No. 20-941

IN THE SUPREME COURT OF THE UNITED STATES

GREGORY ATKINS, et al.,
Petitioners,

v.

DR. KENNETH WILLIAMS,
Medical Director, Tennessee Department of Correction, in his official capacity,
Respondent.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Sixth Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

The Tennessee Department of Correction tests every inmate for hepatitis C on intake, unless the inmate opts out. Those who test positive receive regular monitoring and assessment, and inmates at any stage of disease progression are eligible for (though not guaranteed to receive) expensive direct-acting antiviral treatment. Using criteria that align with guidance from the Federal Bureau of Prisons and give priority to the sickest inmates, an advisory committee comprised of qualified healthcare professionals determines which inmates will receive that treatment. A class of inmates with chronic hepatitis C sued the Department's medical director for injunctive relief, alleging that his failure to immediately provide direct-acting antivirals to every infected inmate violates the Eighth Amendment.

The question presented is whether the Department's medical director is deliberately indifferent to the medical needs of inmates with chronic hepatitis C.

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INTRODUCTION

In an Eighth Amendment case based on a denial of medical care, a prisoner must prove "'deliberate indifference' to his 'serious' medical needs." *Wilson v. Seiter*, 501 U.S. 294, 297 (1991) (quoting *Estelle v. Gamble*, 429 U.S. 97, 106 (1976)). Petitioners—Tennessee prisoners infected with hepatitis C—argued below that the medical director of the Tennessee Department of Correction ("TDOC") violated this standard by failing to immediately treat all chronic hepatitis C patients with expensive direct-acting antivirals. The Sixth Circuit correctly rejected that argument. It did not, as Petitioners contend, hold that a lack of funding provided a *defense* to Petitioners' claim. It simply held that the medical care that Petitioners receive—which includes "in-depth evaluation," "extensive monitoring and continuous care," and eligibility to be considered for antiviral treatment at any stage of disease progression—is the opposite of deliberate indifference, especially "[i]n the real world of limited resources." App. 9-11.

There is no reason for this Court to review that decision. Petitioners urge this Court to grant review to decide whether "the unavailability of funds or other resources negate[s] the subjective component of a deliberate indifference claim," either generally or in suits for injunctive relief specifically. Pet. i-ii. But the Sixth Circuit did not decide either of those broad questions; it instead based its holding on numerous case-specific factors other than funding. App. 9-11. If this Court wishes

to address those questions, it should do so in a case in which they are squarely presented.

Nor is review needed to resolve any circuit conflict. The first purported conflict Petitioners identify concerns whether a lack of funds is a defense in a suit for *damages*. Because this suit seeks only equitable relief, it does not implicate any conflict on that distinct question. And the much shallower conflict Petitioners identify in cases involving claims for equitable relief is illusory. All circuits to have considered what role funding constraints play in injunction suits alleging inadequate medical treatment have adopted the same uniform approach, in which funding is a relevant, but not dispositive, consideration in determining whether an Eighth Amendment violation has occurred. The cases on which Petitioners rely to suggest otherwise are easily distinguishable.

In any event, this case is not an appropriate vehicle for resolving any conflict among the circuits. A ruling in Petitioners' favor on the questions presented would not change the outcome of this case. The district court held that Petitioners failed to satisfy either the objective or subjective component of their deliberate indifference claim, and the holding regarding the objective component provides an alternative ground for affirmance. Moreover, it is far from clear that this case remains "live and justiciable." Pet. 26. Petitioners acknowledge that the named class representatives' claims are now moot. *Id.* Whether the case may proceed notwithstanding that

mootness presents a difficult and fact-intensive question that would complicate this Court's review at the very least if not preclude it altogether.

Even if the decision below were construed as establishing a lack-of-funds "defense," that holding would be correct in the circumstances of this case. The Eighth Amendment does not require prison officials to immediately provide an unusually expensive medical treatment to all infected prisoners, without regard to individual symptoms or disease progression. Nor does it "guarantee prisoners the right to be entirely free from the cost considerations that figure in the medical-care decisions made by most non-prisoners in our society." *Reynolds v. Wagner*, 128 F.3d 166, 175 (3d Cir. 1997) (Alito, J.). To the contrary, federalism and separation-of-powers principles require that a State's elected branches be allowed to consider costs in determining how best to allocate their finite resources.

STATEMENT OF THE CASE

A. Legal background

The Eighth Amendment, which applies to States through the Due Process Clause of the Fourteenth Amendment, *Robinson v. California*, 370 U.S. 660, 666-67 (1962), prohibits "cruel and unusual punishments." U.S. Const. amend. VIII. Although the primary concern of its drafters was to forbid "tortures and other barbarous methods of punishment," *Gregg v. Georgia*, 428 U.S. 153, 170 (1976) (joint opinion of Stewart, Powell, and Stevens, JJ.) (quotation marks omitted), this

Court has held that the Eighth Amendment also protects against "some deprivations that were not specifically part of the sentence but were suffered during imprisonment." *Wilson*, 501 U.S. at 297 (citing *Estelle*, 429 U.S. 97). The Court has made clear, however, that "only the 'unnecessary *and wanton* infliction of pain' implicates the Eighth Amendment." *Id.* (quoting *Estelle*, 429 U.S. at 104).

In *Estelle*, the Court held that an inmate alleging a deprivation of medical treatment must at a minimum show "deliberate indifference to serious medical needs." 429 U.S. at 106. "[O]nly such indifference" can violate the Eighth Amendment. *Id.* Allegations of "an inadvertent failure to provide adequate medical care," or that "a physician has been negligent in diagnosing or treating a medical condition" do not "state a valid claim of medical mistreatment under the Eighth Amendment." *Id.* at 105-06; *see also Wilson*, 501 U.S. at 297.

To establish that a prison official has been deliberately indifferent to a serious medical need, a prisoner must satisfy two requirements—the first objective and the second subjective. First, "the deprivation alleged must be, objectively, 'sufficiently serious'" to violate the Eighth Amendment. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (quoting *Wilson*, 501 U.S. at 298). Second, the prison official must "know[] that [an] inmate[] face[s] a substantial risk of serious harm and disregard[] that risk by failing to take reasonable measures to abate it." *Id.* at 847. In a suit for prospective relief, the subjective factor "should be determined in light of the prison

authorities' current attitudes and conduct." *Id.* at 845 (quoting *Helling v. McKinney*, 509 U.S. 25, 36 (1993)).

