No. 11-398

In the Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

v.

STATE OF FLORIDA, ET AL.

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

BRIEF FOR LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC., AIDS UNITED, ASIAN & PACIFIC-ISLANDER COALITION ON HIV/AIDS, BLACK AIDS INSTITUTE, CENTER FOR HIV LAW AND POLICY, GAY & LESBIAN ADVOCATES & DEFENDERS, GAY & LESBIAN MEDICAL ASSOCIATION, HIV MEDICINE ASSOCIATION, HIV PREVENTION JUSTICE ALLIANCE, LATINO COMMISSION ON AIDS, NATIONAL ASSOCIATION OF PEOPLE WITH AIDS, NATIONAL CENTER FOR LESBIAN RIGHTS, NATIONAL CENTER FOR TRANSGENDER EQUALITY, NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER, U.S. POSITIVE WOMEN'S NETWORK/WORLD, AND TREATMENT ACCESS EXPANSION PROJECT, AS AMICI CURIAE IN SUPPORT OF PETITIONER ON THE MINIMUM COVERAGE REQUIREMENT ISSUE

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INTEREST OF AMICI[1]

Amici are nonprofit organizations that undertake litigation, public policy, and advocacy efforts on behalf of people living with HIV, many of whom are denied or receive inadequate health care due to unlawful discrimination or lack of insurance.[2] 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/AIDS had private health insurance, and nearly 30% had neither public nor private insurance. See AIDS.gov, *Health Care Reform and HIV/AIDS: How Does the Affordable Care Act Impact People Living with HIV/AIDS?* ¶ 2 (Jan. 14, 2011) ("*Health Care Reform and HIV/AIDS*"). These uninsured individuals were unable to obtain private insurance yet did not meet Medicaid or Medicare eligibility requirements. This coverage gap has produced severe economic consequences for society at large, and undercuts public health efforts to combat the national HIV/AIDS epidemic. Amici therefore share a strong interest in ensuring full implementation of the ACA, including its minimum coverage requirement.

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[1] 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 any party authored this brief in whole or in part, and no person or entity, other than amici curiae, their members, or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

[2] A description of each of the amici organizations is included in an appendix hereto.

SUMMARY OF ARGUMENT

The ACA's minimum coverage requirement ("MCR") is the linchpin of Congress's comprehensive response to a broken national health insurance system. The briefs of the United States and many other amici address in detail the fallacy of the purported distinction between economic "activity" and "inactivity," especially in the context of health insurance. Rather than repeat those arguments, amici here provide a focused analysis of the systemic failure of the health insurance market for people living with HIV, and the significance of that failure for the constitutionality of Congress's response in enacting the ACA.

The HIV/AIDS epidemic provides a powerful case study of how quintessentially economic activity by health insurers and consumers has led to devastating consequences for the over 1.2 million Americans living with HIV and for society at large. We have the tools to stem this epidemic, which continues to produce an alarming 50,000 new HIV infections each year. As the 2010 National HIV/AIDS Strategy declares, "[o]ur Nation is at a crossroads" in the battle against HIV. Office of the President of the U.S., *National HIV/AIDS Strategy for the United States* 1 (2010) ("*National HIV/AIDS Strategy*"). But only with comprehensive national health care reform and expanded access to coverage and treatment can we turn the tide on this epidemic.

Several hundred thousand American individuals with HIV have been excluded from the private insurance market and are ineligible for government insurance programs. Private insurers have employed numerous devices, including pre-existing condition exclusions, excessive premiums, annual and lifetime benefit

limits, and, in some cases, outright deceit to remove individuals with HIV from their rolls. As a result, before passage of the ACA, only 17% of Americans with HIV had private health insurance (in contrast to 67% of the non-elderly population generally); 30% lacked either public or private insurance. Very few of these individuals can afford to pay the costs of treating HIV or AIDS out-of-pocket. Yet, if people with HIV could receive consistent access to health insurance and health care, thousands of lives—and billions of dollars—could be saved each year, and the HIV/AIDS epidemic could be dramatically curbed. It is undisputed that Congress acted within its authority under the Commerce Clause in enacting the guaranteed issue and community rating provisions of the ACA, which prevent the widespread exclusion of those living with HIV from the private health insurance market.

The MCR is the critical component by which Congress ensured the availability of health insurance—and life- and cost-saving health care—to those with HIV who otherwise would be denied access. Massachusetts, which adopted comparable health care reform, including an MCR, has succeeded in making health care coverage almost universal, with, in turn, remarkable improvements in the health status of those with HIV and lowered rates of new HIV transmissions. The contrast between Massachusetts' success and the market failures of states addressing the problem in the absence of an MCR provides empiric proof that the MCR is an essential part of Congress's larger regulation of the interstate insurance market, and thus is constitutional under the Necessary and Proper Clause. See *United States* v. *Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring in the judgment).

The experiences of those living with HIV further demonstrate that, even apart from Congress's authority under the Necessary and Proper Clause, enactment of the MCR itself was within Congress's Commerce Clause authority. A person who contracts HIV cannot reasonably expect to "self-insure" against the enormous health care costs of treating the virus, which far exceed most individuals' savings. Such individuals will inevitably rely on publicly-funded programs and the safety net of health care facilities, which are legally required to provide at least emergency care and which pass the costs of these services onto other market participants. When insurance is available, as it is under the ACA, an individual's decision not to acquire health insurance is, in fact, a decision to accept the economic benefits of this socially available insurance without paying for it.

But the great majority of people living with HIV have had no choice in the matter of private insurance coverage. The insurance market has systematically excluded them, with grave consequences to their health, unnecessary spread of HIV, and significant burdens on the economy. Congress acted well within its constitutional authority in enacting the MCR, an essential component of the ACA, in response to this national health care crisis.

