); A. M. W. Coppus, *People with Intellectual Disability: What Do We Know About Adulthood and Life Expectancy?*, 18 DEV. DISABILITIES RSCH. REV. 6, 6–16 (2013).

274. Jessica Arrazola et al., *COVID-19 Mortality Among American Indian and Alaska Native Persons—14 States, January–June 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1853, 1854 (2020).

275. Many commentators have criticized age-only policies for producing racial disparities. *See* Wendi C. Thomas & Hannah Grabenstein, *People Over 75 Are First in Line to Be Vaccinated Against COVID-19. The Average Black Person Here Doesn't Live That Long*, PROPUBLICA (Feb. 12, 2021, 11:30 AM), https://www.propublica.org/article/people-over-75-are-first-in-line-to-be-vaccinated-against-covid-19-the-average-black-person-doesnt-live-that-long {https://perma.cc/Q2EN-J43C]; Akilah Johnson, *Death in the Prime of Life: COVID-19 Proves Especially Lethal to Younger Latinos*, WASH. POST. (Mar. 15, 2021, 4:00 PM), https://www.washingtonpost.com/health/2021/03/15/covid-latinos-life-expectancy/; Fabiola Cineas, *Black and Latino Communities Are Being Left Behind in the Vaccine Rollout*, VOX (FEB. 24, 2021, 8:30 AM), https://www.vox.com/22291047/black-latino-vaccine-race-chicago [https://perma.cc/5VR8-VN8K] ("A Brookings Institution report from June 2020 found that Black people who die of Covid-19 are typically 10 years younger than white people who succumb to the disease. This means that older white people—some of whom aren't as high risk as younger Black people—have been receiving priority.").

276. Press Release, Ctrs. for Disease Control, CDC Statement Regarding ACIP Recommendations (Dec. 3, 2020), https://www.cdc.gov/media/releases/2020/s1203-acip-recommendations.html [https://perma.cc/ZC38-WPYD].

277. Jennifer Tolbert, Jennifer Kates & Josh Michaud, *The COVID-19 Vaccine Priority Line Continues to Change as States Make Further Updates*, KFF (Jan. 21, 2021), https://www.kff.org/policy-watch/the-covid-19-vaccine-priority-line-continues-to-change-as-states-make-further-updates/ [https://perma.cc/4W5R-N2C3].

was blocked after threats from state decisionmakers, and the District of Columbia has prioritized people over sixty-five in hard-hit zip codes.[278]

These plans should also adjust eligibility thresholds downward in states and localities where disadvantage has lowered life expectancy and increased the risk of early death. Some states and localities have already taken these steps.[279] Eligibility threshold adjustment must, however, comport with the legal limits discussed above. Removing or lowering age-based eligibility thresholds for hard-hit occupations or geographic areas is legally unproblematic. In other contexts, states have also lowered age thresholds by considering racial demographics at a neighborhood level.[280] But lowering or removing age-based eligibility limits on the basis of individual race—despite its popularity among advocates[281]—is unlikely to be legal.

Organizations concerned with social justice who have criticized age-based criteria in allocation policies for emergency interventions like ventilators[282] should recognize, and work to offset, the disparity-increasing effects of policies that use age cutoffs to preferentially allocate vaccines or therapeutics to older patients. Given that these organizations recognize that "people of color such as those in African American and Native American communities . . . experience lower life expectancies due to well-documented social disparities and systemic health inequities,"[283] they should recognize that one-size-fits-all age-based cut-

278. Nic Garcia, *Dallas County Shifts Access to COVID Vaccine – Again. Goal Is to Target Most Vulnerable Neighborhoods*, DALL. MORNING NEWS (Jan. 20, 2021, 2:15 AM), https://www.dallasnews.com/news/public-health/2021/01/20/dallas-county-shifts-access-to-covid-vaccine-again-goal-is-to-target-most-vulnerable-neighborhoods/ [https://perma.cc/6N4S-MX4X]; Jenna Portnoy, *D.C. to Open More Coronavirus Vaccine Appointments for Seniors, Health-Care Workers*, WASH. POST (Jan. 20, 2021, 4:24 PM), https://www.washingtonpost.com/local/dc-to-open-more-covid-vaccine-appointments-for-seniors-health-care-workers/2021/01/20/a841df06-5b65-11eb-8bcf-3877871c819d_story.html [https://perma.cc/7EXN-V4VF].

279. Hanna Merzbach, *Inside Portland's Patchwork System to Vaccinate Communities of Color*, PORTLAND MERCURY (Mar. 10, 2021, 2:00 PM), https://www.portlandmercury.com/blogtown/2021/03/10/32101365/inside-portlands-patchwork-system-to-vaccinate-communities-of-color [https://perma.cc/7PAM-FSPJ] ("As of March 5, the state granted federally-qualified health centers, such as Virginia Garcia, flexibility to vaccinate all of their patients, regardless of age."); *Black and Latino Communities are Being Left Behind in the Vaccine Rollout*, VOX (Feb. 24, 2021, 8:30 AM), https://www.vox.com/22291047/black-latino-vaccine-race-chicago [https://perma.cc/L3WM-HVAN] ("As long as someone lives in the designated zip code, irrespective of their job, age, or health status, they can get vaccinated.").

280. Two states use Older Americans Act funding distribution formulas that look at the number of minority individuals age sixty and over, and the number of older people over 75 overall. Utah Admin. Code r. R510-100-1; Ill. Admin. Code tit. 89, § 230.45.

