No. 14-114

IN THE

Supreme Court of the United States

DAVID KING, et al.,

Petitioners,

v.

SYLVIA MATHEWS BURWELL, AS UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES, et al.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF AMICI CURIAE HARVARD LAW SCHOOL CENTER FOR HEALTH LAW AND POLICY INNOVATION, ET AL. IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICI CURIAE[1]

Amici are the Harvard Law School Center for Health Law and Policy Innovation; ADAP Advocacy Association; AID Atlanta, Inc.; AIDS Action Coalition of Huntsville; AIDS Action Committee of Massachusetts; AIDS Alabama; AIDS Foundation of Chicago; AIDS Institute; AIDS Project Los Angeles; AIDS Resource Center of Wisconsin; AIDS Resource Center Ohio; AIDS United; American Academy of HIV Medicine; Association of Nurses in AIDS Care; Caracole, Inc.; Cascade AIDS Project; Center for HIV Law and Policy; Christie's Place; Colorado Organizations Responding to AIDS; Community Access National Network; Community Catalyst; Duke AIDS/HIV and Cancer Legal Project; Equality New Mexico; Gay Men's Health Crisis; God's Love We Deliver; Health-HIV; HIV Medicine Association; Illinois Coalition for Immigrant and Refugee Rights; Justice Resource Institute; Legacy Community Health Services; Lifelong; Los Angeles LGBT Center; Michigan Consumers for Healthcare; Nashville CARES; National Alliance of State and Territorial AIDS Directors; New Hampshire Voices for Health; NJ For Health Care; NO/AIDS Task Force; North Carolina AIDS Action Network; Ohio Public Health Association; Positive Women's Network Colorado; Pozitively Healthy Coalition; Project Inform; Southern HIV/AIDS Strategy

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[1] By letters on file with the Clerk, all parties have consented to the filing of this brief. Pursuant to Supreme Court Rule 37.6, amici state that no counsel for a party authored this brief in whole or in part; no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief; and no person—other than amici, their members, or their counsel—made such a monetary contribution.

Initiative; UHCAN Ohio; Whitman-Walker Health; and Women's Collective.

While each amicus has its own particular mission, they collectively serve populations that are deeply affected by the availability of federal subsidies under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). Several amici are dedicated to addressing the needs and interests of people living with HIV and AIDS, and all amici have can speak to the harmful consequences that would result from a reversal in this case.

Amici write: (1) to demonstrate that Congress's provision in the ACA of federal subsidies to people who have gained access to insurance on the federal exchanges accomplishes Congress's goal of achieving near-universal coverage and improving the Nation's health; (2) to explain the harms—to vulnerable populations, middle- and low-income households, and higher-earning households alike—that Petitioners' erroneous interpretation of the ACA would cause; and (3) to explain the negative effect that Petitioners' proposed interpretation of the ACA would have on the national ability to respond to public health threats, such as the HIV epidemic, the Ebola virus, pandemic flu, or other as-yet unanticipated public health crises.

SUMMARY OF ARGUMENT

One of the central pillars of the ACA is Congress's creation of health insurance exchanges, which expanded access to the private individual health insurance market for households that do not receive employer-sponsored or public health insurance coverage. 42 U.S.C. § 18091(2)(D), (I)-(J). As the Act's structure demonstrates, Congress understood that ensuring na-

tionwide access to affordable health insurance requires eliminating discriminatory practices, mandating coverage to achieve broad insurance risk pools, and extending subsidies to middle- and low-income Americans who cannot afford to purchase coverage on their own. Together, the ACA's insurance market reforms, individual mandate, and subsidies have yielded the Act's core achievement: transforming the private health insurance markets in all 50 States and the District of Columbia such that nearly all Americans now have access to health insurance.

The government persuasively demonstrates, and the court of appeals correctly held, that the language, structure, and purpose of the Act reveal Congress's aim to permit the use of federal subsidies even in States that decline to establish State exchanges. Those arguments will not be repeated here. Amici write to explain that it makes eminent sense that Congress would have provided for such a scenario, and that available data show that the ACA is accomplishing Congress's goal of achieving "near-universal" access to quality health insurance coverage. 42 U.S.C. § 18091(2)(D). Early results include dramatic expansions of health insurance access among middle- and low-income households and significant reforms in the private insurance market that benefit exchange participants of all income levels nationwide. Health insurance plans are now more comprehensive, premium prices have remained stable, and discriminatory insurance coverage practices are prohibited.

Importantly, increased access to health insurance benefits not only the newly insured, but the Nation as a whole, as Congress intended. This brief reports evidence of both types of success. First, Congress's achievement of its goal is reflected in accounts of indi-

viduals and families whose lives are transformed because—through the subsidies available in all States—they can now obtain the health care they need and are less subject to financial insecurity. Second, the ACA's expansion of health insurance access in all States promises to improve the national ability to respond to epidemics and other large-scale public health threats, just as health insurance access improved the ability of States with broad health insurance to combat the HIV epidemic.

The negative results of a reversal in this case go well beyond "adverse policy consequences." Pet. Br. 15. Rather, the evidence shows that Petitioners' proposed interpretation of the ACA would render a significant provision of the Act ineffective in a majority of States. There is no reason to interpret the Act to render the federal exchanges inoperative, depriving millions of people of access to the health insurance on which they now depend, when Congress plainly intended to bring about the very improvements in individual, familial, and national health care that the ACA has provided when interpreted as the Internal Revenue Service and the Fourth Circuit have interpreted it. This Court should affirm the judgment of the court of appeals.

ARGUMENT

REVERSAL OF THE JUDGMENT BELOW WOULD DEPRIVE MILLIONS OF RECENTLY INSURED AMERICANS OF NEW-FOUND ACCESS TO HEALTH INSURANCE, SERIOUSLY THREATEN HEALTH OUTCOMES, AND UNDERMINE THE NATION'S ABILITY TO ADDRESS EPIDEMICS AND OTHER PUBLIC HEALTH THREATS

A. The ACA's Provision Of Federal Subsidies In All States Has Dramatically Improved Health Insurance Access And Is Integral To The Act's Insurance Market Reforms

The ACA's overall impact on the U.S. health care landscape cannot yet be definitively assessed, but the Act has already transformed the private individual health insurance markets nationwide by significantly expanding access among middle- and low-income households and by reforming these markets for all participants. But if individuals and families in 34 States lose access to federal subsidies—as Petitioners would have it—then health insurance would once again become unaffordable for many, and the federal health insurance exchanges would likely collapse. As a result, the individuals and families who have gained so much under the Act would personally suffer the consequences: Millions of middle- and low-income households would lose access to health insurance altogether, and millions more would have to pay significantly higher premiums to maintain coverage.

1. The ACA's subsidies have yielded unprecedented gains in insurance access among middle- and low-income households

Before the ACA's premium subsidies, middle- and low-income Americans had great difficulty obtaining

affordable health insurance coverage. Millions of households could not access affordable health insurance through their employer, were ineligible for Medicaid and Medicare, and were excluded by—or simply could not afford—plans offered on the private individual market. *See* Hall & Lord, *Obamacare: What the Affordable Care Act Means for Patients and Physicians*, BMJ 1, 2 (2014). The 2014 launch of the ACA's health insurance exchanges brought a sea change, as every household with an income between 100 and 400 percent of the Federal Poverty Level (FPL) (between $11,670 and $46,680 for an individual, and between $23,850 and $95,400 for a family of four in 2014) could access comprehensive health insurance, regardless of employment, place of residence, or health status. Notwithstanding a rollout plagued by technical difficulties, 8 million people nationwide enrolled in exchange health plans during the 2014 open enrollment period, with over 6.7 million individuals (85 percent) obtaining access to affordable insurance through subsidies. Jost, *Implementing Health Reform: A Summary Health Insurance Marketplace Enrollment Report*, Health Affairs Blog (May 1, 2014).

The transition from being uninsured or underinsured to being adequately insured with the help of federal subsidies can be life-changing. For example, Phil Sherburne, 43, and his wife Leia Bell, 37, own a small business in Salt Lake City.[2] Because of a preexisting shoulder injury, Mr. Sherburne had been unable to access affordable insurance through the individual mar-

[2] The personal accounts reported in this brief were obtained through personal interviews conducted by the Harvard Law School Center for Health Law and Policy Innovation and are used with permission of the individuals involved.

ket for himself, his family, or the employees of his small business. Many insurers denied him family and small-group coverage altogether; others only offered plans with prohibitively high premiums. When his family was uninsured, Mr. Sherburne could not obtain treatment for his injured shoulder, Ms. Bell could not obtain diagnostic tests for persistent abdominal pain, and the couple had to pay out-of-pocket for all health care for their three sons, ages 13, 10, and 8.

In 2014, after implementation of the ACA, Mr. Sherburne enrolled his family in a health insurance plan through the federally operated exchange in Utah. Mr. Sherburne and Ms. Bell were eligible for subsidies because their projected income was $40,000, or less than 150 percent FPL. With subsidies, the entire family was covered for a premium of just $123 per month; without subsidies, the monthly premium would have been $850. Immediately after becoming insured through the ACA, Mr. Sherburne received his first physical examination in over a decade, visited a dermatologist for cancer screening, and obtained physical therapy that improved his shoulder injury and, his doctor believes, likely eliminated the need for future surgery. Once she became insured, Ms. Bell was able to see a doctor about her abdominal pain and, as a result, received surgery to remove her gallbladder just three days later. The surgery was successful; for the first time in her adult life, Ms. Bell no longer suffers from chronic pain. Mr. Sherburne and Ms. Bell also no longer have to pay out-of-pocket health expenses for their three children. When their son recently broke his thumb, his emergency care and cast were both covered.

Mr. Sherburne and Ms. Bell renewed their health insurance plan on Utah's federal exchange for 2015, and their premium payments remain a low $174, com-

pared to the $805 they would have to pay without subsidies. Without access to their $631 monthly subsidy, Mr. Sherburne and Ms. Bell would be forced to cancel their family's health insurance coverage. Mr. Sherburne and Ms. Bell cannot pay themselves a higher salary without jeopardizing their business; they both drive used cars and have no monthly car payment; their children already wear hand-me-down clothing; and they do not take family vacations. Their budget simply could not accommodate the $9660 annual premium that Petitioners' interpretation of the Act would require them to pay.

Lisa Paterson, 60, who is self-employed and lives in Moab, Utah, likewise could not access or afford comprehensive health insurance on the individual market until the ACA's subsidies made it possible. For four years prior to the ACA, she delayed obtaining the health care she needed because of coverage and cost issues. Ms. Paterson was denied access to comprehensive coverage on the individual market because she suffers from preexisting conditions, including an autoimmune disease, osteoporosis, and a previously torn anterior cruciate ligament. Only by depleting her savings account was she able to purchase a high-deductible catastrophic insurance plan, which had a premium of approximately $330 per month and a $7000 deductible.

In 2014, however, Ms. Paterson signed up for a comprehensive HMO plan through Utah's federally run exchange that, after subsidies, cost her only $16.90 per month. Without the subsidies, Ms. Paterson's monthly premium costs would have been $475.34. In 2014, this comprehensive plan enabled Ms. Paterson to visit her primary care physician four times to monitor her conditions and obtain all recommended preventive care. After a routine mammogram revealed a suspicious mass,

Ms. Paterson received diagnostic testing at a world-renowned cancer institute. During the 2015 open enrollment period, Ms. Paterson purchased a new insurance plan on Utah's federally run exchange and, because she earns less than 133 percent FPL, she now pays just $26.30 for her monthly premium costs, compared to the $501.30 she would have to pay without subsidies. If she loses access to this $475 monthly subsidy, Ms. Paterson's only option for maintaining insurance coverage that costs $6015 annually would be to withdraw funds from her retirement account.

As the 2015 open enrollment period is still underway, complete enrollment data are not yet available. But preliminary data indicate that subsidies will once again enable millions of middle- and low-income Americans to obtain affordable health insurance coverage in States using federal exchanges. HHS, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report* 23 (Dec. 2014). Accordingly, all indications are that the subsidies will continue to play a critical role in reducing the number of uninsured Americans.

2. The subsidies are integral to maintaining insurance market reforms for all exchange participants

The ACA's subsidies are important not only to those who qualify for them, but also to those who do not. Households that do not qualify for subsidies nonetheless benefit substantially from the ACA's reforms to the individual health insurance market, to which the subsidies are integral. Those reforms—which apply to all insureds regardless of whether they receive subsidies—have improved health insurance by ensuring con-

sumer protections, expanding health benefits coverage, and making the individual health insurance market more user-friendly. For many, those reforms have also led to an increase in the number of insurance plan offerings and insurers available.

The ACA's reforms provide that insurers cannot exclude coverage for preexisting conditions, arbitrarily rescind coverage, or base premium rates on an individual's health status. Hall & Lord, *Obamacare* at 3. Plan offerings are also far more comprehensive. Before the ACA, only 2 percent of health plans offered on the individual market covered all ten of the "Essential Health Benefit" categories that the ACA now requires. Boutwell & Freedman, *Coverage Expansion and the Justice-Involved Population: Implications for Plans and Service Connectivity*, 33 Health Affairs 482, 483-484 (2014). Purchasing health insurance on the exchanges is also far easier because insurers are now consolidated into a single marketplace. Further, because insurance plan offerings are now standardized into coverage tiers with defined levels of cost sharing—bronze, silver, gold, and platinum—consumers can more readily compare plans among competing insurers. Hall & Lord, *Obamacare* at 3. For many, the exchanges offer more competitive plan offerings and prices than private insurers offered before the ACA, with new insurers entering the individual markets in response to the opportunity for increased enrollment on the exchanges. *Id.* at 6.