ARGUMENT

I. THE HEALTH CARE INSURANCE MARKET HAS FAILED TO SERVE INDIVIDUALS LIVING WITH HIV, WITH DIRE PUBLIC HEALTH AND ECONOMIC CONSEQUENCES

Currently, an estimated 1.2 million people live with HIV in the United States. Ctrs. for Disease Control & Prevention ("CDC"), *HIV Surveillance—United States*,

1981-2008, 60 Morbidity & Mortality Wkly. Rep. 689, 689 (2011) ("*HIV Surveillance 1981-2008*"). Until enactment of the ACA, the health care insurance market has largely failed these individuals. Most private insurers have refused to provide affordable coverage to those with HIV or have otherwise limited benefits. This market failure has caused serious consequences both for individuals with HIV—who suffer unnecessary illness and premature death—and for society generally in higher overall health care costs and lost productivity. Virtually all this suffering is avoidable: medical care is available that can turn HIV into a chronic, manageable condition. Congress was well within its Commerce Clause authority to address this nationwide market failure by regulating practices in the insurance industry that effectively exclude this segment of our society. U.S. Const. art. I, § 8, cl. 3; see, *e.g.*, *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533, 552-553 (1944) (Congress may regulate sale of insurance under Commerce Clause); *Heart of Atlanta Motel, Inc.* v. *United States*, 379 U.S. 241, 257-258 (1964) (Congress may, under Commerce Clause, prohibit practice of refusing to sell goods or services to certain individuals).

A. With Full Access To Health Insurance, The HIV/AIDS Epidemic Could Be Stemmed

Antiretroviral medications ("ARVs"), a medical breakthrough made in 1996, now allow people living with HIV to approach normal life expectancy. Kathleen McDavid Harrison et al., *Life Expectancy After HIV Diagnosis Based on National HIV Surveillance Data from 25 States, United States*, 53 J. Acquired Immune Deficiency Syndrome 124 (2010); Michael Smith, *HIV Life Expectancy Approaching Normal*, MedPage

Today, June 27, 2008. ARVs also greatly improve quality of life, and allow people with HIV to work and lead economically productive lives. Inst. of Med. of the Nat'l Acads., *Public Financing and the Delivery of HIV-AIDS Care: Securing the Legacy of Ryan White* 89 (2005) ("*Public Financing of HIV/AIDS Care*"); 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) ("*Economic Burden of HIV*").

ARVs act by reducing viral load, *i.e.*, the amount of HIV in blood plasma. For most patients taking ARVs, the viral load drops to clinically undetectable levels within six months of commencing therapy. Deborah Donnell et al., *Heterosexual HIV-1 Transmission after Initiation of Antiretroviral Therapy: A Prospective Cohort Analysis*, 375 Lancet 2092 (2010); see also Edward M. Gardner et al., *The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection*, 52 HIV/AIDS 793, 795 (2011) ("*Spectrum of Engagement in HIV Care*").

Very significantly from a national public health standpoint, suppressed viral load also minimizes infectiousness. *HIV Surveillance 1981-2008*, at 691. When viral load is sufficiently suppressed, the risk of transmission drops measurably. Myron S. Cohen et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 N.E. J. Med. 493, 503 (2011) ("*Prevention of HIV-1 Infection*") (noting 96% reduction in relative risk of transmission with suppressed viral load). Thus early detection of HIV and immediate access to care and treatment with ARVs, when medically appropri-

ate, not only promotes the health of individuals with HIV but also significantly contributes to stemming the spread of HIV. See Anthony S. Fauci, *AIDS: Let Science Inform Policy*, 333 Sci. 13, 13 (2011) ("The fact that treatment of HIV-infected adults is also prevention gives us the wherewithal, even in the absence of an effective vaccine, to begin to control and ultimately end the AIDS pandemic.").

But people living with HIV—and society at large—will only realize these benefits with consistent and continuous access to ARVs and ongoing medical monitoring and care. See Inst. of Med. of the Nat'l Acads., *HIV Screening and Access to Care: Exploring the Impact of Policies on Access to and Provision of HIV Care* 4 (2011) ("Despite the improvements in health for people with HIV who are in care and on treatment, many people with HIV in the United States enter medical care with advanced disease, have inconsistent adherence, or discontinue therapy prematurely.").

The availability of affordable insurance is therefore critical to effective HIV treatment and to stemming the epidemic. Having insurance—and access to care—increases the likelihood of early detection and consistent use of ARVs. See Sandra K. Schwarcz et al., *Do People Who Develop AIDS Within 12 Months of HIV Diagnosis Delay HIV Testing?*, 126 Pub. Health Rep. 552, 553, 555 (2011) ("*Delayed HIV Testing*"); Instit. of Med. of the Nat'l Acads., *Care Without Coverage: Too Little, Too Late* 64-67 (2002) ("*Care Without Coverage*"). Early treatment also improves health outcomes and reduces overall medical costs. People starting HIV medication late—because they were not tested or could not access ARVs—suffer more symptoms of HIV infection, including compromised immune systems, with re-

sulting direct health care costs 1.5 to 3.7 times higher than those entering medically indicated treatment promptly. 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) ("*Economic Burden of Late Entry Into Medical Care*"). Even if one receives early treatment, sustained care is essential. Missing doses of ARVs can lead to increased viral resistance for the particular patient and, more broadly, to spread of dangerous drug-resistant variants of the virus. *Spectrum of Engagement in HIV Care* 795; Robert J. Smith et al., *Evolutionary Dynamics of Complex Networks of HIV Drug-Resistant Strains: The Case of San Francisco*, 327 Sci. 697, 697-701 (2010).

B. Prior To The ACA, The Health Insurance Market Drastically Limited Access To Care For Those With HIV

While successful treatment of HIV and an end to the epidemic are within our nation's reach, without the ACA the insurance market will continue to fail to provide coverage for people living with HIV. Private insurers have largely excluded those with HIV from the market, and the patchwork of publicly funded coverage, despite its cost to the federal government, has not delivered timely or adequate care to many people. See *National HIV/AIDS Strategy* 41 (in 2010, federal government invested more than $19.46 billion in response to HIV epidemic).

1. Private insurers have systematically excluded those with HIV

Private insurers have systematically excluded individuals with HIV from the private insurance market. When the ACA was adopted, 67% of the overall United States population had private health insurance, see Health Res. & Servs. Admin., *Ryan White HIV/AIDS Program—2009 State Profiles*, State Population Data, Chart 3 (2010); the same was true for only 17% of people with HIV, see *Health Care Reform and HIV/AIDS* ¶ 2. Moreover, the situation has been worsening. Between 1996 and 2010, the rate of private insurance for people with HIV *was cut nearly in half*: from 31% to 17%. Compare *Public Financing of HIV/AIDS Care*, Fig. 3-1, at 74, with *Health Care Reform and HIV/AIDS* ¶ 2.