281. Oni Blackstock & Uché Blackstock, *supra* note 65; *see also* sources cited *supra* note 71; Adam K. Raymond, *Racial Inequities Persist in Kentucky's Vaccine Rollout*, SPECTRUM NEWS 1 (Mar. 17, 2021), https://spectrumnews1.com/ky/lexington/news/2021/03/16/racial-inequities-persist-in-kentucky-s-vaccine-rollout [https://perma.cc/F29P-PGG6] (reporting statement of Pastor Timothy Findley that "rather than including only those 70 and older in the first phase of vaccines, for 'Black and Brown people, that number should have come down to 55 and included those with preexisting conditions'").

282. *E.g.*, Letter from Kathryn L. Rucker et al. to Charles Baker, Gov. of Mass. (Apr. 22, 2020), https://www.aclum.org/sites/default/files/field_documents/ltr_admin_on_revised_ma_csc.4.22.20.final_.pdf [https://perma.cc/E92R-YXE6]; Letter from Phil Pangrazio et al., to Douglas A. Ducey, Gov. of Ariz. (June 23, 2020), https://www.azdisabilitylaw.org/wp-content/uploads/2020/06/Letter-to-Gov-Ducey-Crisis-Standards-of-Care-Vulnerable-Arizonans.pdf [https://perma.cc/7DV3-4Z2P].

283. Letter from Kathryn L. Rucker et al. to Charles Baker, *supra* note 282.

offs disproportionately exclude patients of color, who are more likely to die before reaching the eligibility age. Policies that consider years of life saved as well as lives saved—which some community organizations vigorously condemned at the start of the pandemic[284]—may ultimately also benefit minority patients and serve to narrow racial disparities, given the staggeringly disproportionate number of years lost among Black and Hispanic patients.[285]

Policies that prioritize the prevention of early death when allocating ventilators and other critical care treatments would also help address disparities. While some organizations, advocates, and officials have worked to block critical care treatment allocation guidelines that prioritize preventing early deaths,[286] refusing to prioritize the prevention of early deaths entrenches widely documented disparities and fails to counteract other ways that critical care treatment allocation may worsen racial disparities.[287] In contrast, using the risk of early death to prioritize between otherwise similar patients in need of critical care treatments is a legally acceptable option that some states, including Colorado and Pennsylvania, have adopted; prioritizing the prevention of early deaths would save at least as many lives while reducing the stark disparities in death rates and years of life lost that minority communities currently face.[288] When age cutoffs—despite their recognized legal vulnerability[289]—are being used as sole criteria for vaccine access, as many states have done, the argument against using age as one factor in critical care treatment allocation to offset the disparities produced by its use in vaccine allocation rings hollow. Countenancing a vaccine allocation strategy that allows early deaths, while refusing to prioritize preventing early deaths in critical care allocation, is a "heads I win, tails you lose" approach that is not only legally dubious but countenances disparate harm to minority communities.

VI. CONCLUSION

The COVID-19 pandemic has both taken lives and taken them unequally, including by race.[290] The initially tempting approaches of randomly allocating scarce treatments or using individual race to determine access to treatments will fail at effectively and legally stemming this tide. Instead, vaccine and treatment allocation policies that effectively save lives and narrow racial disparities must understand current legal limits on the consideration of race and recognize how

284. *E.g.*, *id.* at 3–4.

285. *See* Bassett, Chen & Krieger, *supra* note 266, at 12 tbl.2.

286. Leslie P. Francis, Teneille R. Brown & James Tabery, *When Is Age Choosing Ageist Discrimination?* 51 HASTINGS CENTER REPORT 1, 1 (2020).

287. *See, e.g.,* Schmidt, *supra* note 64.

288. *See* Shelly Bradbury & Bruce Finley, *Colorado Officials Set Guidelines for Prioritizing Patient Care in Case of Coronavirus Surge*, DENVER POST (Apr. 5, 2020, 3:30 PM), https://www.denverpost.com/2020/04/05/colorado-coronavirus-covid-patient-care-guidelines/ [https://perma.cc/WH8G-DAGE]; David Wenner, *PA. Finalizes Plan for Deciding who gets Life-Saving Care if Hospitals Overwhelmed*, WITF (Apr. 13, 2020, 5:45 PM), https://www.witf.org/2020/04/13/pa-finalizes-plan-for-deciding-who-gets-life-saving-care-if-hospitals-overwhelmed/ [https://perma.cc/LE9G-QBWL].

289. *Section 1557: Frequently Asked Questions*, U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/civil-rights/for-individuals/section1557/1557faqs/index.html (May 18, 2017) [https://perma.cc/ZHQ2-MGSL].

290. *See* Bassett, Chen & Krieger, *supra* note 266, at 2.

policies in other contexts have effectively navigated the current legal landscape. This Article has identified two effective approaches to treatment allocation—facially race-neutral policies that work by considering social and economic sources of vulnerability, often at the neighborhood level, without classifying individuals by race, and policies that prioritize the prevention of early deaths and avoid one-size-fits-all age exclusions. These approaches can both save lives and combat the racial disparities produced by the pandemic while satisfying current law's exacting demands.

TABLE 1: EQUAL PROTECTION AND PLACE-BASED POLICIES FOR DISPARITY REDUCTION

		Aims	
		Racial Disparity Reduction	**Nonracial Disparity Reduction**
Implementation	**Uses Neighborhood-Level Racial Demographic Data**	Berkeley, CA school assignment policy; use of Social Vulnerability Index to address COVID-19 racial disparities	Use of Social Vulnerability Index to address COVID-19 economic or geographic disparities
	Uses No Racial Demographic Data	Many school assignment policies; use of Area Deprivation Index to address COVID-19 racial disparities	Use of Area Deprivation Index to address COVID-19 economic or geographic disparities