Congress understood, however, that the individual market could not be substantially improved solely through regulation of insurers. 42 U.S.C. § 18091(2)(I)-(J). To ensure that the ACA's insurance regulations do not cause healthy people to defer purchasing insurance until they are sick, Congress established the "individual mandate"—the requirement that every person either

purchase health insurance or pay a tax penalty. 26 U.S.C. § 5000A; *National Fed'n of Indep. Bus.* v. *Sebelius*, 132 S. Ct. 2566, 2577, 2580 (2012) (plurality opinion). Congress also ensured that those who are subject to the individual mandate could afford insurance by providing federal subsidies. 42 U.S.C. §§ 18081-18082; 26 U.S.C. § 36B. Together, the individual mandate and federal subsidies have achieved broad insurance coverage nationwide, enabling insurers to offer the ACA's improved insurance products at affordable premiums. *See* Hall & Lord, *Obamacare* at 6.

The individual mandate and subsidies are interdependent. Congress exempted from the individual mandate households that cannot access affordable health insurance. 26 U.S.C. § 5000A(e)(1)(A). In the absence of federal subsidies, many households in States using federal exchanges would become exempt from the individual mandate because they would no longer have access to affordable insurance. *See* Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in* King v. Burwell 6 (Jan. 2015). Removing the subsidy-eligible population from the exchanges' coverage group would subsequently affect the availability of affordable insurance for higher-earning households. A recent study predicts that eliminating the ACA subsidies would cause a near "death spiral," a cycle of sharp premium increases and subsequent disenrollment until only the sickest individuals remain in the market risk pools. Eibner & Saltzman, *Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums and Insurance Coverage* 25 (2014). A death spiral would result in insurance becoming unaffordable for many higher-earning households, thereby exempting an even greater population from the individual mandate. *See* Hall, *Disingenuous: The Latest Legal Challenges to*

Insurance Market Reforms, 44 Hastings Ctr. Rep. 6, 6-7 (2014). The study demonstrates that subsidies are essential to preserving the economic viability of the ACA's reforms to the individual health insurance market nationwide. Thus, the ACA's subsidies are significant even to those who do not qualify for them because, in the absence of subsidies, many higher-earning households would also lose access to the ACA's improved insurance products.

3. Insurance access gains and market reforms in most States would be lost if the decision below is reversed

Since its full implementation began just one year ago, the ACA has already reduced significantly the number of uninsured American households and transformed the individual health insurance markets in all 50 States and the District of Columbia. Implementation is an ongoing process for the federal government, States, insurers, health care providers, and households nationwide, and promises to continue to improve health care in the United States for years to come, provided the Act's intended scheme remains in place.

However, if households in 34 States lose access to subsidies, then the Act's scheme would collapse in these States, and middle- and low-income households would lose everything they gained under the ACA. *See* Bordelon et al., *The Stage is Set: Predicting State and Federal Reactions to* King v. Burwell 5 (Jan. 2015) (eliminating subsidies would "deliver a crippling blow to the health care law and tarnish much of the implementation progress that has been made to date"). Of the 6.7 million individuals who relied on subsidies to access health insurance during the 2014 enrollment cycle, 4.6 million live in States where federal exchanges operate; most, if not

all, of those people would see their new-found insurance become immediately unaffordable. Levitt & Claxton, *The Potential Side Effects of* Halbig (July 31, 2014); *see also* Blumberg et al., *Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in* King v. Burwell 7 (Jan. 2015) (predicting that 99 percent of the subsidy-eligible population would face unaffordable premiums following a ruling for Petitioners). These households, including the Sherburne family and Lisa Paterson in Utah, *see supra* pp. 6-9, would be forced to drop coverage immediately or face an average monthly premium increase of $400. *See* Committee on Energy and Commerce, Minority Staff, *District-by-District Impact of a Potential Supreme Court Ruling Against Affordable Care Act Federal Exchange Tax Credits* 1 (Dec. 2014). The millions of affected households could also encounter devastating liability on their 2015 tax return. *See* Grewal, *How* King v. Burwell *May Create Tax Problems for 2014-2015 Health Care Enrollees*, 32 Yale J. on Reg. Online (forthcoming). By 2016, the total number of middle- and low-income Americans denied access to subsidies could reach 13 million. Committee on Energy and Commerce, *District-by-District Impact* at 1.

Petitioners' argument would not only harm middle- and low-income Americans, but also higher-earning Americans who rely on the individual market to access insurance in the affected States. A recent RAND Corporation study predicts that eliminating the ACA subsidies in the 34 States using federal exchanges would result in substantial unsubsidized premium increases and exchange-wide enrollment declines. Saltzman & Eibner, *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces* 5 (Jan. 2015). This study estimates that, without federal subsidies, *unsubsidized* premiums on the feder-

ally operated exchanges would rise 47 percent, and an estimated 9.6 million people would lose insurance coverage. *Id.* This represents a 70 percent decrease in current federal exchange enrollment and includes higher-earning households as well as subsidy-eligible households. *Id.* The projected premium increases and disenrollment would threaten the ultimate viability of the federal exchanges. *Id.* at 6. Petitioners' argument would thus harm higher-earning Americans who access insurance on the federal exchanges by nearly doubling their premium rates and destabilizing the insurance market on which they rely.

Even if States were to pursue implementing State-based exchanges immediately after losing federal subsidies, that is unlikely to prevent an immediate destabilization of the insurance markets in those States. *See* Bagley et al., *Predicting the Fallout from* King v. Burwell—*Exchanges and the ACA*, 372 New Eng. J. Med. 101 (2015). States would face significant obstacles to establishing State-based exchanges, including the considerable time and resources required, extensive statutory and regulatory requirements, technological challenges, and the timing of State legislative sessions. *Id.* at 101-102. If this Court reverses the court of appeals' judgment, it is highly unlikely that States could establish new State-based exchanges before the vast majority of enrollees were faced with soaring premium costs. *See supra* pp. 12-13. Reversal could therefore prevent millions of Americans from obtaining health insurance for years. *See* Bagley et al., 372 New Eng. J. Med. at 103.

B. Loss Of Affordable Health Insurance Generally Means Worse Health

By increasing access to and improving health care coverage, the ACA's health insurance exchanges have

promoted health outcomes among Americans nationwide. Reversal of the judgment below would not only undermine the Act's statutory scheme, but would also threaten the well-being and longevity of millions of people with serious health care needs.

Having health insurance is associated with improvements in self-reported physical and mental health status and an increased use of preventive care. *See* Van Der Wees et al., *Improvements in Health Status after Massachusetts Health Care Reform*, 91 Milbank Q. 663, 676-678 (2013). Recent studies estimate that expanded access to health insurance decreases annual mortality rates by at least 2.9 percent. *Compare* Sommers et al., *Changes in Mortality After Massachusetts Health Care Reform*, 160 Annals of Internal Med. 585 (2014), *with* Sommers et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 New Eng. J. Med. 1025 (2012). These findings suggest that, by the end of the open enrollment period in February 2015, at least one death will be prevented for every thousand adults who gained insurance access on the exchanges in 2014. *See* Sommers et al., 160 Annals of Internal Med. at 591; Sommers et al., 367 New Eng. J. Med at 1031. One study estimates that 57 percent of the 8 million people who purchased insurance on the exchanges in 2014 were previously uninsured. Hamel et al., *Survey of Non-Group Health Insurance Enrollees: A First Look At People Buying Their Own Health Insurance Following Implementation of the Affordable Care Act* 6 (2014). Accordingly, this evidence suggests that, after just one enrollment year, expanding coverage through the ACA's health insurance exchanges will have saved thousands of lives.

The positive effect of health insurance on health outcomes is partially explained by the increased access

to, and utilization of, health care services. Adequately insured adults are more likely to receive regular preventive care, which increases the likelihood of timely diagnosis and treatment. McMorrow et al., *Determinants of Receipt of Recommended Preventive Services: Implications for the Affordable Care Act*, 104 Am. J. Pub. Health 2392, 2396-2398 (2014). Preventive care services tend to be low-cost and cost effective; one study estimates that increasing access to preventive care in the U.S. could save nearly $4 billion annually by improving population health and reducing medical spending. Maciosek et al., *Greater Use of Preventive Services in U.S. Health Care Could Save Lives At Little Or No Cost*, 29 Health Affairs 1656, 1658 (2010). Adults with health insurance are also more likely to comply with prescribed treatment regimens and follow-up care, which contribute to better overall health. McMorrow et al., 104 Am. J. Pub. Health at 2396-2398. Most significantly, health insurance saves the lives of people who suffer from conditions that are preventable or treatable if they are identified early, such as certain cancers, infections, and heart disease. *See* Sommers et al., 160 Annals of Internal Med. at 591.

In contrast, uninsured people have greater difficulty obtaining the care they need. In 2013, 25 percent of adults without insurance reported going without care in the previous year, largely due to cost, compared to only 4 percent of adults with coverage. *See* Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer: Key Facts About Health Insurance on the Eve of Health Reform* 6 (2013). Uninsured adults receive significantly less preventive care than adults with health insurance, leading to delayed or forgone treatment, later-stage cancer diagnoses, onset of acute conditions such as heart attack or stroke, and premature

death. Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care* 68-73 (2009). The uninsured are also more likely to forgo prescribed medications and less likely than insured individuals to obtain all recommended health care services. Cohen et al., *Strategies Used by Adults to Reduce their Prescription Drug Costs*, 119 NCHS Data Brief 1, 1-6 (2013). Overall, a substantial body of evidence shows that uninsured individuals suffer worse health outcomes, including higher mortality rates, because of insufficient access to the health care system. *See* Kaiser Commission on Medicaid and the Uninsured, *Uninsured: A Primer* at 11-12.

The example of Kimberly Tonyan, 42, of Cornelius, North Carolina, illustrates the point. For years as a working single mother, Ms. Tonyan was unable to afford health insurance for herself and her two daughters. Although Ms. Tonyan took her daughters for check-ups, she herself had not received annual exams or screenings, such as physicals or pap smears, for years, because she could not afford them. Although North Carolina has not established its own exchange, in 2014 she was able to sign up for health insurance through a federally run exchange. Due to her income of approximately $20,000, or less than 133 percent FPL, she was eligible for subsidies that brought the cost of her premiums down from $279 to $27.91 per month, saving her $3013.08 in annual premium costs.

A few months later, Ms. Tonyan began experiencing pain in her abdomen. Because she was now insured, she visited a doctor, who diagnosed her with uterine fibroid tumors and an ovarian cyst. After she had a hysterectomy, her doctors discovered that she had endometrial cancer. Luckily, the cancer was caught and removed early, which meant there was no need for

more extensive and expensive treatment, such as chemotherapy or radiation. Moreover, because endometrial cancer is rare in women in their 40s, Ms. Tonyan's doctor recommended genetic testing. This testing revealed that Ms. Tonyan has Cowden syndrome, a genetic condition associated with a greatly increased risk of breast, thyroid, uterine, and kidney cancer. Because she now knows that she has an 85 percent risk of developing breast cancer, Ms. Tonyan chose to have a preventive mastectomy. Ms. Tonyan credits the ACA with saving her life.

Without the subsidies that made it possible for her to purchase insurance on a federally operated exchange in North Carolina, Ms. Tonyan would not have gone to the doctor when she began experiencing pain in her abdomen and might not have sought treatment until the cancer had spread much further. It is also unlikely that she would have sought testing for Cowden syndrome if she lacked comprehensive health insurance, which would have left Ms. Tonyan unaware of her increased risk for breast cancer and unable to pursue the preventive measures she has taken to preserve her health. Because Cowden syndrome is genetic, Ms. Tonyan's diagnosis is also important for preserving the health of her daughters, who can now pursue genetic testing and preventive measures before their health is at risk.[3]

The ACA's health insurance exchanges and subsidies have already improved health and saved lives.

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[3] Because Ms. Tonyan's health issues have affected her ability to work, she now earns less than 100 percent FPL. Accordingly, she did not qualify for a federal subsidy for the 2015 open enrollment period. Since North Carolina opted out of the ACA's Medicaid expansion, Ms. Tonyan is currently without access to affordable health insurance.

Withholding subsidies from the 34 States using federally operated exchanges would threaten the health of the subsidy-eligible population and higher-earning households alike. Some would lose newly acquired coverage that has already dramatically improved their health. Others, who rely on the individual market to purchase insurance, would lose access to care if premium rates spiral and they are priced out of the market. The Court should not construe the Act in a way that would dismantle large portions of the statute and prevent millions of people from obtaining the health care they need and that Congress sought to make available.

C. The Subsidies' Positive Effect On Health Insurance Access Promises To Improve The Nation's Ability To Fight Epidemic Illnesses, Including HIV

Congress's provision for tax subsidies nationwide also promises an additional national impact: improvement of the population's ability to resist epidemic illnesses. The response to the HIV epidemic—which is the subject of extensive data and analysis—has provided a valuable case study for the effect of expanded access to health insurance on the societal ability to address nationwide epidemics—including not only HIV, but future potential epidemics like the Ebola virus or pandemic flu.

1. HIV remains a serious public health threat, and insufficient insurance undermines HIV care and treatment

An estimated 1.2 million people in this country live with HIV, approximately 168,000 people are unaware of their infection, and, with each passing year, about 50,000 people become newly infected. *See* Bradley et

al., *Vital Signs: HIV Diagnosis, Care, and Treatment Among Persons Living with HIV—United States, 2011*, 63 Morbidity & Mortality Wkly. Rep. 1113, 1114 (2014).