In the individual insurance market, people living with HIV are generally considered "uninsurable" and are routinely rejected when they apply for coverage. Kaiser Family Found., *Financing HIV/AIDS Care: A Quilt With Many Holes* 14 (2004) ("*Financing HIV/AIDS*"). Even when these individuals find an insurance company to cover them, most states have no rating limits, allowing insurers to charge prohibitively expensive premiums. *Public Financing of HIV/AIDS Care* 107-108.

Members of Congress were acutely aware of this problem when considering the ACA. One Senator commented that, when people "get sick with HIV, [or] with full-blown AIDS * * * [insurance companies] just simply cancel their policies and throw them out." 156 Cong. Rec. S1953 (daily ed. Mar. 25, 2010) (statement of Sen. Feinstein); see also 156 Cong. Rec. H1801 (daily ed. Mar. 20, 2010) (statement of Rep. T. Ryan). And a

Representative noted reports that at least one major insurer had routinely raised unfounded allegations of fraud against people diagnosed with HIV.

> Fortis designed a computer program that would automatically flag any policyholder with HIV-AIDS and trigger an automatic fraud investigation. Knowing the treatment was expensive, the executives were looking for anything they could use to revoke health insurance policies for people with HIV. Then, when nothing turned up, they would essentially invent a reason.

156 Cong. Rec. H1717 (daily ed. Mar. 19, 2010) (statement of Rep. McDermott); see also Murray Waas, *Insurer Targeted HIV Patients to Drop Coverage*, Reuters (Mar. 17, 2010).

2. Public programs provide an incomplete and inadequate patchwork of coverage

Through a patchwork of public programs, substantially funded by the United States, the government has tried to fill some—although far from all—of the gaps left by the private insurance market. But public programs have still left uninsured approximately 30% of people living with HIV. See *Health Care Reform and HIV/AIDS* ¶ 2. Moreover, restrictions on public programs, which vary by state, have meant that needed treatment is often delayed, limited, and even unavailable altogether.

a. Through the Medicaid program, 42 U.S.C. 1396 *et seq.*, the federal government supports state health insurance programs for the poor. Yet this state-federal partnership has created cruel and costly paradoxes for people living with HIV. Childless adults with HIV

have been excluded from benefits under states' implementation of Medicaid unless they become disabled by active symptoms or are pregnant. Kaiser Family Found., *Fact Sheet: Medicaid and HIV/AIDS* 2 (2009). In many states, to qualify for Medicaid, a disability determination requires an AIDS diagnosis. This has created a Catch-22 for the many low-income individuals living with HIV: only once their HIV progresses to AIDS do they become eligible for the ARVs that would have prevented AIDS from developing, at which point treatment is more difficult and expensive. *Ibid.*

Medicaid's pre-ACA income thresholds also force many of the working poor who live with HIV to choose between employment and treatment. Treatment with ARVs often makes a person living with HIV well enough to work. *Financing HIV/AIDS* 7; Dana P. Goldman & Yuhua Bao, *Effective HIV Treatment and the Employment of HIV+ Adults*, 36 Health Servs. Res. 1691, 1693 (2004). But increased employment income frequently leads to ineligibility for Medicaid coverage; in turn, the pre-existing condition of HIV likely means a private insurer will not write a health insurance policy. To receive care, many low-income workers have had to stay out of the job market. See *id.* at 1694.

b. The Medicare program, 42 U.S.C. 1395 *et seq.*, covers ordinary health care services for elderly and disabled people. But HIV and AIDS create extraordinary expenses, many of which are not covered by Medicare. Medicare imposes large cost-sharing requirements on beneficiaries and does not cap out-of-pocket spending for many benefit categories. As a result, many people living with HIV need other coverage in addition to Medicare. *Financing HIV/AIDS* 11. Obtaining private supplemental insurance to cover treat-

ment expenses not covered by Medicare is not a viable solution for most beneficiaries living with HIV. Such policies typically have deductibles, cover only a percentage of drug costs, have annual benefit caps, and are too costly for low- and middle-income Medicare beneficiaries. *Public Financing of HIV/AIDS Care* 117.

c. Through the Ryan White CARE Act, 42 U.S.C. 300ff *et seq.*, the federal government functions as the payer of last resort, making grants to states, cities, and nonprofit organizations to provide treatment and medication to HIV patients with no alternative coverage. Ryan White funding is far from adequate to fill the massive gaps in health care for people with HIV. Demand for Ryan White programs has outpaced federal appropriations, and the grants do not correspond to the number of people in need in each state or the actual costs of services. Judith A. Johnson, Cong. Research Serv., RL33279, *The Ryan White HIV/AIDS Program* 12-13 (2011) ("*Ryan White HIV/AIDS Program*"); Kaiser Family Foundation, *HIV/AIDS Policy Fact Sheet: The Ryan White Program* 2 (2007). Many states have responded with cost-cutting measures, including waiting lists for ARVs, limits on access to primary care, and limits on covered medications. *Ryan White HIV/AIDS Program* 12-13; *Public Financing of HIV/AIDS Care* 13, 118.

Despite the federal government's annual investment of over $19 billion responding to the HIV epidemic, an astounding 60% of individuals infected with HIV in the United States do not receive regular HIV care, *Spectrum of Engagement in HIV Care* 795, and transmission of the infection continues at alarming rates.

C. The Insurance Market's Failure To Provide Coverage To Individuals With HIV Has Dire Economic And Public Health Consequences

The insurance market's failure to provide coverage for those with HIV has grave consequences. While proper treatment could substantially stem the spread of HIV, in the current failed system, approximately 50,000 Americans contract HIV each year. *HIV Surveillance 1981-2008*, at 691; see also Joseph Prejean et al., *Estimated HIV Incidence in the United States, 2006–2009*, 6 PLoS ONE e17502 (2011). And while HIV can be well-managed and progression to AIDS arrested with treatment, each year approximately 35,000 Americans are diagnosed with AIDS, and 16,000 die. CDC, *HIV Surveillance Report, 2009*, Tbl. 1b, at 24 and Tbl. 12b, at 45 (2011) ("*2009 HIV Surveillance Report*"). Worst of all, these consequences fall disproportionately on already marginalized and underserved populations.