B. Factual background

1. Petitioners' class action claim

Petitioners are TDOC inmates who are infected with chronic hepatitis C. In 2016, on behalf of themselves and a class of similarly situated inmates, Petitioners sued TDOC's medical director, Dr. Kenneth Williams, in his official capacity under 42 U.S.C. § 1983, alleging that he was being deliberately indifferent to their medical needs in violation of the Eighth and Fourteenth Amendments. App. 1-2, 23-24. Specifically, Petitioners argued that Dr. Williams was violating the Eighth Amendment by failing to provide "immediate, universal treatment" of all class members with direct-acting antivirals. *Id.* at 60. Petitioners sought declaratory and injunctive relief, but they did not seek damages. *Id.* at 5, 17, 23. The district court certified a class and then held a four-day bench trial on the class's claim in July 2019. *Id.* at 1-2, 6, 23.

2. Hepatitis C

Hepatitis C is a contagious virus that spreads through contact with infected blood. App. 2, 25. The virus affects the liver, in some cases diminishing its ability to remove toxins from the body. *Id.* at 2. Approximately 15 to 25 percent of patients infected with hepatitis C spontaneously recover during the acute phase of infection,

which lasts around six months. *Id.* at 2, 25. Patients who do not recover during the acute phase proceed to the chronic stage of infection. *Id.*

Chronic hepatitis C is a progressive disease that causes scarring of the liver, known as fibrosis. *Id.* at 2, 26. The rate at which scarring progresses, if at all, varies widely among patients. *Id.* Medical professionals use a five-point score to measure the progression. *Id.* at 26. Patients with a score of F0 have no significant fibrosis, while patients with scores of F1, F2, and F3 have mild, moderate, and advanced fibrosis, respectively. *Id.* Patients with a score of F4 have progressed to cirrhosis of the liver. *Id.*

The symptoms of hepatitis C also vary among patients and do not depend on a patient's fibrosis stage. *Id.* at 27. Patients in both the acute and chronic phases may experience fatigue, jaundice, nausea, and pain. *Id.* at 26. Patients with more advanced fibrosis may experience vasculitis, skin lesions, and kidney, heart, and cognitive symptoms, while others are asymptomatic. *Id.* Some patients who progress to stage F4 suffer from "decompensated" cirrhosis. *Id.* Those patients experience some degree of liver failure and are at increased risk of developing liver cancer. *Id.* at 27. Others—those with "compensated" cirrhosis—lose no liver function at all. *Id.* at 26-27. Approximately 20 to 40 percent of chronic hepatitis C patients will eventually progress to the cirrhosis stage, and around four percent will develop liver cancer. *Id.* at 27.

At the time of trial, approximately 4,740 of the 21,000 inmates in TDOC custody were known to be infected with chronic hepatitis C. *Id.* at 24. Of the inmates who had been evaluated and staged by fibrosis level, 63 percent were in the F0 or F1 stage, 9 percent were in the F2 stage, and 29 percent were in the F3 or F4 stage. *Id.* at 38.

There is currently no vaccine for hepatitis C. *Id.* at 27. Until 2011, the standard treatment for patients with chronic hepatitis C involved injections of a drug called interferon, which caused severe side effects and brought little success. *Id.* at 2-3, 28. In 2011, the U.S. Food and Drug Administration approved direct-acting antivirals as a treatment. *Id*. at 28. Direct-acting antivirals are extremely effective: they usually result in "virologic cure," which means the virus is no longer detectable in the patient's blood. *Id.* at 3, 28. But they are also extremely costly. *Id.* at 49. In 2015, a course of antiviral treatment cost between $80,000 and $189,000, depending on the complexity of the case. *Id.* At the time of trial, the cost had declined to between $13,000 and $32,000 per course. *Id.*

Petitioners' expert, Dr. Zhiqiang Yao, testified that the "best practice" for treating chronic hepatitis C patients is to begin antivirals "as early as possible" once the chronic phase of the infection commences. *Id.* at 30. The American Association for the Study of Liver Diseases ("AASLD") and other healthcare organizations also

recommend antiviral treatment as the "standard of care" for all chronic hepatitis C patients, regardless of their fibrosis stage. *Id.* at 30-31.

3. Tennessee's comprehensive treatment plan for inmates with hepatitis C

As TDOC's medical director and chief medical officer, Dr. Williams is responsible for developing TDOC's guidance documents for inmate medical treatment. App. 34. In 2019, due in part to the declining cost of antiviral treatment, Dr. Williams developed new guidance to govern the treatment of inmates with hepatitis C. *Id.* at 3, 35. That guidance, which replaced guidance from 2016, is mandatory for all healthcare professionals treating inmates in TDOC custody. *Id.* at 36. It "controls the testing, evaluation, staging, prioritization, treatment, and monitoring of TDOC inmates with chronic" hepatitis C and "is being continuously improved." *Id.* at 37. The guidance is paired with a "workflow" document that outlines the specific steps that providers must take when treating inmates with hepatitis C. *Id.* at 5. The workflow ensures that the guidance is implemented uniformly across TDOC's facilities. *Id.* TDOC also established an electronic recordkeeping program to systematically facilitate prompt, efficient, and consistent treatment of inmates. *Id.* at 48-49.

Under the 2019 guidance, all inmates are tested for hepatitis C at intake unless they opt out. *Id.* at 37. Within two months of diagnosis, all inmates who test positive for hepatitis C receive a baseline evaluation that includes a physical examination,

blood tests, and a non-invasive scan to assess fibrosis progression. *Id.* at 37-38. Inmates with chronic hepatitis C are then enrolled in a chronic care clinic and evaluated at least every six months. *Id.* at 43. These periodic evaluations include, among other things, a physical exam, laboratory testing, and assessment of fibrosis progression. *Id.*

The "cornerstone" of the 2019 guidance is an advisory committee that makes treatment determinations for individual chronic hepatitis C patients. *Id.* at 36. Dr. Williams chairs the committee, and its members include TDOC's associate medical director, an infectious disease specialist, and a pharmacist. *Id.* at 4, 35-36. Unlike the 2016 guidance, under which only inmates with a fibrosis stage of F3 or F4 were eligible to receive antivirals, the 2019 guidance makes *all* inmates with chronic hepatitis C eligible to be considered for antiviral treatment, regardless of fibrosis stage. *Id.* at 38.