It need not be this way. Advancements in medical treatment have vastly improved the length and quality of life for people living with HIV and reduced the likelihood of transmitting the virus to others—but these benefits are only realized by those who can receive sustained clinical care. *See* Goldman et al., *The Prospect of a Generation Free of HIV May Be Within Reach if the Right Policy Decisions Are Made*, 33 Health Affairs 428 (2014). The goal of HIV clinical care is to move patients along a "continuum of care" from infection to diagnosis, engagement in medical care, treatment, and, ultimately, viral suppression. Viral suppression helps people with HIV live longer, healthier lives because suppression preserves the immune system, slows the virus's evolution, and reduces the risk of drug resistance. Cohen et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 New Eng. J. Med. 493, 503 (2011). Further, at the viral suppression stage, an individual's ability to transmit HIV to others is reduced by 96 percent, significantly slowing the spread of the epidemic. *Id.*

Achieving viral suppression is attainable for the majority of people who receive comprehensive and coordinated care, with recent studies finding that over 80 percent of people living with HIV who receive regular health care are virally suppressed. Mugavero et al., *The State of Engagement in HIV Care in the United States: From Cascade to Continuum to Control*, 57 Clinical Infectious Diseases 1164, 1164 (2013); Bradley et al., 63 Morbidity & Mortality Wkly. Rep. at 1115. Unfortunately, just 25 percent of Americans living with HIV are virally suppressed. Mugavero et al., 57 Clini-

cal Infectious Diseases at 1164. A lack of access to health insurance is strongly associated with this low overall rate of viral suppression, *see id.*, while having health insurance is associated with a 71 percent reduction in mortality among this population, Goldman et al., *Effect of Insurance on Mortality in an HIV-Positive Population in Care*, 96 J. Am. Statistical Ass'n. 883, 888 (2001).

The HIV care necessary to treat the virus and impede its transmission is costly. Comprehensive insurance coverage is accordingly essential to promote individual and public health outcomes and to control—and eventually eliminate—this domestic epidemic. As recently as 2010, only 17 percent of people living with HIV had private health insurance, compared with 65 percent of the American population. Snider et al., *Nearly 60,000 Uninsured and Low-Income People with HIV/AIDS Live in States that are not Expanding Medicaid*, 33 Health Affairs 386, 386 (2014). Before the ACA, many people living with HIV were denied private health insurance due to preexisting conditions, offered prohibitively high premium rates because of their diagnosis, or subjected to annual or lifetime caps on coverage. Kates et al., *Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV* 4 (2014).

Some uninsured people living with HIV receive treatment assistance through public programs. For instance, the Ryan White Program, administered by the Department of Health and Human Services as a "payer of last resort," provides limited funding to cities, States, and community-based organizations that offer health care and other services to people living with HIV. Sood et al., *HIV Care Providers Emphasize the Importance of the Ryan White Program for Access to*

and Quality of Care, 33 Health Affairs 394, 394-395 (2014). The Ryan White Program funds State-administered AIDS Drug Assistance Programs (ADAPs), which provide individuals who are uninsured or underinsured with prescription drugs for treating HIV. McManus et al., *Current Challenges to the United States' AIDS Drug Assistance Program and Possible Implications of the Affordable Care Act*, 2013 AIDS Res. & Treatment 1, 1. These programs have never met the needs of all people seeking services; before the ACA, demand for ADAPs ballooned to over 225,000 people living with HIV nationwide. *Id.* at 2. ADAP coverage and eligibility requirements vary widely by State, and many programs have waiting lists for new patients and quantity limits on prescription drug access. *See* Snider et al., 33 Health Affairs at 391.

The Ryan White Program and ADAPs are not designed to function as health insurance plans that provide coverage for a prescribed set of benefits; instead, they focus their limited resources on a core set of HIV services. *See* Snider et al., 33 Health Affairs at 391. People living with HIV have an increased risk and prevalence of comorbidities like cardiovascular disease and diabetes, and many require comprehensive insurance coverage that includes preventive and acute care to improve their health and quality of life. Abara & Heiman, *The Affordable Care Act and Low-Income People Living With HIV: Looking Forward in 2014 and Beyond*, 25 J. Ass'n Nurses in AIDS Care 476, 478 (2014). Coverage through the Ryan White Program and ADAPs simply cannot address these additional health needs.

Again, an example illustrates the point. Tod Haley, 43, of Greensboro, North Carolina, is a loss prevention auditor. Prior to the ACA, Mr. Haley had been unin-

sured since 2007, when his insurer cancelled his health insurance policy after he suffered a herniated disk. In 2008, Mr. Haley, who already could not access insurance because of his preexisting spine injury, was diagnosed with HIV. While he was uninsured, Mr. Haley was able to obtain HIV medications through North Carolina's ADAP. However, Mr. Haley perpetually faced losing access to his life-saving treatment because he had to reapply for ADAP coverage every six months. On several occasions, Mr. Haley was unable to obtain his HIV medications through ADAP because he was waitlisted for coverage. Furthermore, in order to remain eligible for ADAP, Mr. Haley could not earn more than 250 percent FPL. Mr. Haley turned down several employment opportunities in his profession and instead sought minimum-wage positions to ensure that he could continue to obtain his HIV medications.

Because of the ACA, Mr. Haley no longer faces the insecurity of the ADAP renewal process, and he no longer has to choose between advancing his career and receiving his HIV treatment. In 2014, Mr. Haley signed up for health insurance on North Carolina's federally run exchange. During the 2015 open enrollment period, he purchased a new plan offered by Blue Cross Blue Shield. Because of his income of approximately $20,000, or less than 200 percent of FPL, Mr. Haley is now eligible for an ACA subsidy that lowers his monthly premiums to $158 per month from approximately $360. His copayments to see physicians range between $5 and $10, and he pays approximately $15 per month total for his HIV medications. Mr. Haley estimates that his monthly costs for these medications would be approximately $3700 without coverage. Because of his comprehensive coverage, Mr. Haley misses fewer doses of his HIV medications, receives all recommended pre-

ventive care, and obtains ongoing care from a specialist for his herniated disk. If the Fourth Circuit's judgment in this case is overturned, Mr. Haley would lose access to comprehensive health insurance. As a result, he would once again depend on North Carolina's ADAP to access his HIV medications.

People living with HIV who gained comprehensive coverage through the federal exchanges and subsidies in 34 States would suffer disproportionately if they lose health insurance access. Research demonstrates that uninterrupted health insurance is essential to achieving positive health outcomes for people in HIV treatment. Riley, *Population-Level Effects of Uninterrupted Health Insurance On Services Among HIV-Positive Unstably Housed Adults*, 23 AIDS Care 822 (2011). If the decision below is reversed and subsidies become unavailable in a majority of States, people living with HIV who lose access to subsidies or become priced out of failing federal exchanges could suffer harmful treatment disruptions that threaten their lives. These individuals would once again rely on safety-net programs, which were already inadequate before the ACA. Sood et al., 33 Health Affairs at 395.

2. Massachusetts's improvement in HIV health outcomes demonstrates the effectiveness of expanded health insurance coverage in fighting the epidemic

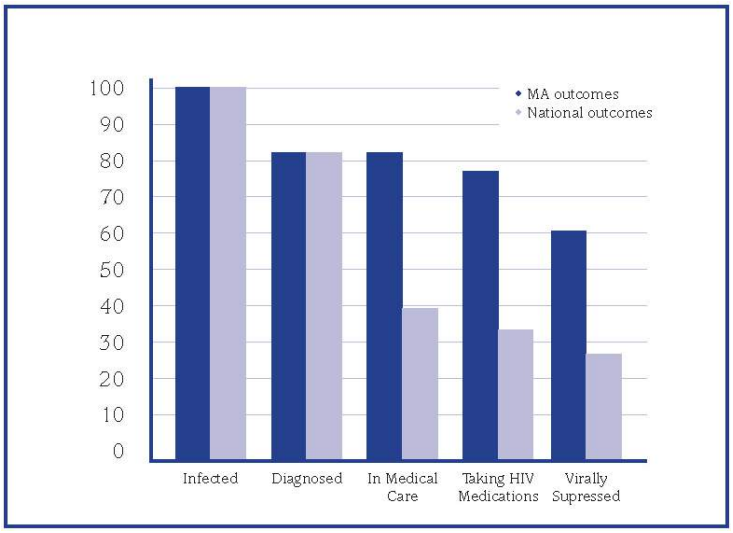
New evidence from Massachusetts demonstrates that expanded health insurance has a proven effect in controlling the HIV epidemic. In 2006, Massachusetts achieved near-universal health insurance coverage by passing a comprehensive health reform law that ex-

panded Medicaid,[4] offered subsidized private insurance, and enacted an individual mandate requiring all Massachusetts residents to purchase health insurance coverage; the Massachusetts statute later served as a model for the ACA. Sommers et al., 160 Annals of Internal Med. at 585; *see also* 42 U.S.C. § 18091(2)(I). Largely as a result of increased coverage, both individual and public health outcomes in Massachusetts are dramatically improved compared to national HIV-related statistics. Harvard Law School Center for Health Law and Policy Innovation, *Massachusetts Case Study: Health Reforms Lead to Improved Individual and Public Health Outcomes and Cost Savings* (June 2012). One study found that, between 2006 and 2009, new HIV diagnoses fell by 25 percent in Massachusetts as compared to a 2 percent *increase* nationwide. *Id.* A more recent study shows that, from 2000 to 2011, the number of HIV-related deaths in Massachusetts declined by 41 percent and the number of HIV infection diagnoses decreased by 44 percent. Harvard Law School Center for Health Law and Policy Innovation, *Massachusetts Case Study: Health Reforms in Conjunction with the Ryan White Program Lead to Improved Individual and Public Health Outcomes and Cost Savings* (May 2014). In contrast, nationwide statistics for HIV-related deaths and new HIV diagnoses remained relatively unchanged. *Id.* People living with HIV in Massachusetts are also far more likely to progress along the HIV continuum of care than people living with HIV nationwide. *Id.*; *see*

[4] In 2001, Massachusetts expanded Medicaid coverage to pre-disabled people living with HIV whose income was less than 200 percent FPL ($23,340 for an individual in 2014). Bovbjerg & Ullman, *Recent Changes in Health Policy for Low-Income People in Massachusetts*, 17 Urban Institute State Update 1, 14 (2002).

also supra p. 20. The following chart compares the percentages of people living with HIV in Massachusetts who are diagnosed, receive regular medical care, take HIV medications, and are virally suppressed to the percentages of people living with HIV nationwide.

Massachusetts Outcomes vs. National Outcomes[5]



Extending health insurance coverage to people living with HIV has made a measurable difference in Massachusetts's ability to combat the HIV epidemic. Congress's adoption of subsidies and private health insurance reform has created a national capacity to

[5] This chart, prepared by the Harvard Law School Center for Health Law and Policy Innovation, reports Massachusetts data from Holman et al., *Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study* (June 2011), and national data from Cohen et al., *Vital Signs: HIV Prevention Through Care and Treatment—United States*, 60 Morbidity & Mortality Wkly. Rep. 1618 (2011).

replicate Massachusetts's successes.[6] One study estimates that, by 2017, increased access to preventive care under the ACA will result in an additional 466,153 HIV screenings, leading to 2598 new diagnoses and reducing the number of people who are unaware of their HIV status by 22 percent. Wagner et al., *The Affordable Care Act May Increase the Number of People Getting Tested for HIV By Nearly 500,000 by 2017*, 33 Health Affairs 378, 384 (2014). By making coverage for HIV testing and treatment available, the ACA will ensure that more people living with HIV will be diagnosed, more will discover their status earlier, more will initiate care, and more will achieve viral suppression, *see supra* pp. 20-21, reducing the overall spread of the epidemic.

3. Reversal of the judgment below would undermine the Nation's ability to address future epidemics and other emerging public health threats

The example of HIV demonstrates the important role that expanded health insurance plays in the Nation's ability to resist and fight epidemics and other emerging public health threats. Insufficient insurance access detrimentally affects public health on a societal level because communities nationwide divert resources from public health programs to cover the

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[6] Of course, other factors—such as income levels, baseline insurance access, and number of physicians per capita—will produce *variance* in the rate at which each State will be able to provide treatment to newly insured people living with HIV. *See* Sommers et al., 160 Annals of Internal Med. at 592. Even accounting for such variables, however, the evidence demonstrates that health insurance improves outcomes and reduces the epidemic's spread. *See* Snider et al., 33 Health Affairs at 391.

health care costs of the uninsured. Recent experiences with the Ebola virus exposed the threat that emerging diseases pose to the U.S. public health system, and a recent study found that half of States are unprepared to cope with outbreaks of severe infectious diseases. *See* Levi et al., *Outbreaks: Protecting America From Infectious Diseases* 16 (Dec. 2014) (25 States and the District of Columbia scored five or lower out of ten indicators related to preventing, detecting, diagnosing and responding to serious infectious disease threats). By reducing overall insurance levels, reversal of the judgment below would not only undermine nationwide efforts to eradicate ongoing epidemics like HIV, but also threaten the ability to respond to future public health threats such as pandemic flu, tuberculosis, measles, or bioterrorism.

Prior to the ACA, the Institute of Medicine found that insufficient insurance access had an adverse spillover effect on public health that reached even the insured population. Institute of Medicine, *America's Uninsured Crisis* at 91-95; Institute of Medicine, *A Shared Destiny: Community Effects of Uninsurance* (2003). Insufficient insurance access adversely affected State and local public health programs because they devoted resources to uninsured residents that were reallocated from population-based health programs supporting disease surveillance and community-wide health interventions. Institute of Medicine, *A Shared Destiny* at 144. This diversion of resources weakened the ability of health departments to respond to emerging public health threats and ongoing illnesses like the HIV epidemic. *Id.* at 13. Communities with high rates of uninsured individuals also had insufficient health care delivery capacity, reduced access to emergency medical services, and fewer available clinical specialists. Institute

of Medicine, *America's Uninsured Crisis* at 91-95. Accordingly, the Institute of Medicine recommended that the President work with Congress to achieve health insurance coverage for all Americans "as quickly as possible." *Id.* at 114.