1. The failure of the insurance market takes a staggering public health and economic toll

As the Institute of Medicine of the National Academies has concluded, the combination of "limited access to private insurance and constrained eligibility for public programs" has directly led to "continued preventable death and disability and little decline in the rate of new infections each year." *Public Financing of HIV/AIDS Care* 135.

Inadequate insurance leads to dramatically worse health outcomes for those with HIV. People without health insurance are much less likely to receive regular HIV care and effective medications. *Care Without Coverage* 66-67. When the uninsured do manage to re-

ceive ARVs after an HIV diagnosis, it happens on average 4.5 months later than privately insured people diagnosed with HIV. *Ibid.* The uninsured are also substantially more likely to discontinue drug therapy after they begin. *Id.* at 67. Consistency is critical when people with HIV are treated with ARVs. Inconsistent access leads to drug resistance, which in turn can lead to a quicker progression to AIDS and increased risk of medical complications requiring emergency room visits, hospitalizations, and other significant costs for both the individual and the public. See *Public Financing of HIV/AIDS Care* 135. Without adequate treatment, a person is more likely to suffer a damaged immune system and become vulnerable to opportunistic infections. See AIDS.gov, *Stages of HIV* ¶ 5 (Oct. 12, 2010). When HIV is allowed to advance to AIDS, treatment is far more expensive; thus the lack of early access to treatment resulting from inadequate insurance leads to much greater overall health care costs. See *Economic Burden of Late Entry Into Medical Care* 1075-1078.

The ultimate consequence of having no insurance for those with HIV is often premature death. When a person with HIV has health insurance of any kind, the chance that the person will die within six months decreases by 71% to 85%. *Care Without Coverage* 67. This is in part because uninsured adults are more likely to receive a "late" HIV diagnosis—that is, they do not get tested until 12 months or fewer before getting AIDS. *Delayed HIV Testing* 555-556 and Tbl. 3. A late diagnosis puts a person at higher risk for short-term mortality, since the individual will have a reduced window of opportunity to take ARVs that prevent the onset of potentially life-threatening opportunistic infections. *HIV Surveillance 1981-2008*, at 692. The broader

social consequences are also dramatic. The economy is projected to suffer $29.7 billion in lost earnings due to the premature deaths of those who contracted HIV in 2002 alone. *Economic Burden of HIV* 453.

Lack of insurance also leads to increased rates of transmission and exacerbates an epidemic that could be substantially curtailed. Since the uninsured are less likely to obtain testing and know their HIV status, the chance that they will unwittingly transmit the infection increases. "[A]nnual transmission rates in the United States are some 3.5 times higher among people with undiagnosed HIV infection compared to those who are diagnosed." Ronald O. Valdiserri, *Late HIV Diagnosis: Bad Medicine and Worse Public Health*, 4 PLoS Med. 975, 975 (2007). People who are uninsured and thus under-treated are more likely to transmit HIV: "[R]eceiving sustained comprehensive treatment can help to prevent transmission of HIV to others because drug therapies reduce viral loads thus potentially rendering the individual less infectious." *Public Financing of HIV/AIDS Care* 135. ARV therapy thus reduces the relative risk of spreading HIV to others by as much as 96%. *Prevention of HIV-1 Infection* 503. By one estimate, society saves $910,800 (discounted to 2002 dollars) each time a transmission of HIV is prevented. *Economic Burden of HIV*, Tbl. 3, at 455.

2. The combined effect of the HIV epidemic and lack of insurance falls hardest on already marginalized groups

Marginalized and underserved populations are particularly hard-hit by the HIV epidemic, exacerbating the harms from the insurance industry's exclusion of persons with HIV. The groups with the highest inci-

dence of HIV have the lowest incidence of private insurance: Black and Latino people with HIV are much more likely to be uninsured. *Public Financing of HIV/AIDS Care* 272. As a result, they bear a disproportionate share of the harmful public health and economic consequences of being an uninsured person with HIV.

Black men and women comprise 12% of the U.S. population, but 44% of people with new HIV infections. See Kaiser Family Found., *Fact Sheet: The HIV/AIDS Epidemic in the United States* 2 (2011). "Survival after an AIDS diagnosis is lower for Blacks than for most other racial/ethnic groups, and Blacks have had the highest age-adjusted death rate due to HIV disease throughout most of the epidemic." *Ibid.* The HIV/AIDS epidemic has placed younger gay and bisexual men (ages 13-29) at particularly acute risk: in 2009, they accounted for 27% of all new HIV infections and 44% of infections among all gay and bisexual men. *Ibid.* Likewise, transgender communities in the United States suffer a high prevalence of HIV. See CDC, *HIV Infection among Transgender People* 1-2 (2011).

Without engaging in greater risk behaviors than others, people in underserved demographic groups still are more likely to contract HIV due to the sheer number of HIV-positive people in their social networks. *National HIV/AIDS Strategy* 12. And the disparity in rates of infection has only grown worse since the onset of the epidemic: "[T]hose newly infected with HIV are more likely than in the past to be poor, members of a racial/ethnic minority group, and uninsured or publicly insured." *Public Financing of HIV/AIDS Care* 38.

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In sum, the ACA tackles a complex series of economic and public health problems arising from the exclusion of persons with HIV from the private insurance market. After 30 years spent propping up private and state markets with federal funds, Congress determined it was time for a comprehensive and more effective federal solution. As explained below, the MCR was an essential ingredient of that solution.

II. The MCR Is An Essential Feature Of Congress's Solution To The Health Insurance Crisis For Those With HIV

The ACA directly responds to the failures of the health insurance market. It prevents insurers from denying coverage to consumers with pre-existing conditions and from charging discriminatory rates based on these conditions. 42 U.S.C.A. 300gg, 300gg-1(a), 300gg-3(a), 300gg-4(a).[3] These "guaranteed issue" and "community rating" provisions are unquestionably valid exercises of Congress's Commerce Clause power. See *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533, 552-553 (1944). As the lessons of the HIV/AIDS health care crisis demonstrate, the MCR is critical to making these provisions effective, and therefore is within Congress's power under the Necessary and Proper Clause. U.S. Const. art. I, § 8, cl. 18; see, *e.g.*, *Gonzales* v. *Raich*, 545 U.S. 1, 36 (2005) (Scalia, J., concurring) (observing that Congress may enact a sta-

[3] The ACA also broadens the availability of Medicaid by setting uniform eligibility standards, including that, as of 2014, Medicaid will be available to persons with incomes up to 133% of the federal poverty level, regardless of whether they are disabled. 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII).

tute that is "an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut" without the statute) (internal quotation omitted).