Consistent with TDOC's goal to treat inmates "in a cost effective manner that is most efficient for the greatest number of individual inmates," the 2019 guidance establishes criteria for prioritizing antiviral treatment among inmates. *Id.* at 35, 38. The highest priority is given to inmates with fibrosis at stage F4 or F3 and those with coinfection or comorbid conditions, regardless of fibrosis stage. *Id.* at 38-39. Inmates with fibrosis at stage F2 or with comorbid chronic kidney disease receive the next highest priority, followed by inmates at stage F0 or F1 without comorbid

conditions. *Id.* at 39. The guidance makes clear that the "prioritization criteria are not comprehensive and do not include all possible patient conditions or clinical scenarios." *Id.* at 4 (quotation marks omitted). Rather, "[a]ll treatment decisions are patient-specific." *Id.* (quotation marks omitted).

TDOC's prioritization approach mirrors that of the Federal Bureau of Prisons. *Id.* at 41. Moreover, Dr. Yao acknowledged that he used a similar prioritization system when treating hepatitis C patients at the Veterans' Administration. *Id.* at 60. And the AASLD also historically recommended prioritization of antiviral treatment. *Id.* at 42-43.

The advisory committee meets at least once a month, often twice, to determine whether individual patients should receive direct-acting antivirals. *Id.* at 39. The committee makes its determinations based on a patient's medical records, after front-line providers perform a "complete workup" of the patient. *Id.* at 36. As of July 16, 2019, TDOC had prescribed antivirals for approximately 450 inmates, or about 10 percent of inmates known to have chronic hepatitis C, including some patients with lower-stage fibrosis. *Id.* at 24-25, 39.

The number of inmates the committee considers for antiviral treatment at its meetings is increasing. *Id.* at 40. At the time of trial, Dr. Williams predicted that the number of patients considered at each meeting would soon quadruple. *Id.* He further predicted that the committee would review and treat all known inmates with

stage F3 or F4 fibrosis with direct-acting antivirals within the next twelve months. *Id.* at 7, 48-49.

TDOC has always used all funds budgeted for hepatitis C to purchase direct-acting antivirals. *Id.* at 7. Dr. Williams has repeatedly and successfully sought to increase that budget. *Id.* While TDOC's budget for hepatitis C was only $600,000 in 2016, that amount increased to $2.6 million in 2017 and 2018 and to almost $30 million in 2019, thanks to a one-time appropriation of nearly $25 million. *Id.* Dr. Williams planned to "spend every penny" of that money on antiviral treatment and predicted that TDOC's 2019 budget would allow it to provide antiviral treatment to over 1,800 inmates. *Id.* (quotation marks omitted).

C. Decisions below

Following trial, the district court issued its findings of fact and conclusions of law and entered judgment in favor of Dr. Williams. App. 22-70. The court observed that TDOC's treatment of inmates with hepatitis C prior to 2019 had been "erratic, uneven, and poor." *Id.* at 44-45. But the only issue before the court was the constitutionality of the 2019 guidance. *Id.* at 5-6, 48, 59.

Although the district court found that chronic hepatitis C is a "serious medical condition," *id.* at 58, it concluded that TDOC's 2019 guidance was not objectively so "incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness." *Id.* at 59 (quotation marks omitted). The court

found that Dr. Yao's testimony and the AASLD's recommendations established that early and universal antiviral treatment is the "best practice" or "gold standard" for treating chronic hepatitis C. *Id.* at 61-62 (quotation marks omitted). But Petitioners had nevertheless failed to satisfy the objective component of their deliberate indifference claim because the Eighth Amendment guarantees only adequate care, not the best possible care. *Id.* at 61-63. Even Dr. Yao acknowledged that prioritization of patients may be necessary when treatment resources are limited. *Id.* at 60. The "multifaceted set of policies and protocols" for hepatitis C treatment that TDOC put in place in 2019 were an "improvement from past treatment protocols" and served the "dual goals of maximizing and prioritizing treatment." *Id.* at 61. Even if not the "gold standard," the 2019 guidance was not "so unreasonable or so contrary to medical standards that no competent medical professional would make similar choices." *Id.* at 62-63.

Turning to the subjective component of Petitioners' claim, the district court concluded that Petitioners failed to establish that Dr. Williams "acted with a culpable state of mind equivalent to criminal recklessness." *Id.* at 66. The proof instead established "the opposite": that Dr. Williams "has used, and is using, his medical judgment to provide reasonable care for" inmates with chronic hepatitis C through the "creation, administration, and modification of TDOC policies and treatment protocols." *Id.*

A divided panel of the court of appeals affirmed. Although the district court held that Petitioners failed to satisfy either the objective or subjective component of their deliberate indifference claim and although Dr. Williams disputed both components in his appellate brief, the court of appeals stated that the only question on appeal was whether Petitioners had satisfied the subjective component. *Id.* at 9.[1]

The majority concluded that the "answer to that question is clear." *Id.* "Rather than reveal indifference," the record "support[ed] the conclusion that" Dr. Williams "sought to employ the finite resources at his disposal to maximize their benefit for the inmates in his care." *Id.* at 10. Among other things, he "required an in-depth evaluation of every inmate infected with hepatitis C," "required extensive monitoring and continuous care for every infected inmate," and "required an advisory committee of medical professionals . . . to make individualized decisions regarding treatment for every infected inmate, and to revise those decisions when the inmate's condition so warranted." *Id.* at 9-10. And he revised TDOC's "criteria for access to direct-acting antivirals to favor the sickest inmates—regardless of whether an inmate had advanced liver scarring." *Id.* at 10.

[1] Petitioners are incorrect that Dr. Williams "conceded every aspect of Petitioners' deliberate indifference claim" except the subjective component. Pet. 11. Dr. Williams argued below that Petitioners failed to satisfy both the objective and subjective components of their claim. *See* Br. of Defendant-Appellee Dr. Kenneth Williams at 23-42, *Atkins v. Parker*, No. 19-6243 (6th Cir. Feb. 24, 2020) (Dkt. No. 21). And he continues to press both arguments in this Court. *See* pp. 23-27, *infra*.

Although the majority agreed with Petitioners that treating all chronic hepatitis C patients with antivirals is the "best practice," it concluded that Dr. Williams's failure to provide such treatment did not establish deliberate indifference. *Id.* at 10 (quotation marks omitted). Petitioners were "in essence demand[ing] that [Dr. Williams] spend money he did not have." *Id.* Petitioners' suggestion that "Dr. Williams violated the Constitution by failing to ask the legislature for even more money" was "not even a colorable ground upon which to reverse the district court." *Id.* The record instead showed that Dr. Williams "repeatedly sought budget increases for hepatitis C treatment, indeed with considerable success; and that he spent 'every penny' of those funds on treating sick inmates." *Id.* Dr. Williams thus was not deliberately indifferent. *Id.* at 11.