The President and Congress responded with the ACA, which expanded access to the private health insurance market with the help of federal subsidies. A successful response to an infectious disease threat requires that sick people have unimpeded access to the health care system so that infected individuals do not delay seeking treatment, diseases are recognized quickly, and the risk of spreading the disease within the community is minimized. Lurie, *H1N1 Influenza, Public Health Preparedness, and Health Care Reform*, 361 New Eng. J. Med. 843, 844 (2009). By increasing access to routine and emergency medical care, the ACA enables earlier detection, treatment, and control of new diseases. *Id.*; Reeve et al., *The Impacts of the Affordable Care Act on Preparedness Resources and Programs: Workshop Summary* 8-9 (2014).

A successful response to an infectious disease threat also requires community resilience, which is the ability of a healthy community to withstand and recover from a public health emergency. *See* Vinter et al., *Public Health Preparedness in a Reforming Health System*, 4 Harv. L. & Pol'y Rev. 339, 339-340 (2010). Again, Congress improved community resilience through the ACA: Increased health insurance access ensures that individuals regularly receive needed care and reduces population levels of chronic diseases and vaccine-preventable illnesses, so that fewer people will suffer from already compromised health in the event of a public health emergency. Lurie, 361 New Eng. J. Med. at 844; Vintner et al., 4 Harv. L. & Pol'y Rev. at 344.

The availability of subsidies in all States has enabled significant coverage gains among previously uninsured households and improved access to the health care system for all Americans. *See supra* pp. 5-12. As communities become healthier nationwide, the Nation will be better able to cope with ongoing epidemics such as HIV and emerging public health threats such as the Ebola virus or a future flu outbreak. Petitioners' desired toppling of the ACA's statutory scheme in a majority of States, however, would negate all gains in these States and stymie national efforts to promote public health security, threatening the entire population, both insured and uninsured.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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JANUARY 2015

No. 14-114

In the Supreme Court of the United States

DAVID KING, ET AL., PETITIONERS
v.
SYLVIA MATHEWS BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

BRIEF FOR LAMBDA LEGAL DEFENSE & EDUCATION FUND, INC., ASIAN & PACIFIC ISLANDER COALITION ON HIV/AIDS, BLACK AIDS INSTITUTE, GAY & LESBIAN ADVOCATES & DEFENDERS, GLMA: HEALTH PROFESSIONALS ADVANCING LGBT EQUALITY, HIV PREVENTION JUSTICE ALLIANCE, NATIONAL AIDS & EDUCATION SERVICES FOR MINORITIES, NATIONAL BLACK JUSTICE COALITION, NATIONAL MINORITY AIDS COUNCIL, AND LATINO COMMISSION ON AIDS AS AMICI CURIAE SUPPORTING RESPONDENTS

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In the Supreme Court of the United States

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ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

INTEREST OF AMICI CURIAE

Amici are nonprofit organizations that undertake litigation, public policy, and advocacy efforts on behalf of people living with HIV, many of whom receive inadequate healthcare due to lack of insurance.[1] Amici have a particular concern for communities of color and the disconcerting health disparities they experience. When the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended), was enacted, only 17% of Americans with HIV had private health insurance. See AIDS.gov, *The Affordable Care Act Helps People Living With HIV/AIDS* 1

[1] A description of each of the amici organizations is included in Appendix I, *infra*. The parties have consented to the filing of amicus curiae briefs in support of either party or of neither party, in letters on file with the Clerk. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amici curiae, their members, or their counsel made a monetary contribution to the brief's preparation or submission.

(2013). The inability of uninsured individuals to obtain private insurance has produced severe economic consequences for society at large, and has undercut public health efforts to combat the national HIV/AIDS epidemic. Amici therefore share a strong interest in full implementation of the ACA, including ensuring that all qualifying purchasers have access to the subsidies that make health insurance affordable, irrespective of their state of residence.

Amici are cognizant of the volume of briefing submitted to the Court for this case. Amici have endeavored not to repeat the legal arguments of the government or the factual arguments presented by the Harvard Law School Center for Health Law and Policy Innovation amicus brief (CHLPI Brief), especially regarding the benefits already realized by healthcare reform implementation, both in Massachusetts and through the ACA. Instead, amici will focus on the devastating impact that withdrawal of ACA subsidies would have on people of color living with HIV and on their communities, and on the troubling equal protection problems raised by petitioners' interpretation of the ACA. These constitutional problems would be avoided if the Court affirms the Fourth Circuit's decision below.

SUMMARY OF THE ARGUMENT

The Court should uphold the challenged IRS regulation that makes federal tax subsidies for health insurance available to low-income individuals in all 50 states. The IRS interpretation of the ACA is the one most consistent with Congress's expressly stated purpose of creating near-universal coverage. Petitioners' contrary reading, by contrast, would lead to an absurd

and catastrophic public health result, especially in the context of HIV, where miraculous medical breakthroughs have changed the question from "how do we save people?" to "why is anyone still dying?" While it is possible to overcome the dramatic racial and ethnic health disparities that persist in HIV diagnoses, treatment, and health outcomes, such success will be possible only if affordable access to health insurance remains in place. The ACA's provision of subsidies to low-income individuals represents a step in the right direction at this critical "crossroads" identified in the United States' first National HIV/AIDS Strategy, see The White House Office of National AIDS Policy, *National HIV/AIDS Strategy for the United States* vii (2010) (NHAS). It is well-known that access to healthcare dramatically improves the lives of individuals living with HIV. But widespread access to insurance can also lead to a precipitous decline in new infections, especially in marginalized communities. To deny these opportunities to communities most affected by the HIV epidemic would not only flout Congressional intent, but also inflict grievous and unjustifiable injury on vulnerable communities of color, which are heavily overrepresented in many states that have been resistant to implementation of the ACA.

Upholding the IRS regulation would avoid the profound equal protection problem created by petitioners' interpretation of the ACA. The federal government, through the ACA, plainly committed to run and fund exchanges in every state where a state's government refused to do so. The level of government that sets up an exchange in a given state is irrelevant and invisible to those vulnerable consumers, and surely an irrational criterion on which to impose such a draconian conse-

quence of making health insurance unaffordable. Consistent with Congress's intent, the Constitution, and appropriate public policy, the Court should uphold the IRS regulation that avoids this problem by providing equal access to affordable health insurance in all 50 states.

ARGUMENT

I. THE PRINCIPAL PURPOSE OF THE ACA WAS TO CREATE NEAR-UNIVERSAL ACCESS TO HEALTH INSURANCE, WHICH IS OF PARTICULAR IMPORTANCE TO PEOPLE LIVING WITH HIV

The purpose of the ACA was to enable people who were previously ineligible or who lacked sufficient financial resources to purchase affordable, quality health insurance with the aim of "achiev[ing] near-universal coverage." 42 U.S.C. 18091(2)(D); see also *Nat'l Fed'n of Indep. Bus.* v. *Sebelius*, 132 S. Ct. 2566, 2580 (2012) (ACA intended to "increase the number of Americans covered by health insurance and decrease the cost of health care").[2] Rather than achieving this goal through a single-payer system, Congress established a multi-

[2] This brief discusses the affordability of private insurance made possible by the ACA and the IRS regulation. While flawed, private insurance is superior to the current jumble of public healthcare options, which can be interrupted or reduced in fiscally challenging times, undergo income eligibility modifications, involve complicated screening processes to ensure that no other avenues of care are available, and be limited to treatment of particular medical conditions. See Kathleen A. McManus et al., *Current Challenges to the United States' AIDS Drug Assistance Program and Possible Implications of the Affordable Care Act*, AIDS Research and Treatment 1-4 (2013); The Henry J. Kaiser Family Found., *National ADAP Monitoring Project Annual Report* 7-16 (2005); National Alliance of States and Territorial AIDS Directors, *ADAP Watch* (2011); NHAS at 21.

payer, market-based solution that preserved the role of private insurers in the healthcare market, while simultaneously expanding access to healthcare and reducing its costs.

To attain its goal, Congress needed to address two key obstacles. One obstacle was the ability of insurers to shut individuals with preexisting conditions out of the market by demanding prohibitively high premiums or denying coverage altogether. These practices had a singularly devastating impact on people living with HIV. See The Henry J. Kaiser Family Found., *Financing HIV/AIDS Care: A Quilt with Many Holes*, HIV/AIDS Policy Issue Brief 14 (Apr. 30, 2004) (noting in 2004 that "people with HIV are generally considered 'uninsurable' and are routinely rejected when they apply for coverage."); Mark Bolin, *The Affordable Care Act and People Living with HIV/aids: A Roadmap to Better Health Outcomes*, 23 Annals Health L. 28, 29 (2014) (stating that private health insurers have "systematically excluded" people living with HIV/AIDS "in an effort to contain costs"). To rectify the hardships suffered by people who were unable to access health insurance, the ACA prohibited insurers from declining coverage or charging rates above the community insurance rates to individuals with preexisting conditions. See 42 U.S.C. 300gg(a), 300gg-1, 300gg-3, 300gg-4.

The second obstacle to near-universal health insurance was affordability: many low-income people were forced to forego insurance and opt instead for purchasing basic necessities such as food and shelter. Again, this problem was pronounced for people living with HIV, the majority of whom are low income. See The Henry J. Kaiser Family Found., *Assessing the Impact of the Affordable Care Act on Health Insurance Cover-*

age of People with HIV 1 (2014) (Assessing the Impact) (noting that approximately 87% of adults in HIV care have incomes below 400% of the federal poverty level). Congress addressed this problem in part by providing federal tax subsidies to low income individuals to purchase health insurance. 26 U.S.C. 36B.

The ACA has great potential to shift the paradigm of the HIV epidemic. See Assessing the Impact at 4-8 (detailing the benefits of the ACA). When the ACA was enacted, only 17% of people in the U.S. with HIV/AIDS had private health insurance. AIDS.gov, *Health Care Reform and HIV/AIDS: How Does the Affordable Care Act Impact People Living with HIV/AIDS?* ¶ 2 (Jan. 14, 2011). In 2009, fewer than half of people with HIV were in regular care because of barriers to obtaining healthcare. Irene Hall et al., *Differences in Human Immunodeficiency Virus Care and Treatment Among Subpopulations in the United States*, 173 JAMA Int'l Med. 1337, 1338 (2013). Of the adults in HIV care in 2009, only 30% were covered by private insurance policies. See Assessing the Impact at 4. The ACA's subsidies and anti-discrimination provisions provide people living with HIV the opportunity to purchase affordable insurance that meets their medical needs.

II. THE PRIMARY OBSTACLE TO TREATING HIV AND PREVENTING ITS TRANSMISSION IS NOT A LACK OF TREATMENT OPTIONS; IT IS A LACK OF ACCESS TO HEALTH INSURANCE

A. HIV Is Highly Treatable And Preventable, Provided That Affordable And Reliable Medical Care Is Available

The virus that causes AIDS has caused the death of roughly 650,000 people in this country. See Centers for Disease Control and Prevention, *HIV in the United States: At A Glance*, http://www.cdc.gov/hiv/statistics/basics/ataglance.html (last visited Jan. 22, 2014). In the early days of the epidemic, there was no medication that effectively halted the "pervasive, and invariably fatal, course of the disease." *Bragdon* v. *Abbott*, 524 U.S. 624, 637 (1998). Nor were there treatments that would dramatically reduce the chances of transmitting or contracting HIV.

That is no longer the case. In 1996, a "near-miraculous" treatment regimen consisting of multiple antiretroviral drugs, referred to as Highly Active Anti-Retroviral Treatment (HAART), was introduced. Howard Grossman, *AIDS—The Dark Years*, 8 MedGenMed 57 (2006). The HAART regimen operates to reduce the amount of active virus in a person with HIV, and generally within months renders the level of the virus "undetectable" by medical standards. See Yunhai Yao et al., *The effect of a year of highly active antiretroviral therapy on immune reconstruction and cytokines in HIV/AIDS patients*, 29 AIDS Res. & Human Retroviruses 691, 691 (2013). By halting the progression from HIV to AIDS, HAART has reduced the number of annual HIV-related deaths from more than

50,000 in 1995 to fewer than 14,000 today. See Centers for Disease Control and Prevention, *Diagnoses of HIV Infection in the United States and Dependent Areas, 2012*, HIV Surveillance Report 24, 44 (2014). As a result of new treatment options, a person living with HIV now can enjoy a lifespan and quality of life on par with HIV-negative individuals,[3] *if* he or she has access to affordable, reliable, comprehensive health insurance.

These benefits of HAART obviously are life-changing to those living with HIV—and also can be life-changing to those who are HIV-negative. The medical community now questions whether those whose viral loads have been medically suppressed to undetectable levels are even capable of transmitting HIV to others. See Dep't of Health and Human Servs., Division of Public Health, Epidemiology Section, Communicable Disease Branch, *Fiscal Note for Permanent Rule Changes for North Carolina Division of Public Health* 5 ("When patients are virally suppressed, their likelihood of transmitting HIV is dramatically decreased to the point that they are essentially non-infectious.").

Furthermore, there are now highly-effective medical options that HIV-negative individuals can use that reduce greatly the possibility of contracting HIV. In particular, the antiretroviral drug Truvada—a two-medication tablet used as part of a HAART regimen by some people living with HIV—has been approved by the FDA for HIV-negative individuals to take to prevent them from contracting the virus. When used consistently and correctly, this type of regimen, known as

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[3] See Centers for Disease Control and Prevention, *Living with HIV*, http:/www.cdc.gov/hiv/living/index.html (last visited Jan. 21, 2015).