The success of Massachusetts' health insurance reforms, which include an MCR, in significantly improving health care for those with HIV, and the failure of those states that attempted reforms without an MCR, provide "empirical demonstration" of the necessity of the MCR to the regulatory regime. *United States* v. *Comstock*, 130 S. Ct. 1949, 1966-1967 (2010) (Kennedy, J., concurring).

A. Massachusetts' Experience Demonstrates That Health Insurance Reform Paired With An MCR Makes Access To HIV Treatment Affordable And Achievable

In 2006, Massachusetts enacted health care reform legislation similar to the ACA, featuring an MCR and nearly universal insurance coverage for persons with HIV. See Harvard Law School Center for Health Law and Policy Innovation, *Massachusetts HIV/AIDS Resource Allocation Project* 3-5 (Dec. 13, 2011) (Working Paper) ("*Massachusetts HIV/AIDS*").[4] Massachusetts' reforms have made critical HIV treatments widely affordable and accessible. See *id.* at 1-2. The resulting benefits to those living with HIV in Massachusetts have been remarkable. They foretell what the nation

[4] In addition, in 2001, Massachusetts obtained a waiver from the federal government allowing it to provide Medicaid coverage to all persons living with HIV who are within 200% of the federal poverty level. See *Massachusetts HIV/AIDS* 1.

can expect once the ACA is fully implemented and people with HIV receive nearly universal coverage.

First, because treatment reduces the chances of transmission significantly, nearly universal insurance coverage has reduced the HIV transmission rate. Between 2005 and 2008, Massachusetts had a 37% *decrease* in HIV infections, while the nation had an 8% *increase*. *Massachusetts HIV/AIDS* 1, 7. Second, with nearly universal coverage, Massachusetts is "vastly outpacing the rest of the country in the declining rates of hospitalization and the percentage of patients with suppressed viral loads," with 64.6% achieving total viral load suppression in Massachusetts compared to 48.6% nationwide. *Id.* at 1, 10. As a result of the suppressed viral loads, Massachusetts had 6.5 AIDS diagnoses per 100,000 persons in 2009, compared with 11.2 per 100,000 nationally. *Id.* at 7. Third, the death rate for individuals living with HIV "is far lower and falling faster in Massachusetts than the rest of the nation." *Id.* at 1. Massachusetts' age-adjusted HIV/AIDS death rate is almost half the national average (2% versus 3.7%), and has fallen by 42% since 2002, compared with a 24% drop nationwide. *Id.* at 7-8.

Nearly universal health coverage—and the resulting improvements in clinical outcomes—have allowed Massachusetts to focus its federally-subsidized HIV programs on preventive care "rather than paying for urgent, late-stage medical care." *Massachusetts HIV/AIDS* 14. Unlike programs in the many states with long waiting lists and formulary limits on drugs important to treatment of HIV and AIDS, Massachusetts' drug assistance program "has no waiting list, an unrestricted formulary, and covers citizens up to 481% of the federal poverty limit." *Id.* at 15. Despite having

one of the most comprehensive drug assistance programs in the nation, Massachusetts has seen a "$7 million *decrease* in state spending on HIV/AIDS medications since 2004." *Id.* at 15 (emphasis added).

By contrast, people living with HIV fare far worse in states that have not adopted health insurance reform. Respondent Florida, for example, did not undertake reforms like Massachusetts, with correspondingly far worse health outcomes for people living with HIV. According to Census data, in Florida, 20.8% of residents are uninsured, compared with Massachusetts' rate of 5.6%, the lowest in the nation. U.S. Census Bureau, *Current Population Survey, 2011 Annual Social and Economic Supplement*, Tbl. HI06 (2011).[5] Florida's HIV infection rate, 33 of every 100,000 people, is the highest for any state in the nation, see *2009 HIV Surveillance Report*, Tbl. 19, at 64, and five times that of Massachusetts, see *Massachusetts HIV/AIDS* 7. The rate of AIDS diagnoses in Florida (23.7 per 100,000 people) is roughly four times that of Massachusetts (6.5). *2009 HIV Surveillance Report*, Tbl. 20, at 65. The age-adjusted death rate from HIV in Florida is 8.3 for every 100,000 people—four times higher than that of Massachusetts (2.0). CDC, *Deaths: Final Data for 2007*, 58 Nat'l Vital Stat. Rep. 1, Tbl. 29, at 101 (2010).

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[5] These Census estimates on uninsured rates are used to allow direct comparison between Massachusetts and Florida; other sources put the Massachusetts uninsured rate even lower, at 1.9%. See *Massachusetts HIV/AIDS* 12; Mass. Div. of Health Care Fin. & Policy, *Health Care in Massachusetts: Key Indicators* 12 (May 2011).

B. States That Enacted Partial Reforms Without An MCR Fail To Provide Affordable And Accessible Care To People Living With HIV

Seven states (Kentucky, Maine, New Jersey, New Hampshire, New York, Washington, and Vermont) have tried to expand access to affordable insurance through much-needed guaranteed issue and community rating reforms, but have done so without an MCR. In each case, the effort "simply [did] not work." *Florida* v. *HHS*, 648 F.3d 1235, 1349 (11th Cir. 2011) (Marcus, J., dissenting). Indeed, enacting these essential reforms without an MCR produced the opposite of their intended effect. Premiums skyrocketed, many insurers stopped issuing new policies or left the state altogether, and the number of uninsured individuals rose. *Ibid.* Kentucky later repealed its reforms, 1998 Ky. Acts 1881, and Maine just recently undid much of its reforms, 2011 Me. Laws 114. In contrast, in Massachusetts the size of the private insurance market remains nearly identical to national medians, insurers operating in the State are financially healthy, and the number of uninsured has declined dramatically. See *Massachusetts HIV/AIDS* 22.