Judge Gilman dissented. *Id.* at 12-21. He believed it was unreasonable for TDOC to "ration[]" antivirals because the "medical establishment's guidance has evolved" in recent years as data "began to show the benefits of early treatment and the long-term risks of delay." *Id.* at 13. Judge Gilman also believed that TDOC was constitutionally required to "make whatever financial or prison-population adjustments necessary in order for it to treat all of the inmates with chronic hepatitis C remaining in its custody." *Id.* at 18. He acknowledged, however, that the Constitution does not forbid all "consideration of cost by prison officials" and that

an official "may choose a less expensive treatment among several reasonable options." *Id.* at 20.

REASONS FOR DENYING THE PETITION

Certiorari should be denied for four reasons. First, the Sixth Circuit did not decide the questions presented by the petition. Second, this case does not implicate any conflict among the lower courts that warrants this Court's review. Third, this case would be a poor vehicle to resolve any such conflict. And fourth, the decision below is correct because the Eighth Amendment does not mandate that prisoners receive immediate and universal access to costly medical treatment that even non-prisoners may be unable to obtain.

I. The Sixth Circuit Did Not Decide the Questions Presented.

Petitioners ask this Court to review two broad questions. The first is whether the "unavailability of funds or other resources negate[s] the subjective component of a deliberate indifference claim under the Eighth Amendment." Pet. i. The second is whether a defendant can "assert [a lack-of-funds] defense when sued in his or her official capacity for injunctive relief." *Id.* at ii. But the decision below did not address those questions. Because this Court is "a court of review, not of first view," it should deny certiorari rather than consider those questions in the first instance. *Cutter v. Wilkinson*, 544 U.S. 709, 718 n.2 (2005).

The Sixth Circuit did not purport to recognize a lack-of-funds defense to Eighth Amendment deliberate indifference claims, either generally or in suits for injunctive relief specifically. The Sixth Circuit instead focused on the narrow question before it: whether Dr. Williams "so recklessly ignored the risk of hepatitis C, in designing and implementing the 2019 guidance, that he was deliberately indifferent to that risk." App. 9 (quotation marks omitted). To answer that question, the Sixth Circuit relied on many case-specific facts apart from funding availability: that Dr. Williams "required an in-depth evaluation of every inmate infected with hepatitis C," secured "advanced diagnostic equipment" to accurately measure liver scarring, mandated "extensive monitoring and continuous care for every infected inmate," and required an advisory committee of medical professionals "to make individualized decisions regarding treatment for every infected inmate, and to revise those decisions when the inmate's condition so warranted." *Id.* at 9-10. The funds available to Dr. Williams were but one consideration in the Sixth Circuit's analysis, *id.*, not an outcome-dispositive element as Petitioners argue.

Not surprisingly, since the Sixth Circuit did not recognize a lack-of-funds defense at all, it had no occasion to consider whether the availability of the defense should vary depending on the type of relief sought. Indeed, it would have had no occasion to do so even if it *had* recognized such a defense. Petitioners sought only

equitable relief, not damages. So this case presented no opportunity to tease apart whether suits for injunctive relief require a different rule than suits for damages.

If this Court is interested in considering the availability of a lack-of-funds defense, it should do so in a case in which the question is squarely presented. This is not that case. The petition should be denied for that reason alone.

II. There Is No Conflict That Warrants This Court's Review.

Petitioners contend that "[t]he federal courts of appeals have split on whether a lack of funds or other resources can defeat a deliberate indifference claim by undercutting the mental state requirement." Pet. i. They identify two purported conflicts: one concerning whether a lack-of-funds defense is available in suits for damages; and a much shallower second conflict concerning whether a lack-of-funds defense is available in suits for injunctive relief. Since this case involves only a claim for equitable relief, it does not implicate the first conflict at all. And the second conflict is illusory.

As for the first purported conflict, Petitioners contend that five circuits—the Sixth, Eighth, Tenth, Ninth, and Eleventh Circuits—have held that lack of funding *can* defeat a deliberate indifference claim in a *damages suit*, while four circuits—the Second, Third, Fourth, and District of Columbia Circuits—have held the opposite. Pet. 12-16, 19. But even if that conflict were genuine, it would provide no reason to grant review *in this case*. It is undisputed that Petitioners sought only "injunctive

and declaratory relief, not damages." Pet. 8. Petitioners claim that this distinction in relief is significant; they say that four of the circuits that recognize a lack-of-funds defense in suits for damages have reached the opposite conclusion in suits for injunctive relief. Pet. 12. If that is true, then granting review in this case, which involves only a claim for equitable relief, would provide no opportunity to resolve the primary conflict that Petitioners identify.

The second purported conflict in cases involving claims for injunctive relief provides no reason to grant certiorari either, because it is wholly illusory. Petitioners maintain that the Sixth Circuit is now the only court that recognizes a lack-of-funds defense to deliberate indifference claims that seek exclusively equitable relief. Pet. 19-20. But as explained above, the Sixth Circuit did not adopt any bright-line rule that a lack of funding will *always* defeat a deliberate indifference claim. *See* p. 16, *supra*. Instead, funding constraints are but one of many relevant considerations in determining whether an Eighth Amendment violation has occurred.

Petitioners are also mistaken that other circuits have adopted the opposite bright-line rule, in which a lack of funds is *never* relevant to whether prison officials were deliberately indifferent in an injunction suit. Pet. 2, 12-16, 18. To the contrary, four of the circuits that Petitioners place in that camp—the First, Third, Seventh, and Eleventh, *see id.*—have expressly recognized that funding is a relevant, though not

dispositive, consideration in determining whether a prison official has been deliberately indifferent to an inmate's medical needs.

In *Zingg v. Groblewski*, 907 F.3d 630 (1st Cir. 2018), the First Circuit rejected the "proposition that there is a per se Eighth Amendment prohibition against corrections officials considering cost" in deciding what medical treatment to provide inmates. *Id.* at 638. In *Reynolds*, 128 F.3d 166 (Alito, J.), the Third Circuit explained that "the deliberate indifference standard of *Estelle* does not guarantee prisoners the right to be entirely free from the cost considerations that figure in the medical-care decisions made by most non-prisoners in our society." *Id.* at 175. And the en banc Seventh Circuit agrees that "the cost of treatment is a factor in determining what constitutes adequate, minimum-level care." *Petties v. Carter*, 836 F.3d 722, 730 (7th Cir. 2016) (en banc), *cert. denied*, 137 S. Ct. 1578 (2017); *see also Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir. 1999) (holding that "the civilized minimum" level of care required by the Eighth Amendment "is a function both of objective need and of cost"); *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997) ("A prison is not required by the Eighth Amendment to give a prisoner medical care that is as good as he would receive if he were a free person, let alone an affluent free person.").