Pre-Exposure Prophylaxis (PrEP), rivals condoms in its ability to keep HIV-negative persons free of HIV, irrespective of their partner's HIV status or the consistency of condom use.[4] See Centers for Disease Control and Prevention, *Fact Sheet: Pre-Exposure Prophy-Prophylaxis for HIV Prevention* (2014) (noting 92% lower risk of contracting HIV among study participants who took medication consistently). Yet despite its incredible potential to slash the rate of new infections, PrEP is prohibitively expensive for most Americans.[5]

In 2015, we have the medical solutions to turn the tide in the HIV epidemic. What is necessary is to connect the treatments with the people who need them. Given the optimistic prognosis for most everyone who has been diagnosed with HIV in a timely manner, and the availability of medication that essentially prevents the transmission of HIV, it is nothing short of a national disgrace and public health catastrophe that, until the ACA, the healthcare system had so often failed to provide access to these essential medications.

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[4] While condom use has saved the lives of countless people, the number of new infections has not declined this century. Thus, the National HIV/AIDS strategy has warned that the country must "move away from thinking that one approach to HIV prevention will work, whether it is condoms, pills, or information." NHAS at viii; see also *id.* at 15.

[5] While the manufacturer of Truvada has a medication assistance program, utilizing this option requires knowledge of the existence of the program, a prescription, and regular medical monitoring—further underscoring the importance of reliable access to a healthcare professional.

B. The ACA, By Providing Subsidies To Low-Income Americans, Has The Potential To Have A Significant Impact On The HIV/AIDS Epidemic

The ACA has the potential to be a significant force in the battle against HIV. Not only does the statute prohibit insurers from denying coverage based on pre-existing condition exclusions, 42 U.S.C. 300gg-3, charging discriminatory rates, 42 U.S.C. 300gg(a), and imposing benefits caps, 42 U.S.C. 300gg-11, it also provides federal tax subsidies to low-income individuals to make coverage affordable. 26 U.S.C. 36B. According to one estimate, nearly 200,000 people living with HIV could gain new coverage as a result of the ACA, while many more would enjoy new insurance options or benefits. See Assessing the Impact at 9. Moreover, through the subsidies, at-risk populations have a greater incentive to be tested for HIV and have greater access to PrEP in order to prevent further spread of the virus.

The subsidies and other provisions of the ACA fill the crucial gap in healthcare access for people with HIV. Because people with HIV typically could not access health insurance before enactment of the ACA, many relied on an assortment of private or government services for healthcare. The most significant source of funding has been the Ryan White Comprehensive AIDS Resources Emergency Fund (Ryan White Program), which is supported by a discretionary federal grant funded at $2.32 billion in fiscal year 2014. Health Resources and Services Administration, *About the Ryan White HIV/AIDS Program*, http://hab.hrsa.gov/abouthab/aboutprogram.html (last visited Jan. 21, 2015). Among the programs funded by the Ryan White Program are the state-based AIDS Drug Assistance

Programs (ADAPs), which function as the "payer of last resort" for people with HIV to obtain HIV-related care. Kathleen A. McManus et al., *Current Challenges to the United States' AIDS Drug Assistance Program and Possible Implications of the Affordable Care Act*, AIDS Research and Treatment 1 (2013) (McManus).

Yet the Ryan White Program simply has not provided reliable, comprehensive healthcare. Because the Ryan White Program was intended to supplement the regular healthcare system, not supplant it, significant gaps in coverage remained. See The Henry J. Kaiser Family Found., *Financing HIV/AIDS Care: A Quilt with Many Holes*, HIV/AIDS Policy Issue Brief 12-14 (Apr. 30, 2004). As noted by the National HIV/AIDS Strategy, "the level of need" for Ryan White and ADAP "has always exceeded available funding." NHAS at 22. Moreover, the Ryan White Program's focus on people living with HIV means that preventive measures for at risk populations fall outside the scope of the Program. For example, Ryan White funding does not assist HIV-negative persons in obtaining PrEP, because generally only individuals who have already contracted HIV qualify for Ryan White Services. See San Francisco AIDS Foundation, *PrEP Facts* 5 (2014).

The demand for ADAP services has been particularly high in recent years, resulting in expanding wait

lists and delayed treatment.[6] See National Alliance of States and Territorial AIDS Directors (NASTAD), *National ADAP Monitoring Project Annual Report Module One* 26-27 (Jan. 2012) (indicating that from 2003 to 2011, the number of ADAP clients soared from 128,465 to 226,419). Between August 2010 and August 2011, the national ADAP wait list swelled from 2,937 to 9,217, resulting in many patients not receiving HIV medications prescribed according to CDC treatment guidelines. McManus at 2. Because the level of need has far outpaced available funds, overwhelmed state ADAP programs have restricted the types of coverage they provide. For example, Virginia—where nearly two-thirds of ADAP clients are people of color[7]—for a period of time constricted access to HIV medications only to those with CD4 counts under 200, which long has

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[6] In some respects, the Ryan White funding shortfall is the product of the many successes in the fight against HIV, which have led more people to seek life-saving HIV medications. More people are now getting tested and know their status. In just a few short years, the percentage of people living with HIV who are unaware of their status has been cut by a third, from 21% to 14%. Compare NHAS at 7, with Centers for Disease Control and Prevention, *CDC Fact Sheet: HIV Testing in the United States* (2014). Additionally, based on research findings, the government over time has made the criteria for immediate antiretroviral treatment more inclusive; today, the Department of Health and Human Services recommends antiretroviral treatment for everyone who tests positive for HIV. McManus at 1-2. These factors have increased demand for HIV medications and have intensified the strain on funding streams. I.V. Bassett et al., *AIDS Drug Assistance Programs in the era of routine HIV testing*, 47 Clinical Infectious Diseases 695, 696 (2008).

[7] See Dep't of Health and Human Servs., *2012 State Profiles*, *Ryan White HIV/AIDS Program: Virginia*, http://hab.hrsa.gov/stateprofiles/AIDS-Drug-Assistance-Program.aspx#chart2 (last visited Jan. 21, 2015) (available under "Virginia" drop down).

been the definition of an AIDS diagnosis. See Virginia Dep't of Health, *Virginia AIDS Drug Assistance Program (ADAP) Updates* (2011), http://www.vdh.state.va.us/epidemiology/DiseasePrevention/Programs/ADAP/updates.htm. The Virginia ADAP also eliminated all medications from formulary that were not antiretrovirals, vaccines, or treatments for opportunistic infections, dropping treatments for health conditions not directly related to HIV despite the fact that HIV or AIDS may exacerbate certain conditions such as kidney disease and mental health issues. Coverage was also dropped for certain comorbidities like hypertension that are far more common among African Americans.[8] McManus at 2; NHAS at 27.

The ACA's promise of access to affordable, comprehensive care has the potential to dramatically improve healthcare outcomes both for those living with HIV and those who are HIV-negative, while the deprivation of such access would do just the opposite, exacerbating distrust in the public health system and discouraging testing and involvement with healthcare professionals. By providing affordable and comprehensive coverage, the ACA creates new health insurance and treatment options for people currently receiving care from ADAP programs, allowing them to move away from the limited and inconsistent care these programs have historically provided.[9] Under the ACA,

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[8] The 2009-2010 death rates for hypertension were 100% to 200% higher for blacks than whites. American Heart Association, *African Americans & CVD—2014 Statistical Fact Sheet* (2014).

[9] But because some states with inadequate ADAP coverage, such as Virginia, have federally-facilitated exchanges, petitioners' interpretation of the ACA would take these options away.

people with HIV are able to access HAART, thereby enjoying a quality of life and lifespan similar to HIV-negative people, and ensuring the virus is not transmitted to others. See Centers for Disease Control and Prevention, *Living with HIV*, http:/www.cdc.gov/hiv/living/index.html (last visited Jan. 21, 2015). For HIV-negative people at higher risk for HIV, the availability of subsidized insurance provides access to PrEP and the ability to protect themselves from the disease. Moreover, the knowledge that healthcare is available and affordable, even for people with preexisting conditions "provides an important incentive for HIV testing." McManus at 1. By ensuring available care, the ACA can outweigh numerous disincentives for testing, including societal stigma, discrimination, stress, anxiety, and depression.[10]

In addition, the battle against HIV requires diagnosing and treating other sexually-transmitted infections (STIs), which can increase susceptibility to HIV. See NHAS at 26 (concurrent STIs increase risk for HIV transmission); *id.* at 34-35 ("In many cases, it is not possible to effectively address HIV transmission or care without also addressing sexually transmitted disease."). Some STIs can be easily self-diagnosed while others have no apparent symptoms but may put the individual at substantially higher risk of contracting HIV due to breaks in the skin or open sores. Centers for Disease Control and Prevention, *STDs and HIV—CDC*

[10] There is a regrettable legal and social regime in place that provides disincentives to learning of one's HIV status. At least 32 states have laws that criminalize otherwise lawful behavior when engaged in by people living with HIV, NHAS at 36; in each such state, not knowing one's status immunizes one from criminal liability.

Fact Sheet 1 (2014). Just as HIV disproportionately impacts communities of color, see *infra* Section II.C, there are also dramatic racial disparities in the prevalence of STIs.[11] As noted above, eligibility for the Ryan White Program is generally limited to individuals diagnosed with HIV; it does not cover treatment for STIs for HIV-negative individuals at risk of contracting the disease. See Health Resources and Services Administration, HIV/AIDS Programs, *Eligible Individuals & Allowable Funds for Discretely Defined Categories of Services*, Policy Notice 10-02 (2010), http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html. Thus, the affordable, comprehensive care available under the ACA is a critical part of the effort to prevent the transmission of HIV in the United States.

C. Despite Tremendous Medical Advances, HIV Remains A Significant Problem For Communities Of Color, Which Experience Much Higher Rates Of Transmission And Substantially Worse Health Outcomes

While medical advances against HIV have improved healthcare outcomes as a whole, all boats have not been lifted equally by this rising tide. The CHLPI Brief explains how essential the subsidies are to lower-income

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[11] For example, in 2012, the chlamydia rate was more than six times as high for black women and more than eight times as high for black men than their white counterparts, and the syphilis rate was 6.1 times higher for blacks than whites. Centers for Disease Control and Prevention, *STDs in Racial and Ethnic Minorities*, http://www.cdc.gov/std/stats12/minorities.htm (last visited Jan. 27, 2014). The gonorrhea rate disparity factor for adults was 26 times for all black men compared to their white counterparts. Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance 2009* 2 (2010), http://www.cdc.gov/std/stats09/surv2009-Complete.pdf.

individuals seeking health insurance. This need is even more acute for people of color living with or at risk of contracting HIV. African Americans are vastly overrepresented among people living with HIV and in the rate of new diagnoses. See Centers for Disease Control and Prevention, *Fact Sheet: HIV Among African Americans* 1 (Nov. 2014) (African Americans represent 41% of Americans living with HIV and 44% of new infections); Centers for Disease Control and Prevention, *Fact Sheet: HIV Among African Americans* 1 (Dec. 2014) (African Americans represent 12% of the U.S. population but 44% of new infections); *ibid.* (African Americans diagnosed with HIV at a rate of eight times the diagnosis rate of whites).

While the differences are somewhat less stark, other racial and ethnic minorities such as Latinos and American Indians and Native Alaskans (AI/AN), are also disproportionately impacted by HIV. Latinos represent less than 16% of the population, but they accounted for approximately 20% of people living with HIV infection in 2011. Centers for Disease Control and Prevention, *Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2012*, 3 HIV Surveillance Supplemental Report 19, 57 (2014). The AIDS death rate is substantially higher for AI/AN men and women than for their white counterparts in every region of the country. NHAS at 13; Centers for Disease Control and Prevention, *HIV Among American Indians and Alaska Natives* 1 (2014).

Placing the lens of sexual orientation over these racial disparities brings an even bleaker picture into focus. Among those most at risk are black men who have sex with men (MSM), who accounted for nearly 25% of

new HIV infections in 2009, despite comprising only 1% of the population.[12] Gregorio A. Millett et al., *Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK, and USA: a meta-analysis*, 380 Lancet 341, 341 (2012). Critically, virtually all of the disparities in HIV infection rates can be explained by two factors: (1) access to healthcare and health insurance, and (2) characteristics of the partner pool, such as HIV prevalence and levels of viral suppression. Patrick S. Sullivan et al., *Explaining Racial Disparities in HIV Incidence in a Prospective Cohort of Black and White Men Who Have Sex With Men in Atlanta, GA: A Prospective Observational Cohort Study*, Annals of Epidemiology (forthcoming 2015). For example, a 2010-2014 longitudinal study in Atlanta found that the risk of HIV infection for black MSM was 2.9 times that of white MSM which could be explained almost entirely by these two factors. *Ibid.*

Statistically, African Americans have not only higher HIV prevalence rates but also less disposable income and access to health insurance. As a result, they receive "worse outcomes on the HIV continuum of care, including lower rates of linkage to care, retention in care, being prescribed HIV treatment, and viral suppression." *Fact Sheet: HIV Among African Americans* 2 (Dec. 2014). Moreover, for three decades African Americans have consistently had higher death rates from AIDS than their white counterparts, and have accounted for half of all AIDS-related deaths. See Centers for Disease Control and Prevention, *Mortality Slide Series*, http://www.cdc.gov/hiv/pdf/statistics

[12] As is often done by researchers, amici use the term "MSM" to capture those men who have sex with men but do not identify as gay or bisexual.