The differences in insurance market policy between Massachusetts and these seven states translate into critical health consequences for people living with or at higher risk for HIV and AIDS. In Massachusetts, 10.8 new AIDS cases per 100,000 people were diagnosed in 2005, the year before it enacted its reforms with an MCR. By 2009, that number had dropped to 6.5—a 39.8% decrease. Compare *2009 HIV Surveillance Report* Tbl. 20, at 65, with CDC, *HIV Surveillance Report, 2005*, Tbl. 14, at 28 (2007) ("*2005 HIV Surveillance Report*"). None of the states that implemented health

reform without an MCR fared as well; indeed, in two nearby New England states, Maine and New Hampshire, new AIDS cases *increased*. Compare *2009 HIV Surveillance Report*, Tbl. 20, at 65, with *2005 HIV Surveillance Report*, Tbl. 14, at 28.

Furthermore, the states that attempted reform without an MCR also fared worse than Massachusetts in rates of diagnosed new infections. In Massachusetts, the number of new HIV infections decreased by 37.4% between 2005 and 2009. Mass. Dep't of Pub. Health, *The Massachusetts HIV/AIDS Epidemic at a Glance: Detailed Data Tables and Technical Notes*, Tbl. 1, at 2 (2010). By contrast, Washington saw a decrease of just 3.4%, and New York of 10.8%. Wash. State Dep't of Health, *Washington State HIV Surveillance Quarterly Report*, Tbl. 1, at 5 (2011); N.Y. State Dep't of Health, *New York State HIV/AIDS Surveillance Annual Report*, Tbl. 1, at 20 (2010).

As the Massachusetts experience shows, opening the health insurance market to persons living with HIV significantly reduces spread of the epidemic and costs of care, and allows these individuals to lead healthy, economically productive lives. Congress anticipated that the same positive results would follow nationwide from the ACA.[6]

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[6] See, *e.g.*, 155 Cong. Rec. H12,910 (daily ed. Nov. 7, 2009) (statement Rep. Kanjorski) ("While I believe that caring for our fellow citizens is a moral imperative, it also makes economic sense to have as many people covered by insurance as possible. * * * [I]t is in the best interest of all of our health to make sure that sick people are treated quickly and affordably so that infectious diseases are not spread."); 155 Cong. Rec. H11,855-56 (daily ed. Oct. 27, 2009) (statement Rep. Jackson-Lee) (same).

C. Piecemeal State Solutions Are Inadequate To Address The Health Care Coverage Crisis For Those Affected By The HIV/AIDS Epidemic

Nor can it be argued that each state should decide individually whether to implement an MCR and remove HIV-related barriers to insurance. States have already tried to regulate the financing of health care for people living with HIV, and the result has been systemic market failure, with needless HIV transmission and human suffering.

Piecemeal local attempts to extend insurance coverage for those living with HIV will not curb the national epidemic.[7] If the MCR is not implemented nationally, states such as Florida will continue to have large, and likely growing, populations of uninsured individuals with HIV. These individuals—often unaware of and untreated for their infection—are more likely to transmit the virus to others. As the Institute of Medicine of the National Academies has explained, "the current federal-state partnership for financing HIV care is unresponsive to the fact that HIV/AIDS is a national

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[7] Recognizing the national interstate crisis posed by the HIV/AIDS epidemic, for the last several decades, the federal government has taken the lead in setting and coordinating national HIV/AIDS policy. See, *e.g.*, Ryan White CARE Act of 1990, 42 U.S.C. 300ff *et seq.*, as amended (supplementing and helping to standardize HIV testing and treatment nationwide); CDC, *HIV Prevention Strategic Plan: Extended Through 2010* 10 (2007) (explaining that government must "strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs").

epidemic with consequences that spill across state borders." *Public Financing of HIV/AIDS Care* 6. For these reasons, the White House's National HIV/AIDS Strategy has established a uniform set of standards and priorities for combating the epidemic, explaining that "overlapping and competing programs also hinder efforts at the State and local levels." *National HIV/AIDS Strategy* 42. The ACA, including the MCR, is a critical element of the national response to this epidemic.

III. The HIV/AIDS Epidemic Illustrates Why Congress's Enactment Of The MCR Was Within Its Constitutional Authority

The ACA represents a permissible exercise of Congress's authority under the Commerce Clause to enact comprehensive reform of the interstate health insurance market, which has excluded persons living with HIV and other serious health conditions, causing national public health and economic problems of severe magnitude. As the dynamics of the insurance market for those with HIV demonstrate, the MCR is the linchpin that allows these reforms to function as intended. Thus, regardless of whether it is within Congress's Commerce Clause authority to adopt the MCR as a stand-alone provision, it is well within Congress's authority under the Necessary and Proper Clause as an essential element of the larger regulation of interstate commerce.

Furthermore, independent of the Necessary and Proper Clause, the MCR, even viewed in isolation, also passes muster under the Commerce Clause. The MCR addresses a consumer's economic decision whether to pay for health care insurance or depend on the social

insurance of a health care system paid for by others. Again, HIV provides an example of the point. Once the virus is contracted and symptoms emerge, an individual cannot realistically avoid accessing the health care system, and will almost certainly rely on available forms of health care coverage in doing so. Congress acted within its Commerce Clause authority to regulate this economic behavior.

A. The MCR Is Necessary And Proper To Congress's Exercise Of Its Power Under The Commerce Clause

Respondents do not dispute that Congress had the authority under the Commerce Clause to enact those provisions of the ACA directly regulating and prohibiting the policies and practices of insurance companies that deny health insurance to individuals with HIV. These practices—which have led to the nationwide failure of the health insurance market to provide coverage to individuals living with HIV—are quintessential economic activity that Congress may regulate under the Commerce Clause. See *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533, 552-553 (1944) (Congress may regulate sale of insurance under Commerce Clause); *Heart of Atlanta Motel, Inc.* v. *United States*, 379 U.S. 241, 257-258 (1964) (Congress may, under Commerce Clause, prohibit practice of refusing to sell goods or services to certain individuals).

The experience of the HIV epidemic further demonstrates that the MCR is an indispensable prerequisite to making those ameliorating reforms effective, and therefore is within Congress's power under the Necessary and Proper Clause. Under that Clause, Congress may enact statutes that are "an essential part of a larg-

er regulation of economic activity, in which the regulatory scheme could be undercut" without the statute. *Gonzales* v. *Raich*, 545 U.S. 1, 36 (2005) (Scalia, J., concurring in the judgment) (internal quotation omitted).