The Eleventh Circuit very recently considered the role of cost in a decision that, like the decision below, rejected a claim that prison officials were deliberately

indifferent to the medical needs of inmates with hepatitis C by failing to provide immediate, universal treatment with direct-acting antivirals. *Hoffer v. Sec'y, Fla. Dep't of Corr.*, 973 F.3d 1263 (11th Cir. 2020). Following the First, Third, and Seventh Circuits, the Eleventh Circuit made clear that "cost considerations" are not "off-limits to reviewing courts charged with determining whether prison officials have acted in so reckless and conscience-shocking a manner as to violate the Constitution." *Id.* at 1277. Rather, "cost can (and often will) be a relevant criterion in determining what the Eighth Amendment requires in a particular circumstance," even if it "can never be an absolute defense to what the Constitution otherwise requires." *Id.*

Petitioners cite no case holding to the contrary. Many of the cases they cite hold only that a lack of funding will not excuse government officials from providing prospective remedies for conduct that *actually violates* the Constitution. As the en banc Ninth Circuit put it, "prison officials may be compelled to expand the pool of existing resources in order to remedy *continuing Eighth Amendment violations*." *Peralta v. Dillard*, 744 F.3d 1076, 1083 (9th Cir. 2014) (en banc) (emphasis added), *cert. denied*, 574 U.S. 1073 (2015); *see also Wellman v. Faulkner*, 715 F.2d 269, 274 (7th Cir. 1983) (holding that lack of funding did not excuse "appalling medical deficiencies" that amounted to "cruel and unusual punishment"); *Williams v. Bennett*, 689 F.2d 1370, 1388 (11th Cir. 1982) ("[W]hen a court is considering

injunctive relief against the operation of an unconstitutionally cruel and unusual prison system, it should issue the injunction without regard to legislative financing."); *Ramos v. Lamm*, 639 F.2d 559, 573 n.19 (10th Cir. 1980) (suggesting in a footnote that "lack of funding is no excuse for depriving inmates of their constitutional rights"); *Smith v. Sullivan*, 611 F.2d 1039, 1043-44 (5th Cir. 1980) (lack of funding will not "excuse the perpetuation of unconstitutional conditions of confinement"); *Todaro v. Ward*, 565 F.2d 48, 52-53, 54 n.8 (2d Cir. 1977) (stating that "[i]nadequate resources" will not "excuse the denial of constitutional rights" in a case where the record left "no doubt" that "medical practices and procedures . . . were constitutionally infirm"); *Finney v. Ark. Bd. of Corr.*, 505 F.2d 194, 202 (8th Cir. 1974) ("lack of funds" will not "justify lack of competent medical care" when the deficiencies at issue "are of a constitutional nature"). Because none of these cases holds that funding considerations are entirely irrelevant to deciding whether an Eighth Amendment violation has occurred, they do not conflict with the decision below.

Moreover, many of the cases Petitioners cite considered deliberate indifference claims in contexts other than medical treatment. Four of the cases addressed claims that prison officials were deliberately indifferent to inmate safety. *See LaMarca v. Turner*, 995 F.2d 1526, 1530-31, 1536-37 (11th Cir. 1993); *Morgan v. Dist. of Columbia*, 824 F.2d 1049, 1056-57 (D.C. Cir. 1987); *Williams*, 689 F.2d

at 1374; *Ramos*, 639 F.2d at 572-74. Two of the cases addressed claims that prisons were unconstitutionally overcrowded. *See Smith*, 611 F.2d at 1041-44; *Finney*, 505 F.2d at 201-02. Another two addressed claims that inmates had been unconstitutionally deprived of exercise. *See Williams v. Greifinger*, 97 F.3d 699, 700 (2d Cir. 1996); *Mitchell v. Rice*, 954 F.2d 187, 191-92 (4th Cir. 1992). And another involved a claim that prison officials unconstitutionally deprived prisoners of heat. *Rozecki v. Gaughan*, 459 F.2d 6, 7 (1st Cir. 1972).[2] As subsequent case law from the First, Third, and Eleventh Circuits makes clear, even courts that supposedly have rejected the "lack of funds" defense in those distinct contexts nevertheless recognize that cost is a relevant consideration when inadequate *medical treatment* is alleged. *See* pp. 19-20, *supra*. That is because the "deliberate indifference standard" does not shield prisoners from the "cost considerations that figure in the medical-care decisions made by most non-prisoners in our society." *Reynolds*, 128 F.3d at 175 (Alito, J.). Thus, even if those cases had adopted the bright-line rules that Petitioners attribute to them, they would not conflict with the decision below because this case involves a materially different issue.

In short, the decision below is of a piece with other lower court decisions holding that cost is a relevant—but not dispositive—factor in determining whether

[2] The First Circuit's decision in *Rozecki* also predates *Estelle* and does not apply the deliberate indifference standard. 459 F.3d at 8.

a prison official's provision of medical care to an inmate violates the Eighth Amendment. No court has held to the contrary. There is therefore no conflict that warrants this Court's review.

III. This Case Is a Poor Vehicle to Decide the Questions Presented.

Petitioners contend that this case "present[s] an ideal opportunity" for this Court to resolve the questions presented. Pet. 25. Not so. The questions presented are not outcome-dispositive in this case, and this case may be moot because none of the named plaintiffs has a personal stake in the outcome.

A. Deciding the questions presented in Petitioners' favor would not affect the outcome of this case.

Even if the questions presented were worthy of review, the Court still should deny certiorari because they are purely academic in this case: regardless of how the Court might decide them, Petitioners still cannot succeed on their deliberate indifference claim.

First, even if a lack of funds cannot by itself "negate" the subjective component of a deliberate indifference claim, Pet. i, it is still a relevant consideration in deciding whether prison officials have been deliberately indifferent to a serious medical need. Petitioners acknowledge as much. Pet. 28 ("The cost of a particular treatment may influence whether the Eighth Amendment requires it."). So did the dissent below. App. 20 (Gilman, J., dissenting) ("None of this is to say that the

Constitution forbids *any* consideration of cost by prison officials."). And the federal courts of appeals are in uniform agreement on this point. *See* pp. 18-20, *supra*.