_surveillance_HI V_mortality.pdf; Centers for Disease Control and Prevention, *Epidemiology of HIV Infection Through 2012*, http://www.cdc.gov/hiv/pdf/statistics _surveillance_epi-hiv-infection.pdf. While HIV has become a treatable, albeit serious, health condition for many, the adage that "when white America catches a cold, black America catches pneumonia" rings chillingly true in the case of HIV.[13]

Widespread access to health insurance could reduce the alarming rates of new infections among communities of color, including blacks and Latinos. Indeed, the data suggest that following implementation of the ACA, the percentages of uninsured are already going down, particularly among the groups with the greatest need. In the fourth quarter of 2014, the uninsured rate dropped 4.2 percentage points in a year to 12.9% for U.S. adults as a whole—the lowest rate since Gallup began measuring the uninsured rate in 2008. Jenna Levy, *In U.S., Uninsured Rate Sinks to 12.9%* (Jan. 6, 2014), http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx. And Gallup's survey found that the uninsured rate had dropped most dramatically among African Americans (declining 7 percentage points in a year) and Americans earning less than $36,000 per year (declining 6.9 percentage points in a year). *Id.* Likewise, in the first year of enrollment, the uninsured rate declined by 8 percentage points among LGBT adults with incomes under 400% of the federal poverty level.

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[13] A form of pneumonia—Pnuemocystis Jirovecii (Carinii) Pneumonia—is often the cause of death in patients with AIDS. See AIDS.gov, *Opportunistic Infections and Their Relationship to HIV/AIDS*, https://www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/potential-related-health-problems/opportunistic-infections/ (last visited Jan. 21, 2015).

See Center for American Progress, *Moving the Needle: The Impact of the Affordable Care Act on LGBT Communities* 2-3 (2014).

III. ELIMINATING AFFORDABLE HEALTH INSURANCE WOULD HAVE DEVASTATING PUBLIC HEALTH IMPLICATIONS FOR PEOPLE OF COLOR

Eliminating subsidies for people living with HIV in states with HHS-created and facilitated exchanges would have disastrous consequences, not only by removing access to life-saving medications, but also by exacerbating distrust in the public health system and discouraging testing and involvement with healthcare professionals.[14] Distrust of the healthcare system, lack of awareness of the efficacy of treatment, and stigma already contribute to disparities in healthcare for people of color. See NHAS at 26. Widespread access to affordable healthcare for the first time promises to address these social barriers to care, particularly when people of color see other people of color attaining dramatically better health outcomes. Petitioners' interpretation of the ACA threatens to undo any progress that has been made, creating devastating public health

[14] While the focus of this brief is the human suffering and loss that could result if subsidies were withdrawn, the financial and economic impact would also be devastating. By one estimate, society saves $910,800 (in 2002 dollars) each time a transmission of HIV is prevented. Angela B. Hutchinson et al., *The Economic Burden of HIV in the United States in the Era of Highly Active Antiretroviral Therapy*, 43 J. Acquired Immune Deficiency Syndrome 451, 455 (2006). Arresting the progression of HIV to AIDS is similarly fiscally compelling. People belatedly starting HIV medications can incur direct healthcare costs 1.5 to 3.7 times higher than those receiving prompt care. John A. Fleischman et al., *The Economic Burden of Late Entry Into Medical Care for Patients with HIV Infection*, 48 Medical Care 1071, 1075-1078 (2010).

consequences far beyond the HIV context. States that have high HIV infection rates, large populations of residents of color, and HHS-created or facilitated exchanges compellingly demonstrate the negative effect that an adverse ruling would have for real people of color living with HIV. For example, a recent case study noted the particular devastation of the HIV epidemic in nine states: Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas,. Susan Reif et al., *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States*, J. Community Health 7 (Dec. 19, 2014) (e-publication ahead of print). These states, which Reif refers to as the "Deep South" states, have many salient points in common. They have not expanded Medicaid. See Appendix II, *infra*. Irrespective of income level, adults in those states cannot get Medicaid coverage unless they are a senior, have a child, are pregnant, or are disabled.[15] See The Henry J. Kaiser Family Found., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* 2-4 (2014). None of these states has established its own exchange, so under petitioners' interpretation of the ACA, low-income adults in these states would remain without insurance subsidies. See Appendix III, *infra*. These states constitute nine of the thirteen most populous states that have refused both to expand Medicaid and to set up their own exchanges. Kaiser Family Found., *The Coverage Gap* at 6.

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[15] While people living with HIV can become "disabled" within the meaning of Medicaid eligibility if their condition worsens due to inadequate healthcare, requiring an individual's health to deteriorate to that point before being provided healthcare is an absurd and arguably cruel public health approach.

These southernmost states are also states where HIV is most prevalent and fatal. See Appendix IV, *infra*. They constitute eight of the twelve states in 2011 with the highest adult HIV incidence. Centers for Disease Control and Prevention, *Rates of diagnoses of HIV infection among adults and adolescents, by area of residence, 2011—United States and 6 dependent areas*, 23 HIV Surveillance Report 1 (2013) (2011 rates). Likewise, they contain fourteen of the seventeen U.S. cities with the highest rates of new HIV infections in 2011. *Id.* at 75-78. And they constitute eight of the ten states with the highest HIV/AIDS fatality rates from 2002 to 2006. Susan Reif et al., *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States*, J. Community Health 2 (Dec. 19, 2014) (e-publication ahead of print).

In these southern states, the impact of HIV is felt most acutely by people of color.[16] They constitute half of the 18 states that have more than a million African American residents. Sonya Rastogi, *The Black Population: 2010* 8 (2011). 58.5% of Ryan White cases in these states are African Americans, and 15.3% are Latinos. See Dep't of Health and Human Servs., *2012 State Profiles, Ryan White HIV/AIDS Program*, http://hab.hrsa.gov/stateprofiles/AIDS-Drug-Assistance-Program.aspx (last visited Jan. 21, 2015). These states include two of the three states with the most La-

[16] By contrast, if petitioners prevail, the residents of sixteen states currently would continue to receive subsidies; in each of those states except Maryland, New York, and Connecticut, blacks account for less than 10% of the population. United States Census Bureau, *State & Country QuickFacts*, http://quickfacts.census.gov/qfd/index.html (last visited Jan. 27, 2015). In seven of the sixteen states, blacks account for fewer than one in 20 residents. *Ibid.*

tino residents—Texas and Florida—which, along with California account for more than 55% of the nation's Latino population. Sharon R. Enis et al., *The Hispanic Population: 2010* 6-7 (May 2011). The withdrawal of subsidies is likely to have a more profound effect on the Latino community in the future: of the dozen states with the fastest-growing Latino populations from 2000 to 2010, ten rely on federal exchanges. See *ibid.*

Access to comprehensive and affordable insurance is especially important, given the historical inability of these states to provide care for those living with HIV. When ADAP waiting lists were at their peak of more than 9,200 patients in August 2011, the geographic disparity of those lists was pronounced: 86% of those patients lived in these southern states; 95.6% if Virginia is included. African Americans and Hispanics represented 64% of clients on the August 2011 ADAP waiting lists. Krista Cox, *ADAP waiting lists continue to grow; 9,217 individuals on waiting lists, 64% are African American or Hispanic*, Knowledge Ecology Int'l (Aug. 16, 2011), http://keionline.org/node/1200.

The country's first National HIV/AIDS strategy, released in 2010 just months after passage of the ACA, extolled the benefits of getting tested for HIV and of "increasing access to care." NHAS at 16, 21-23. Americans have been urged to get tested and to sign up for newly-affordable healthcare. To break the promise of improved healthcare by providing and then withdrawing affordable access to care could damage irreparably the credibility of public health initiatives in the minds of already marginalized communities. Indeed, "[l]osing access to medications may discourage [people living with HIV] from pursuing care at all." McManus at 3. "[T]he presence of wait lists * * * may reduce a person's

motivation and ability to engage in HIV care." *Ibid.*; see also M. J. Mugavero et al., *Health care system and policy factors influencing engagement in HIV medical care: piecing together the fragments of a fractured health care delivery system*, 52 Clinical Infectious Diseases S238, S240 (2011). In fact, testing people for HIV when uninterrupted access to HIV medication will not follow presents an ethical dilemma for medical professionals. See McManus at 4-5 ("Ethically it is wrong to actively increase HIV testing while there is limited access to the standard of care for low income, underinsured, and uninsured patients."); J. Y. Kim & P. Farmer, *AIDS in 2006—moving toward one world, one hope?*, 355 New England J. of Med. 645 (2006) (advocating that public health officials should "adopt universal-access plans and waive fees for HIV care").

To rip away the subsidies that have allowed so many to afford healthcare for the first time would intensify profound distrust in public health institutions, particularly for African Americans, who already are wary of the healthcare system. See NHAS at 26. Studies have documented this distrust, with many pointing to the understandable disdain of the healthcare system in the wake of the infamous "Tuskegee Study of Untreated Syphilis in the Negro Male." See Vicki S. Freimuth et al., *African Americans' views on research and the Tuskegee Syphilis study*, 52 Social Science & Med. 797 (2001).[17] Other studies show that African Americans' wariness of the healthcare system is rooted in systemic distrust of institutions. Carla Shoff & Tse-Chuan Yang, *Untangling the associations among dis-*

[17] The Tuskegee Study spanned over four decades, including a quarter-century after the widespread acceptance of penicillin as an effective treatment and ended in 1972—hardly ancient history.

trust, race, and neighborhood social environment: A social disorganization perspective, 52 Soc. Sci. Med. 4 (2012).

In short, the HIV prevalence, demographics, history, and refusal of many states to set up exchanges all support deferring to the IRS regulation that makes health insurance more affordable nationwide.[18] The regulation neither calls out any state nor imposes additional obligations on any states based on historical transgressions. Instead, it merely treats all residents of all states alike. By contrast, the petitioners' view of the ACA leaves persons living with and at risk of HIV in these states at the mercy of a systematic breakdown that allows a potentially deadly disease to go untreated and un-prevented. This is not what Congress intended.

IV. PETITIONERS' READING OF THE ACA DIVIDES SIMILARLY-SITUATED INDIVIDUALS INTO THOSE WITH ACCESS TO AFFORDABLE HEALTHCARE AND THOSE WITHOUT, CREATING SERIOUS EQUAL PROTECTION ISSUES

The principal purpose of the ACA was to create near-universal access to health insurance for all Americans. See *supra* Section I. To achieve this, affordable, quality healthcare had to be brought within the reach of individuals who had previously been ineligible for insurance or unable to afford it, in every state. The exchanges are a sufficiently important part of the ACA's

[18] Further support for the regulation is provided by the respondents' argument that it defies credulity to believe that Congress would include a draconian provision denying subsidies to residents of states not creating their own exchange as an incentive for such creation—especially while not clearly informing the states of the consequences of inaction. Gov't Br. 40-41.

solution that, if a state is unwilling to run its own exchange, the federal government committed to fund and run the exchange in the state's stead. According to petitioners, however, Congress divided the low-income individuals that the ACA is designed to help, and who are otherwise identically-situated, into two distinct categories: those who have access to affordable healthcare because they live in states that created their own exchanges, and those without affordable healthcare options because they live in states with HHS-created or facilitated exchanges. This type of separation of people "into two discrete groups that are accorded radically disparate treatment" brings to the fore significant constitutional equal protection concerns. *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 438 (1982) (Blackmun, J., concurring). Congress cannot have intended for the draconian consequence of denying affordable health care to a state's most vulnerable residents to hinge on whether a state government or HHS sets up the exchange.

In two concurring opinions, six Justices of the *Logan* Court found a violation of the Equal Protection Clause where an Illinois law terminated fair employment act claims if the state commission responsible for handling the claims did not schedule a hearing within 120 days. *Id.* at 438-444 (Blackmun, J., concurring; Powell, J., concurring). *Logan* has been subsequently invoked by courts examining the validity of government systems that punish particular groups of people for circumstances beyond their control. See, *e.g.*, *Fed. Express Corp.* v. *Holowecki*, 552 U.S. 389, 404 (2008) ("It would be illogical and impractical to make the [timeframe for commencement of an action] dependent upon a condition subsequent over which the parties

have no control." (citing *Logan*, 455 U.S. at 444 (Powell, J., concurring))); *Lawrence* v. *Chancery Court*, 188 F.3d 687, 695 (6th Cir. 1999) (declaring that a state's practice is subject to an equal protection challenge under *Logan* if it irrationally "penalizes a definable group of litigants due to circumstances beyond their control").

Petitioners' argument that Congress conditioned access to subsidies on residence in a state with its own exchange in order to incentivize states to establish exchanges, Pet. Br. 1-5, is particularly troubling. Petitioners' proposed interpretation conditions access to affordable healthcare on the ability of poor, marginalized individuals to spur action by state-level officials. This would visit grave adverse consequences on a subset of individuals who "possess[] no power" to set up exchanges—and who are the very subset of individuals Congress intended to help—rendering the result "unfair and irrational" in violation of the Equal Protection Clause. *Logan*, 455 U.S. at 444 (Powell, J., concurring).