The remarkable success of Massachusetts' health insurance reforms, which include an MCR, in improving health outcomes for those with HIV, and the contrasting failures of those states that attempted health insurance reform without an MCR (see Section II.B., *supra*), provide "empirical demonstration" that the MCR is necessary to the success of the overall regulatory regime. *United States* v. *Comstock*, 130 S. Ct. 1949, 1966-1967 (2010) (Kennedy, J., concurring). In short, "effectuat[ing] guaranteed issue and community rating reforms without some form of individual mandate . . . simply does not work." *Florida* v. *HHS*, 648 F.3d 1235, 1349-1350 (11th Cir. 2011) (Marcus, J., dissenting).

Without the MCR, the ACA would be far less effective in curtailing the HIV epidemic and its economic costs. In fact, it likely would do the opposite. Insurance premiums would be prohibitive for many people with HIV, providers would be scarce or nonexistent, and ultimately few people with HIV would have private coverage. Thus, the absence of the MCR would leave a "gaping hole" in the ACA, see *Raich*, 545 U.S. at 22, transforming Congress's efforts to ensure health care for all into an exercise in futility.

Even if the Eleventh Circuit were correct that the small number of people who have "not made a voluntary choice to enter the stream of commerce" do not engage in economic activity that is independently within the scope of Congress's Commerce Clause authority, *Florida* v. *HHS*, 648 F.3d at 1291-1292, Congress could nonetheless adopt the MCR as a necessary and proper

measure to regulate the private insurance market's systematic exclusion of millions of Americans, including those with HIV. "The relevant question" under the Necessary and Proper Clause "is simply whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power." *Raich*, 545 U.S. at 36-37 (Scalia, J., concurring in the judgment). The MCR was not just "reasonably adapted" to the "legitimate end" of reforming the private insurance market to allow participation for those with medical conditions like HIV; it was absolutely imperative to achieving these goals.

B. The HIV/AIDS Epidemic Demonstrates That Congress Was Also Within Its Commerce Clause Authority In Enacting The MCR

The Eleventh Circuit ruled the MCR unconstitutional under the Commerce Clause because it would "compel[] non-market participants to *enter into* commerce," which, according to the majority, is unconstitutional. *Florida* v. *HHS*, 648 F.3d at 1311. The court's analysis ignores the reality that failure to pay for health insurance in reliance on a health care system and insurance market that will be available to the individual at the moment of need *is* economic activity. The dynamics of health care and coverage for those who live with HIV proves the point.

Although a person may hope not to contract HIV, it is inconceivable that a person who does contract the virus would forego accessing health care services. When diagnosed with HIV, a person will need costly medical treatments for the rest of that person's life. If untreated, a person infected with HIV will inevitably re-

quire medical services for opportunistic infections and AIDS symptoms, at even greater expense than if the infection had been promptly treated.

A person who does not pay for health care insurance knows that at least the safety net of health care facilities, supported by the insurance market and government subsidies, will still be available to that person. See, *e.g.*, Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd (requiring hospitals to provide emergency services, regardless of ability to pay); Ryan White CARE Act, 42 U.S.C. 300ff *et seq.* (providing funding to cities and states for certain services for people living with HIV or AIDS who lack alternative coverage).

Thus, even individuals who do not pay for insurance obtain some of its benefits—the assurance that the health care system will be there, at least to some extent, when most needed. When a person makes a "voluntary choice" not to purchase *private* health insurance, the person has invariably chosen to rely on *social* insurance against future catastrophic illnesses like HIV or AIDS. "Individuals must finance the cost of health care by purchasing an insurance policy or by self-insuring cognizant of the backstop of free services required by law." *Thomas More Law Ctr.* v. *Obama*, 651 F.3d 529, 544 (6th Cir. 2011) (Sutton, J., concurring in part).

Indeed, the characterization of those who do not pay for insurance as engaging in "self-insurance" is particularly a misnomer in the context of HIV. The costs of treating HIV are simply too prohibitive to pay on one's own. They cannot be anticipated or budgeted for in advance, and exceed most people's savings by several orders of magnitude. "Even among those individuals

who have resources, the costs of HIV care can quickly exhaust their assets and may leave them impoverished." *Public Financing of HIV/AIDS Care* 270. The anticipated undiscounted lifetime cost of HIV medications per person is $618,900, or around $2,100 per month. Bruce R. Schackman et al., *The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States*, 44 Med. Care 990, 994 (2006). In addition, people living with HIV or AIDS usually require several thousand dollars per year in doctor's visits, laboratory tests, and drugs to prevent or treat HIV-related opportunistic infections. *Public Financing of HIV/AIDS Care* 270. Health care for medical conditions this serious "can be so expensive that most everyone must have some access to funds beyond their own resources in order to afford them." See *Florida* v. *HHS*, 648 F.3d at 1357 (Marcus, J., dissenting in part).

Moreover, other provisions of the ACA preventing an insurer from denying coverage because of a pre-existing condition make rational the economic decision to postpone paying for insurance until an individual needs to make heavy use of the health care system, such as after an HIV diagnosis. This economic activity also takes advantage of the financial contributions of others to the health care and health insurance markets, and, as the experience of a number of states has already shown, without an MCR renders measures to reform the market unsustainable.

Consequently, the court of appeals was wrong to suggest that the MCR unconstitutionally "compel[s] non-market participants to *enter* into commerce." *Florida* v. *HHS*, 648 F.3d at 1311. Every time an individual chooses whether to pay for health care insurance now or to depend later on the guaranteed availability of a

system paid for by others, that person makes an economic decision, which, in the aggregate, has a monumental impact on interstate commerce.

Of course, the great majority of people with HIV have had no choice but to rely on social insurance or forego critical care, due to economic barriers and exclusionary practices of the private health insurance market. These are not the individuals whom the Eleventh Circuit identifies as being unconstitutionally "compelled" to "enter into commerce." See *Florida* v. *HHS*, 648 F.3d at 1311 (emphasis omitted). Instead, they have been involuntarily excluded from a segment of commerce, with dire consequences for their health and economic productivity, and for the national HIV/AIDS crisis. The ACA, including the linchpin MCR, puts within reach an end to the HIV/AIDS epidemic, and it was well within Congress's power to enact.

CONCLUSION

The Court should reverse the judgment of the Eleventh Circuit Court of Appeals on the minimum coverage provision issue.

Respectfully submitted.