The Sixth Circuit and the district court merely applied that settled principle: they treated funding considerations as one relevant factor among many in determining that Dr. Williams was not deliberately indifferent to the medical needs of inmates with hepatitis C. App. 9-11 (Sixth Circuit opinion) (relying on the extensive testing, monitoring, and treatment protocols that Dr. Williams developed, in addition to funding constraints); *id.* at 36-40, 49, 66-67 (district court opinion) (same). Regardless of what this Court might decide about the availability of a lack-of-funds defense in the abstract, there is no question that Dr. Williams was not deliberately indifferent to the needs of inmates with hepatitis C in this case. If the Court wishes to address the so-called "lack of funds defense," Pet. i, it should do so in a case where a lack of funds is actually asserted *as a defense* to conduct that would otherwise qualify as deliberate indifference—that is, where a lack of funds is the *only* claimed reason that the defendant's conduct does not satisfy the subjective component of deliberate indifference.

Second, even if this Court were to hold that Petitioners established the subjective component of deliberate indifference, Dr. Williams would still prevail because, as the district court correctly held, Petitioners failed to establish the objective component. App. 59-66. To violate the Eighth Amendment, a deprivation

of care must be "sufficiently serious," such that it denies "the minimal civilized measure of life's necessities." *Farmer*, 511 U.S. at 834 (quoting *Wilson*, 501 U.S. at 298, and *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)). When an inmate receives *no* medical attention for a serious condition, he suffers a deprivation that is sufficiently serious to satisfy the objective component. *Rhinehart v. Scutt*, 894 F.3d 721, 737 (6th Cir. 2018); *see also Estelle*, 429 U.S. at 104-05 & n.11. But when an inmate receives ongoing medical attention for his condition and complains that the care is inadequate, "the objective component of an Eighth Amendment claim requires a showing of care so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness." *Rhinehart*, 894 F.3d at 737 (quotation marks omitted); *see also Estelle*, 429 U.S. at 104 & n.10 (describing cases in which medical staff "thr[ew] away the prisoner's ear and stitch[ed] the stump" or injected a prisoner with penicillin "with knowledge that [the] prisoner was allergic" to the drug). Only in those rare cases of grossly incompetent care has an inmate been denied "the minimal civilized measure of life's necessities." *Farmer*, 511 U.S. at 834 (quoting *Rhodes*, 452 U.S. at 347); *see also Hudson v. McMillian*, 503 U.S. 1, 9 (1992) (explaining that the Eighth Amendment does not require that inmates "have unqualified access to health care").

The care that inmates with chronic hepatitis C receive from Dr. Williams is not so inadequate as to deny them "the minimal civilized measure of life's

necessities." *Farmer*, 511 U.S. at 834 (quoting *Rhodes*, 452 U.S. at 347). Upon being diagnosed with hepatitis C, inmates receive a prompt, comprehensive baseline evaluation that includes blood and fibrosis tests. App. 62. Inmates undergo reassessment every six months at a chronic care clinic where they receive "close, regular, and comprehensive monitoring." *Id.* at 5, 62. This reassessment "consists of a physical exam, bloodwork and other laboratory tests, patient-specific hepatitis C counseling, . . . additional measurement of liver scarring," and, for inmates with advanced scarring, "an ultrasound screening for cancer." *Id.* at 5. TDOC uses the information from these assessments "to determine whether to revise an infected inmate's course of treatment or—in the case of inmates who are not receiving direct-acting antivirals—whether to change their priority level for those drugs." *Id.* "Treatment by the chronic care clinic continues until an inmate is administered [direct-acting antivirals] and achieves [virologic cure]." *Id.* at 62. This course of care is not so "grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness." *Rhinehart*, 894 F.3d at 737 (quotation marks omitted). As the Eleventh Circuit recently explained in a nearly identical case, "diagnosing, monitoring, and managing conditions—even where a complete cure may be available—will often meet the 'minimally adequate medical care' standard that the Eighth Amendment imposes." *Hoffer*, 973 F.3d at 1273.

Petitioners fault Dr. Williams for falling short of the "gold standard" of hepatitis C care: immediate, universal direct-acting antiviral treatment regardless of fibrosis stage or other indicators of disease progression. App. 62. But the Eighth Amendment does not require that prisoners receive the gold standard of care. *See Farmer*, 511 U.S. at 834; *Hudson*, 503 U.S. at 9. Because the challenged hepatitis C guidance does not deprive inmates of the objective, minimally adequate level of care mandated by the Eighth Amendment, Petitioners' claim fails regardless of how this Court might rule on the subjective component of their claim. *See Hoffer*, 973 F.3d at 1277 ("[B]ecause we have held that the Eighth Amendment's 'minimally adequate care' does *not* require the Secretary to prescribe [direct-acting antivirals] to all F0- and F1-level inmates, without respect to comorbid conditions or disease progression, the issue of a cost 'defense' never arises.").

In sum, if the Court wishes to decide whether a lack of funds can negate the subjective component of a deliberate indifference claim, it should do so in a case in which that defense is cleanly presented and outcome dispositive. This case is a poor vehicle for resolving that question because Dr. Williams has never maintained—and the Sixth Circuit did not hold—that a lack of funds was the only reason he was not deliberately indifferent. Nor could Petitioners satisfy the objective component of deliberate indifference in any event.

B. This case may be moot.

Petitioners contend that this case still presents a live controversy even though all four named plaintiffs have either begun antiviral treatment, completed it, or been paroled. Pet. 26. But it is far from clear that this case remains justiciable.

In the class action context, the Court has held that the mootness of the named plaintiffs' claims does not "inexorably" moot the entire action where a class has been properly certified. *Sosna v. Iowa*, 419 U.S. 393, 401 (1975). But neither has the Court "adopted a flat rule that the mere fact of certification of a class by a district court [i]s sufficient to require [the Court] to decide the merits of the claims of unnamed class members when those of the named parties ha[ve] become moot." *Kremens v. Bartley*, 431 U.S. 119, 130 (1977). Instead, whether a certified class action may proceed if the named plaintiffs' claims become moot on appeal depends on "the specific circumstances of the given case at the time it is before this Court." *Id.* at 133 (quoting *Franks v. Bowman Transp. Co.*, 424 U.S. 747, 755 (1976)). Among the factors the Court considers in this case-specific inquiry is whether the claim at issue is so inherently transitory that it will inevitably "evade review" before a lawsuit runs its normal course. *Id.*; *see also Sosna*, 419 U.S. at 402.