Certainly, within constitutional limits, Congress is free to use its powers to create incentives for certain states to legislate in particular ways. See *South Dakota* v. *Dole*, 483 U.S. 203 (1987) (conditioning federal highway funds on raising state drinking ages to 21). But distinguishing between residents of different states—providing healthcare subsidies to some but not others—is not rationally related to the federal government's interest in encouraging states (rather than HHS) to run state health insurance exchanges, and is directly contrary to the ACA's express goal of near-

universal healthcare.[19] Even if lower-income people do not constitute "discrete and insular minorities," they are nonetheless largely unable to control the "political processes ordinarily to be relied upon to protect minorities." *United States* v. *Carolene Products Co.*, 304 U.S. 144, 152 n.4 (1938); see also *Bullock* v. *Carter*, 405 U.S. 134, 144 (1972) (addressing "disparity in voting power based on wealth," stating "we would ignore reality were we not to recognize that [the Texas filing-fee system] falls with unequal weight on voters * * * according to their economic status"); Joe Soss & Lawrence R. Jacobs, *The Place of Inequality: Non-participation in the American Polity*, 124 Pol. Sci. Q. 95, 97 (2009) ("[A]lthough formal political rights are widely distributed in the United States, these rights are exercised far more often by those with higher [socioeconomic status] than by those with lower [socioeconomic status]."). Given this lack of political clout, the federal government does not have a rational basis to use a group of lower-income individuals as hostages to encourage state officials to establish state-operated exchanges.[20]

Moreover, the subsidies are a poorly fitted and disproportionate incentive to establish state-run exchang-

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[19] Nor is there a rational connection between this proffered governmental interest and the disparate application of the employer and individual mandates posited by petitioners. See Pet. Br. 8-9.

[20] This is unlike federal Medicaid funding, which Congress conditioned on the adoption of a "State plan for medical assistance" meeting several enumerated requirements. 42 U.S.C. 1396a. Conditioning the provision of funds to states in connection with a particular federal program on the satisfaction of certain program requirements is altogether different from conditioning the availability of subsidies for individual persons within a state on the state's decision to create its own ACA exchange.

es. While the work entailed in creating the exchange may be somewhat burdensome insofar as it requires maintenance of a website and other administrative obligations, the allocation of this task between the federal government and the states is not of such paramount importance that it would be worth jeopardizing the Act as a whole to ensure that states perform this function.[21]

Congress would not have reached the contrary conclusion—that the mere offer of subsidies would have been a sufficient incentive—in the context of the health insurance exchanges. See *Halbig* v. *Burwell*, 758 F.3d 390, 415-416 (D.C. Cir. 2014) (Edwards, J., dissenting) ("Simply put, § 36B(b) interpreted as Appellants urge would function as a poison pill to the insurance markets in the States that did not elect to create their own Exchanges. This surely is not what Congress intended."). Moreover, ACA subsidies, unlike Medicaid funds, are provided by the federal government directly to federal taxpayers. Given the political powerlessness of lower-

[21] As the government has argued, it is untenable to suggest that Congress created the draconian incentive system imagined by petitioners. See Gov't Br. 43-45. In the context of the Medicaid expansion, Congress determined that offering even significant additional Medicaid funds to the states was not a sufficient enticement to convince them to expand Medicaid. Instead, Congress concluded that it must threaten to take away existing Medicaid funds in order to convince the states to provide their citizens with additional healthcare assistance. See *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2601-2607. Congress would not have reached the contrary conclusion—that the mere offer of subsidies would have been a sufficient incentive—in the context of the health insurance exchanges. See *Halbig* v. *Burwell*, 758 F.3d 390, 415-416 (D.C. Cir. 2014) (Edwards, J., dissenting) ("Simply put, § 36B(b) interpreted as Appellants urge would function as a poison pill to the insurance markets in the States that did not elect to create their own Exchanges. This surely is not what Congress intended.").

income individuals eligible for subsidies, relying on political pressure from these individuals is an exceptionally poor means to compel the states to act.

Here, as in *Logan*, Congress's "method of furthering [its] purposes—if [incentivizing the states] was in fact the legislative end—has so speculative and attenuated a connection to its goal as to amount to arbitrary action." 455 U.S. at 442 (Blackmun, J., concurring). Congress's "rationale must be something more than the exercise of a strained imagination; while the connection between means and ends need not be precise, it, at the least, must have some objective basis. That is not so here." *Ibid.*; see also *Clinton* v. *New York*, 524 U.S. 417, 429 (1998) (even a legitimate, frequently-used legislative tactic can lead to "absurd and unjust" results in certain applications). Congress's primary aim in passing the ACA was to expand access to health insurance to residents of *all* states. When this clearly-articulated goal is considered, there is no rational basis to create radically disparate treatment across state lines. Indeed, the *Logan* Court was dismayed at the arbitrary termination of discrimination claims, irrespective of their merit. *Logan*, 455 U.S. at 437 n.10, 444 (Powell, J., concurring). Here what petitioners have proposed is even more dire, akin to the creation of a 120 day limit that punished only claimants with the most compelling or meritorious cases. Petitioners' position would result in denying subsidies to the marginalized communities most affected by—and at risk for—HIV.

The IRS regulations not only reflect the correct implementation of the ACA based on the statutory text, see Gov't Br. 19-35; they also avoid the profound equal protection problems that would arise by making healthcare affordable to some, yet prohibitively expen-

sive to others similarly situated, based solely on their state government's inaction. This Court has repeatedly cited the "cardinal principle of statutory interpretation * * * that when an Act of Congress raises a serious doubt as to its constitutionality," the Court should "ascertain whether a construction of the statute is fairly possible by which the question may be avoided." *Zadvydas* v. *Davis*, 533 U.S. 678, 689 (2001) (citation and internal quotation marks omitted); see also, *e.g.*, *United States* v. *X-Citement Video*, 513 U.S. 64, 73 (1994) ("[W]e do not impute to Congress an intent to pass legislation that is inconsistent with the Constitution as construed by this Court."). This Court has chastised agencies that have created constitutional questions by their interpretations; here, the IRS regulation is consistent with the statutory text and avoids such a problem, militating strongly in favor of deference. See *Edward J. DeBartolo Corp.* v. *Florida Gulf Coast Building & Constr. Trades Council*, 485 U.S. 568, 576-577 (1987) (rejecting agency interpretation that ignored "asserted constitutional considerations"); *Allentown Mack Sales & Serv.* v. *NLRB*, 522 U.S. 359, 387 (1998); *Miller* v. *Johnson*, 515 U.S. 900, 924 (1995) (rejecting Department of Justice interpretation that raised issues under the Equal Protection Clause). Accordingly, the Court should reject petitioners' interpretation, which both undermines Congress's primary purpose for the ACA and creates profound, unnecessary equal protection problems.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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APPENDIX I

DESCRIPTION OF AMICI

Formed in 1973, Lambda Legal Defense and Education Fund, Inc. (Lambda Legal) is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, and transgender (LGBT) people and those living with HIV through impact litigation, education, and public policy work. Lambda Legal has represented the interests of people living with HIV since the beginning of the HIV/AIDS epidemic, and our work has ensured access to treatment, promoted effective prevention policies, and helped combat discrimination, bias, and stigma. Lambda Legal has litigated and won major HIV-related cases, and previously has advocated or served as amicus curiae before this Court on behalf of persons who are LGBT or living with HIV, including *National Federation of Independent Business* v. *Sebelius*, 132 S. Ct. 2566 (2012), *Cooper v. Federal Aviation Administration*, No. 10-1024 (U.S. Sup. Ct., argued Nov. 30, 2011), *Lawrence v. Texas*, 539 U.S. 558 (2003), and *Romer v. Evans*, 517 U.S. 620 (1996).

Founded in 1989 with a mission to provide HIV/AIDS services and advocate for Asian and Pacific Islanders Living with HIV/AIDS, Asian & Pacific Islander Coalition on HIV/AIDS (APICHA) now provides comprehensive primary care, preventive health services, and mental health and supportive services to medically underserved and marginalized residents of New York City, particularly Asians and Pacific Islanders, LGBT individuals, and recent immigrants from communities of color. APICHA is noted for its culturally competent and linguistically appropriate services,

with capacity to serve over fifteen Asian languages plus Spanish in addition to English.

Founded in May of 1999, the Black AIDS Institute is the only national HIV/AIDS think tank focused exclusively on Black people. The Institute's mission is to stop the AIDS pandemic in Black communities by engaging and mobilizing Black institutions and individuals in efforts to confront HIV. The Institute interprets public and private sector HIV policies, conducts trainings, offers technical assistance, disseminates information, and provides advocacy mobilization from a uniquely and unapologetically Black point of view. The Institute's motto describes a commitment to self-preservation: "Our People, Our Problem, Our Solution."

Gay & Lesbian Advocates & Defenders (GLAD) is a public interest legal organization dedicated to ending discrimination based upon sexual orientation, HIV status, and gender identity and expression. GLAD's AIDS Law Project, founded in 1984, has litigated numerous cases in state and federal court addressing access to health care for people with HIV. GLAD was counsel in *Bragdon v. Abbott*, 524 U.S. 624 (1998), which involved a dentist who refused to provide dental care to people with HIV.

GLMA: Health Professionals Advancing LGBT Equality (GLMA) is the largest and oldest association of lesbian, gay, bisexual, and transgender (LGBT) healthcare and health professionals. GLMA's mission is to ensure equality in healthcare for LGBT individuals and healthcare professionals, using the medical and health expertise of GLMA members in public policy and advocacy, professional education, patient education and referrals, and the promotion of research. GLMA

was founded in 1981 in part as a response to the call to advocate for policy and services to address the growing health crisis that would become the HIV/AIDS epidemic. Since then, GLMA's mission has broadened to address the full range of health issues affecting LGBT people, including ensuring that all healthcare providers provide a welcoming environment to LGBT individuals and their families and are competent to address specific health disparities affecting LGBT people.

Founded in 2009, the HIV Prevention Justice Alliance (HIV PJA) is a coalition of more than 80 organizations and a network of 13,000 individuals working at the intersection of HIV/AIDS, health care, social justice, and human rights through education, training, public policy work, public health, and community mobilization. HIV PJA is dedicated to representing the interests of people living with HIV as key agents of HIV prevention and the best voices to speak out for effective prevention policies, health care, and against discrimination, bias, and stigma. HIV PJA is headquartered and staffed in Chicago, with a diverse steering committee of members representing communities across the United States.

National AIDS & Education Services for Minorities (NAESM) was created in an effort to counteract the ever-increasing spread of HIV/AIDS in communities of color. NAESM exists to address health disparities experienced by African American people, particularly the overwhelming number of health issues that affect the lives and well-being of black gay men. Since the opening of its doors in 1990, the mission of NAESM has been to provide national and local leadership to address the myriad health and wellness issues confronted by black gay men through advocacy, services, and educa-

tion. A large part of this leadership has been NAESM's annual National African American MSM Leadership Conference on HIV/AIDS and other Health Disparities, which brings together hundreds of national and community leaders in the fight against the HIV epidemic.

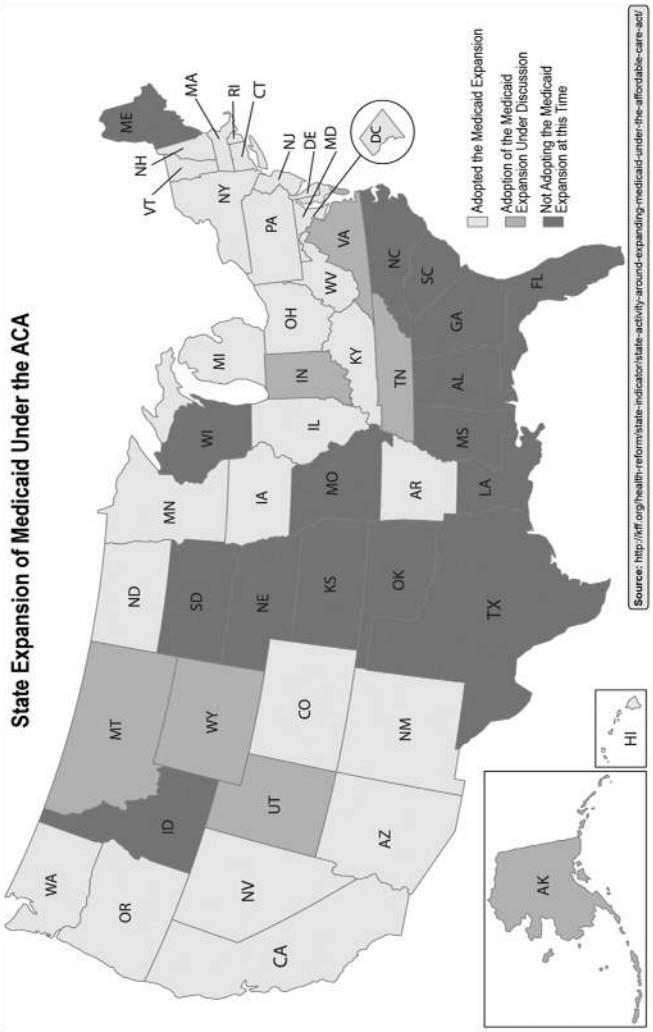
The National Black Justice Coalition (NBJC) is a civil rights organization dedicated to empowering Black lesbian, gay, bisexual and transgender (LGBT) people. NBJC's mission is to end racism and homophobia. Part of NBJC's efforts is public education work to highlight that African Americans are disproportionately represented in the HIV epidemic and often have few treatment resources to achieve good health outcomes and avoid new infections. NBJC has emphasized both the importance of Black LGBT leadership and the promise of the ACA in the fight against the epidemic, if we ever hope to see an AIDS-free generation.

The National Minority AIDS Council (NMAC) represents a coalition of faith-based and community-based organizations, as well as AIDS service organizations, advocating and delivering HIV/AIDS services in communities of color nationwide. Since 1987, NMAC has developed leadership in communities of color through a variety of public policy education programs, national conferences, research programs, capacity building, technical assistance and trainings, and digital and electronic resource materials. As such, NMAC has a very well-informed perspective as to the effect withdrawal of subsidies in 34 states will have on the access to healthcare and health of people of color living with or at higher risk of HIV in the states potentially affected by the outcome of this case.