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APPENDIX

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 its work has ensured access to treatment, promoted effective prevention policies, and helped combat discrimination, bias, and stigma. Lambda Legal has appeared in this Court as counsel to parties or amici in cases addressing discrimination against people who are LGBT or living with HIV, including *Romer* v. *Evans*, 517 U.S. 620 (1996), *Lawrence* v. *Texas*, 539 U.S. 558 (2003), and *Cooper* v. *Federal Aviation Administration*, No. 10-1024 (U.S. Sup. Ct., argued Nov. 30, 2011).

The mission of **AIDS United** is to end the AIDS epidemic in the United States through national, regional and local policy/advocacy, strategic grant-making, and organizational capacity building. With partners throughout the country, AIDS United works to ensure that people living with and affected by HIV/AIDS have access to the prevention and care services they need and deserve. AIDS United programs and initiatives include the development and implementation of sound public health policy in response to the HIV/AIDS epidemic. The organization works to advance federal policies that improve the quality of life and ensure access to treatment and care for all those living with HIV/AIDS.

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."

The **Center for HIV Law and Policy ("CHLP")** is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP's interest in this case is consistent with its mission to reduce the impact of HIV on vulnerable and marginalized communities and to secure the rights of people affected by HIV. Equitable access to essential health care is the foundation of the ability of communities affected by

HIV to participate productively in society, and is central to meeting the national public health goal of reducing new HIV infections and HIV-related deaths in the United States.

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.

The **Gay & Lesbian Medical Association ("GLMA")** is the world's largest and oldest association of LGBT health care professionals. GLMA's mission is to work to ensure equality in health care for LGBT individuals and health care 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.

The **HIV Medicine Association ("HIVMA")** is a national organization representing more than 4,800 HIV medical providers, researchers, and scientists working in all 50 states and more than 50 countries. HIVMA is nested within the Infectious Diseases Society of America and was created in 2001 to promote access to quality HIV care and to advocate for federal

policies that ensure a comprehensive and humane response to the AIDS pandemic informed by science and social justice. As an organization representing frontline medical providers caring for many uninsured and underinsured patients with HIV/AIDS, HIVMA has a strong interest in supporting sound health care financing policies that improve access to lifesaving care and treatment for people living with HIV/AIDS.

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, and human rights through education, training, public policy work, public health, and community mobilization. We are 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 in Chicago, has staff in New York City, and steering committee members in those cities as well as Philadelphia, Atlanta, Seattle, Portland (OR), San Francisco, Los Angeles, Boston, Jackson (MS), Washington (DC), and Detroit.

The **Latino Commission on AIDS ("Commission")** is a nonprofit membership organization founded in 1990 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.

As it has been for more than 25 years, the **National Association of People with AIDS ("NAPWA")** is the oldest, most trusted voice for saving and improving the lives of people impacted by HIV/AIDS. NAPWA founded National HIV Testing Day, the nation's first official HIV awareness day, to encourage all Americans to take responsibility and know their status. Founded in 1983, NAPWA advocates for the lives and dignity of all people living with HIV/AIDS, especially the 1.2 million Americans who live with it today. NAPWA believes that full implementation of the ACA is critical to the lives of countless individuals living with HIV/AIDS and other chronic, disabling conditions. NAPWA wants the epidemic to end, and for life to be better for people with HIV until it does.

Founded in 1977, the **National Center for Lesbian Rights ("NCLR")** is a national legal organization committed to advancing the civil and human rights of LGBT people and their families through litigation, public policy advocacy, and public education. NCLR advocates for laws and policies that promote the health and well-being of those living with HIV.

The **National Center for Transgender Equality ("NCTE")** is a national social justice organization devoted to advancing equality for transgender people through education and advocacy. Founded in 2003, NCTE advocates for policy reform at the federal level on a wide range of issues affecting transgender people (including HIV/AIDS, ACA implementation, and other

health policies), provides technical assistance to organizations and institutions at the state and local levels, and works to create greater public understanding of issues affecting transgender people. NCTE receives inquiries from thousands of transgender people and their loved ones each year, including numerous people living with HIV or AIDS. Because transgender people are disproportionately affected by HIV and more likely to be uninsured, NCTE has a strong interest in ensuring that nondiscriminatory, affordable health care is accessible to all individuals.

Formed in 1987, the **National Native American AIDS Prevention Center ("NNAAPC")** is a national Native organization committed to addressing the impact of HIV/AIDS on American Indians, Alaska Natives, and Native Hawaiians through culturally appropriate advocacy, research, education, and policy development. Acknowledging that 28.4% of American Indians are currently living in poverty in the U.S., that many Native people harbor a historical distrust of Western medicine, that American Indian and Alaska Native people have the third and fourth highest rates of new HIV infections annually in the U.S., and that recent research demonstrates that people living with HIV who are linked to regular care stand a significantly decreased chance of transmitting HIV, NNAAPC supports efforts that will bring affordable and accessible healthcare to all Native peoples.

Based in Washington, DC and Boston, the **Treatment Access Expansion Project ("TAEP")** is a national organization that has worked since 1996 to improve access to affordable, comprehensive, high quality healthcare for poor and low-income people living with

chronic medical conditions, including HIV/AIDS. TAEP plays a leadership role within the HIV/AIDS community in addressing emerging healthcare opportunities and challenges by coordinating and informing efforts of national, state, and local partners to expand access to care. TAEP specifically focuses on four goals: supporting HIV testing and linkage to care initiatives, reducing the number of people diagnosed late in their disease progression, promoting early access to care and treatment, and eliminating HIV-related stigma and discrimination. TAEP has been integrally involved in shaping and carrying out the national HIV/AIDS community's advocacy efforts related to healthcare reform and the ACA.

Founded in 1991, **Women Organized to Respond to Life-threatening Diseases ("WORLD")** is a women centered HIV organization serving HIV-positive women in the Bay Area and around the nation. As one of the first women-centered AIDS service organizations in the country, WORLD's mission is to improve the lives and health of women, girls, families, and communities affected by HIV through peer-based education, wellness services, advocacy, and leadership development. In 2008, the **U.S. Positive Women's Network** ("**PWN**") was founded as a project of WORLD to address gaps for HIV-positive women in national and local laws and HIV policies. PWN is a national network with regional chapters in Oakland, San Diego, Philadelphia, the state of Colorado, the Midwest, and the Deep South, where it advocates for the rights and health of women living with HIV.