In cases in which the named plaintiff's claim will inevitably become moot in the normal course of litigation, "there is a significant benefit in according the class representative the opportunity to litigate on behalf of the class, since otherwise there

may well never be a definitive resolution of the constitutional claim on the merits by this Court." *Kremens*, 431 U.S. at 133. But the same cannot be said when the class's claim is not so inherently transitory. In that circumstance, the Court usually requires a continuing adverse relationship between the named plaintiff and the defendant. *See Sosna*, 419 U.S. at 402 ("In cases in which the alleged harm would not dissipate during the normal time required for resolution of the controversy, the general principles of Art. III jurisdiction require that the plaintiff's personal stake in the litigation continue throughout the entirety of the litigation."); *Franks*, 424 U.S. at 755-56 & n.8 (characterizing "the 'capable of repetition, yet evading review' dimension of *Sosna*" as prudential rather than constitutional but reaffirming its relevance in the class action context); *Kremens*, 431 U.S. at 133 (reiterating that "the 'evading review' element [is] one factor to be considered in evaluating the adequacy of the adversary relationship" between unnamed class members and a defendant).

Thus, the Court has often considered whether a named plaintiff's claim will inevitably evade review when deciding whether unnamed members of a certified class "may succeed to the adversary position of a named representative whose claim becomes moot." *Kremens*, 431 U.S. at 133; *see also, e.g.*, *Bell v. Wolfish*, 441 U.S. 520, 526 n.5 (1979) (mootness of class representatives' claims did not moot class action "because of the temporary nature" of the harm allegedly suffered); *Gerstein v. Pugh*, 420 U.S. 103, 110 n.11 (1975) (holding that class action challenging pretrial

confinement was not moot despite conviction of class representatives because "[p]retrial detention is by nature temporary, and it is most unlikely that any given individual could have his constitutional claim decided on appeal before he is either released or convicted").

Here, the harm that the class complains of is not so transitory in nature that it will invariably evade review "during the normal time required for resolution of the controversy." *Sosna*, 419 U.S. at 402. Many inmates in Tennessee are serving lengthy sentences, and the disease progression of hepatitis C is such that some of these inmates may not require antivirals for years—if at all. App. 2. If Petitioners are correct that thousands of inmates will be denied antivirals for the foreseeable future, Pet. 26,[3] there is no reason that one of those inmates could not serve as a class representative and thereby ensure that at least one named plaintiff retains a "personal stake in the litigation . . . throughout [its] entirety." *Sosna*, 419 U.S. at 402. But Petitioners have not asked this Court to remand for the substitution of new class representatives with live claims, *cf. Dillard v. Indus. Comm'n of Va.*, 416 U.S. 783, 792 (1974), or to substitute new class representatives on appeal, *cf. Baxter v. Palmigiano*, 425 U.S. 308, 310 n.1 (1976).

[3] As discussed below, *see* pp. 31-33, *infra*, there are reasons to doubt this assertion by Petitioners, and those reasons create mootness concerns of their own.

Respondent is aware of only one case in which the Court reached the merits of a class action claim notwithstanding the mootness of the named plaintiff's claim when the underlying claim was not so transitory that it would necessarily evade review. *Franks*, 424 U.S. at 752-57. But the Court reached the merits in *Franks* only after careful "examination of the circumstances and the record of th[at] case." *Id.* at 756. The record in *Franks* revealed that the unnamed class members who would succeed to the adversary position of the named plaintiff were "identifiable individuals, individually named in the record" who would plainly benefit from a favorable decision by the Court. *Id.* Given that reality, the Court was satisfied that a "live controversy" existed. *Id.*

Unlike in *Franks*, the unnamed class members here are not "identifiable individuals, individually named in the record." *Id.* Instead, Petitioners seek to avoid mootness by invoking the claims of an unspecified number of unidentified inmates. Pet. 26. Petitioners contend that "thousands of infected inmates remain untreated and would benefit from a favorable decision by the Court." *Id.* But even if that assertion was true when the district court and court of appeals issued their decisions, it is unlikely to remain true during the pendency of any merits proceedings before this Court.

Recent internal data from TDOC reveals that most, if not all, consenting inmates with chronic hepatitis C may well receive direct-acting antivirals before the Court would issue a decision in this case.[4] At the time of trial in July 2019, there were about 4,740 inmates known to be infected with chronic hepatitis C. App. 24. Between July 1, 2019, and February 24, 2021, TDOC treated 1,978 inmates with direct-acting antivirals. Counsel has been informed that TDOC's current goal moving forward is to administer antivirals to between 75 and 150 inmates in stages F3 and F4 each month and at least 200 inmates in stages F0 through F2 each month. At those rates, the current population of untreated inmates in stages F3 and F4 (265 inmates as of February 24) would receive antivirals within two to four months, and the current population of untreated inmates in stages F0 through F2 (2,307 inmates as of February 24) would receive antivirals within a year. Those estimates do not account for new hepatitis C infections that will be diagnosed during intake in the coming months, but they nonetheless demonstrate that TDOC is well on its way to

[4] Although this recent data is not in the record, counsel are mindful of their obligation to call to this Court's attention any facts that may moot this case "*without delay*." *Bd. of License Comm'rs of Town of Tiverton v. Pastore*, 469 U.S. 238, 240 (1985) (emphasis in original); *see also* Stephen M. Shapiro et al., *Supreme Court Practice* § 13.11(k)(3), pp. 13-36 to 13-37 (11th ed. 2019) ("Any important factual or legal development occurring after the decision below was rendered . . . should be brought to the Court's attention . . . if the development may change the status of the case or the need for the Court to resolve the questions raised.").

providing direct-acting antivirals to most if not all inmates with chronic hepatitis C in the reasonably foreseeable future.[5]

Given TDOC's ongoing efforts to treat infected inmates with antivirals and the prospect that some infected inmates will be released from custody in the coming months, it is unclear how many inmates, if any, might benefit from any eventual decision of this Court. The lack of clarity in this fluid situation distinguishes this case from *Franks* and should give the Court pause about whether it can properly reach the merits. *See* 424 U.S. at 756.