The Latino Commission on AIDS (Commission) is a nonprofit membership organization founded in 1990 and dedicated to addressing the impact of HIV/AIDS and health challenges in the Latino/Hispanic community. The Commission realizes its mission by promoting health advocacy, HIV testing, and health promotion; developing prevention programs for high-risk communities; implementing community participatory research/evaluation initiatives; and providing capacity building services. The Commission is the leading national Latino AIDS organization, coordinating National Latino AIDS Awareness Day and other prevention and advocacy programs across the United States and its territories.

APPENDIX II

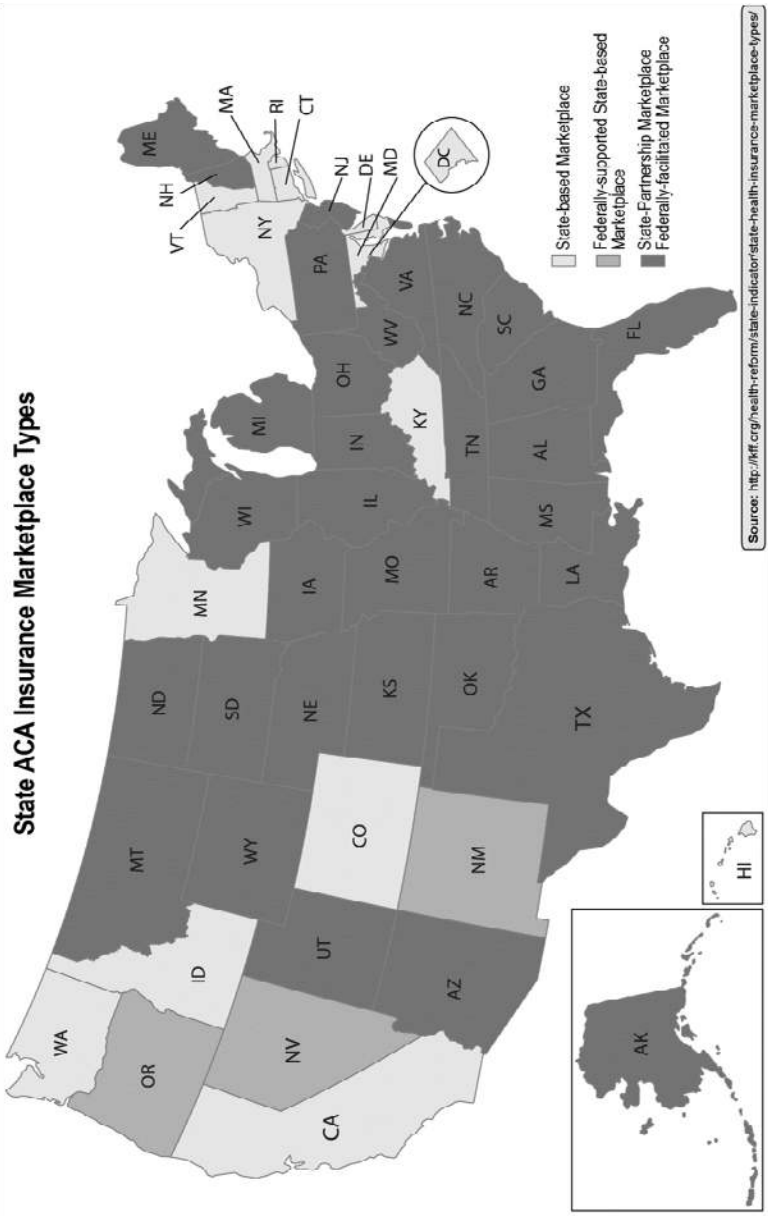
MAP OF STATES THAT EXPANDED MEDICAID UNDER THE ACA[1]



[1] This map does not reflect the Medicaid expansion announced by Indiana on January 27, 2015.

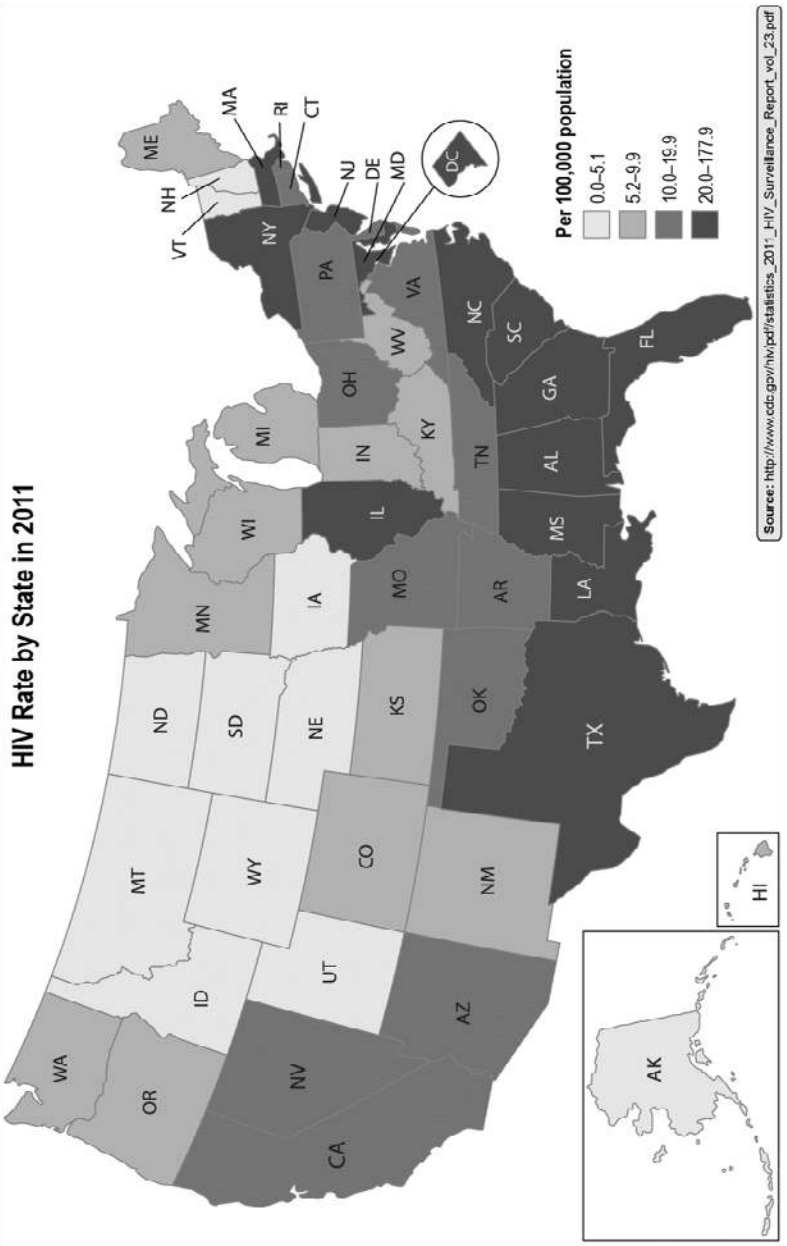
APPENDIX III

MAP OF STATE ACA INSURANCE MARKETPLACE TYPES



APPENDIX IV

MAP OF HIV RATES BY STATE IN 2011



King v. Burwell: Frequently Asked Questions

By Lambda Legal
FEBRUARY 26, 2015

Q: What is the issue being addressed in King v. Burwell?
A: King v. Burwell is about whether all people who purchase health insurance under the Patient Protection and Affordable Care Act are eligible to receive subsidies – or, as the challengers would have it, only residents of those 13 or so states who set up their own healthcare exchanges. Without these subsidies, many low and middle income people will not be able to afford health insurance, which of course would defeat Congress's purpose in passing the Affordable Care Act.

Q: How would a negative decision affect people living with HIV?
A: The great majority of HIV-positive people in the States affected make less than 400% of the poverty level, would become ineligible for subsidies and will no longer be able to afford health insurance. Without health insurance, they may no longer have access to the life-saving medication and care they need.

Listen to our teleconference with Lambda Legal Counsel Greg Nevins and HIV Project Director Scott Schoettes, "King v. Burwell at the Supreme Court":

Q: If people with HIV are no longer able to afford health insurance, couldn't they just fall back into the old system of HIV care?

A: We couldn't easily return to that system and we wouldn't really want to do so. In addition to the fact the old system of HIV care is already adapting and changing to work alongside Obamacare, the truth is that the old system wasn't working that well. Despite the hundreds of millions of dollars spent on this system over the past 25 years, in 2011 only 28% of the more than 1.1 million people living with HIV in the United States had achieved viral suppression. As recently as a few years ago, there were waiting lists to get HIV drugs in several states, and those are the very states whose residents would lose their subsidies if this legal challenge is successful.

Q: Why does Lambda Legal's brief focus upon communities of color?

A: Within the states potentially affected by the decision in this case, there is a veritable public health emergency going on within communities of color when it comes to HIV. In this country, a Black person is 8 times more likely to contract HIV than a white person, and after infection has a 13% greater chance of an AIDS-related death. If we don't correct course, these disparities are only going to get worse. Lambda Legal thought it important to bring these racial disparities to the Court's attention and to provide a legal framework in which the Justices could take them into account while making their decision about Congress's intent in passing this legislation.

Q: So lack of access to healthcare for people of color increases susceptibility to HIV infection. Are there behavioral differences at work also?

A: No, it seems not. For instance, multiple epidemiological studies have shown that black gay and bisexual men engage in the same or less risky behavior than their white counterparts. There is, however,

another factor that plays into higher rates of new infection within certain communities: the tendency of people towards same-race sexual partners. Certain communities have a higher percentage of people with HIV, and when the percentage of people with HIV within the pool of potential sexual partners is higher, the chances of contracting HIV increase accordingly. Layer on top of the lower testing and treatment rates within communities of color and the fact that transmission is more likely to occur if people do not know they are HIV-positive or are not able to access treatment, and it is easy to see the snowball effect that leads to the significantly higher prevalence of HIV within certain communities.

Q: How would an adverse decision affect people who are trying to stay HIV-negative?
A: Profoundly. The The federal Ryan White HIV/AIDS Program doesn't cover medications for people who are HIV-negative, so it doesn't provide health insurance that would cover Pre-Exposure Prophylaxis (PrEP), which has been shown to be highly effective in preventing HIV transmission. Also, limited access to healthcare for people of color historically has led to much higher rates of untreated sexually-transmitted infections, which in turn greatly increases susceptibility to HIV.

Q: If the U.S. is one of the wealthiest countries in the world, and the place where most of these very effective HIV medications have been developed, why are people still dying here?
A: There are a number of contributing factors, but the primary reason is that healthcare had not previously been made affordable and accessible to everyone in this country. We have the medical infrastructure to deliver this care, we have medications that turn HIV into a chronic, manageable condition, and we now have multiple effective methods of preventing its transmission. But only with the passage of the Affordable Care Act did we as a country make this a priority and muster the political will to make affordable healthcare a reality. And only with the preservation of the ACA can we achieve our goal of an AIDS-free generation.

SEE ALSO: HEALTH CARE FAIRNESS, HIV, KING V. BURWELL, HEALTH CARE FAIRNESS, HIV, KING V. BURWELL

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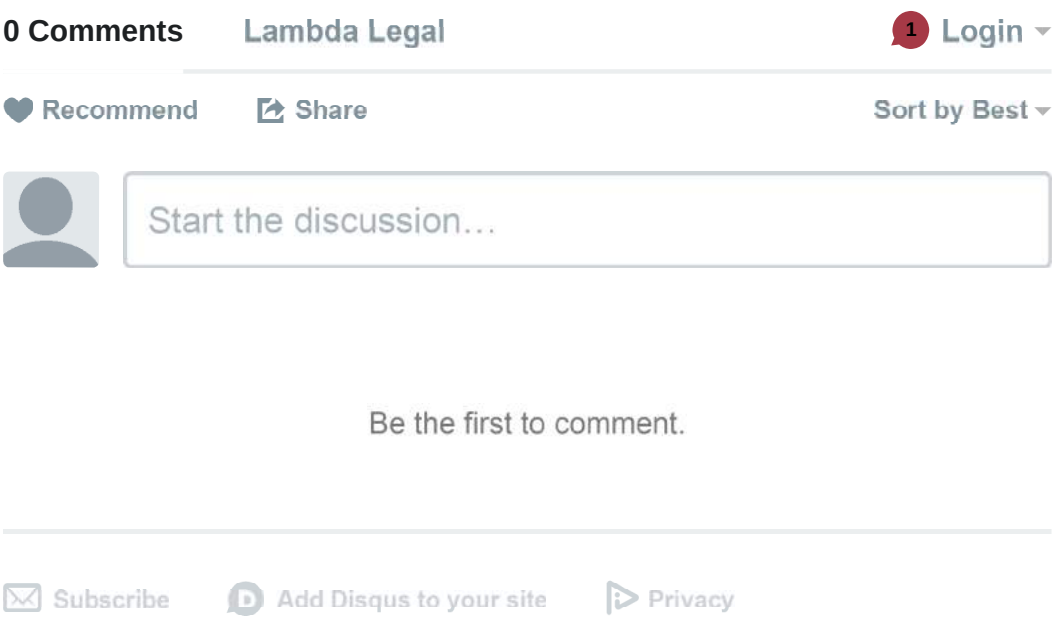

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ACA Provisions Addressing Discrimination in Health Insurance

Allison Rice
Duke Health Justice Clinic

Section 1557, 42 USC § 18116

(a) In general

Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Continued application of laws

Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) Regulations

The Secretary may promulgate regulations to implement this section.

Section 1331, 42 USCA § 18031. Affordable choices of health benefit plans

(c) Responsibilities of the Secretary

(1) In general

The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;