At the very least, the issue of mootness will complicate this Court's review and require continual monitoring if this Court grants certiorari. The Court must undertake a searching inquiry into "the specific circumstances of [this] case at the time it is before this Court." *Kremens*, 431 U.S. at 133 (quoting *Franks*, 424 U.S. at 755). And if it becomes clear that the case is moot after the Court grants review, the Court will be obliged to dismiss the case on jurisdictional grounds. *See N.Y. State Rifle & Pistol Ass'n v. City of New York*, 140 S. Ct. 1525, 1526 (2020) (per curiam). These mootness questions—which the Court must resolve before reaching the merits—are yet another reason to deny review.

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[5] Since trial, some 250 inmates have refused antiviral treatment, raising a question whether this case could be moot even if some class members remain untreated. *See Franks*, 424 U.S. at 756 ("No questions are raised concerning the continuing desire of *any* of these class members for the . . . relief presently in issue." (emphasis added)).

IV. The Decision Below Is Correct.

As explained above, *see* pp. 23-27, *supra*, Petitioners' deliberate indifference claim fails regardless of the amount of funding available for antiviral treatment. The district court correctly concluded that the care inmates with chronic hepatitis C receive from Dr. Williams is not objectively inadequate, App. 58-66, and both the district court and the Sixth Circuit concluded that Petitioners failed to satisfy the subjective component of deliberate indifference for reasons other than a lack of funding, *id.* at 9-11, 66-67. Critically, moreover, the Sixth Circuit never held that the absence of sufficient funds automatically negates the subjective component of a deliberate indifference claim. *Id.* at 9-11.

But even if the decision below were construed as establishing a lack-of-funds "defense," that holding would be correct in the circumstances presented here, where a deliberate indifference claim is based on the failure to immediately provide unusually expensive medical treatment to all infected inmates regardless of disease progression. "Healthcare can be expensive—sadly, sometimes prohibitively so." *Hoffer*, 973 F.3d at 1277. "Every minute of every day, ordinary Americans forgo or delay beneficial—and even life-altering—medical treatment because it's just too expensive." *Id.* at 1276-77. The Eighth Amendment does not immunize incarcerated inmates from that reality. *Id.* at 1277.

Given this reality, if a particular medical treatment is expensive enough, that fact alone means that prisons are not constitutionally required to immediately provide the treatment to inmates—even if they would be constitutionally required to provide the treatment if it were less expensive. *See Ralston*, 167 F.3d at 1162 (explaining that what the Eighth Amendment requires in this context "is a function both of objective need and of cost"); *accord Hoffer*, 973 F.3d at 1276. Demands for "expensive interventions" raise "very serious questions," especially if the underlying medical condition poses no imminent threat to life or limb. *Ralston*, 167 F.3d at 1162. Under the contemporary standards of decency that this Court applies in the Eighth Amendment context, it is not cruel and unusual for a prison to refuse medical treatments that are prohibitively expensive. After all, expense prohibits many Americans outside prison walls from receiving such treatments. *See Hoffer*, 973 F.3d at 1276-77; *Maggert*, 131 F.3d at 671; *Reynolds*, 128 F.3d at 175 (Alito, J.); *see also* App. 6, 60 (explaining that Petitioners' own expert previously used a prioritization system for distributing direct-acting antivirals at the Veterans' Administration when resources were limited).

Direct-acting antivirals are sufficiently expensive that the Eighth Amendment does not mandate that Tennessee universally and immediately provide them to all inmates with chronic hepatitis C, as Petitioners seek. At the time of trial, there were approximately 4,740 inmates known to have chronic hepatitis C, and the cost of a

single course of antivirals was between $13,000 and $32,000. App. 24, 49. Thus, it would cost Tennessee somewhere between $60 and $150 million dollars to grant the class the immediate relief it seeks, not including future inmates who will enter custody with hepatitis C or contract the disease in prison. "In the real world of limited resources," there is nothing unconstitutional about failing to immediately provide unusually expensive drugs—the gold standard of care—to all inmates with chronic hepatitis C. *Id.* at 10-11.

Petitioners argue that judicial sensitivity to state budgetary concerns creates federalism problems, Pet. 24, but they have it exactly backwards. "Federalism concerns are *heightened* when . . . a federal court decree has the effect of dictating state or local budget priorities." *Horne v. Flores*, 557 U.S. 433, 448 (2009) (emphasis added). And that is precisely the effect that the relief Petitioners seek would have, in an area—prison management—that carries heightened federalism concerns of its own. *See, e.g.*, *Thornburgh v. Abbott*, 490 U.S. 401, 407-08 (1989) ("[T]he judiciary is ill equipped to deal with the difficult and delicate problems of prison management . . . ." (quotation marks omitted)); *accord Lewis v. Casey*, 518 U.S. 343, 385-88 (1996) (Thomas, J., concurring).

"When a federal court orders that money be appropriated for one program, the effect is often to take funds away from other important programs." *Horne*, 557 U.S. at 448. And besides that predictable effect, mandating that inmates receive the most

expensive medical care—the gold standard—may have other unintended consequences. *See Colwell v. Bannister*, 763 F.3d 1060, 1087 (9th Cir. 2014) (Bybee, J., dissenting) (explaining that mandating expensive medical care may lead prisons to release inmates instead of treating them and that it "remains to be seen" whether those inmates "will have the resources then to attend to their own medical needs"). These realities provide all the more reason for federal courts to consider both the cost of medical care and funding constraints when deciding whether prison officials have been deliberately indifferent to serious medical needs.

Petitioners also contend that federal courts "provide a necessary check on the tendency to devalue prisons," Pet. 22, but this case proves that elected officials—not federal judges—are best suited to balance the competing interests at stake. *See Jones v. N.C. Prisoners' Labor Union, Inc.*, 433 U.S. 119, 137 (1977) (Burger, C.J., concurring) ("[I]t 'reflects no more than a healthy sense of realism' on our part to understand that needed reforms in the area of prison administration must come, not from the federal courts, but from those with the most expertise in this field"—"prison administrators themselves." (quoting *Procunier v. Martinez*, 416 U.S. 396, 405 (1974))). TDOC's practice of providing ongoing care and monitoring for all inmates with hepatitis C while prioritizing the sickest inmates to receive expensive direct-acting antivirals effectively balances the State's competing interests in caring for sick inmates and funding other important programs. By contrast, Petitioners'

proposed remedy—immediate antiviral treatment for all inmates with chronic hepatitis C, regardless of disease progression—is completely unworkable and would usurp the authority of the elected branches by "tak[ing] funds away from other important programs." *Horne*, 557 U.S. at 448.

CONCLUSION

The petition for a writ of certiorari should be denied.

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