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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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

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[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 consequence 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-

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[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*

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[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

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[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/statis tics _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

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[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-

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[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-*

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[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

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[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-

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[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 expensive 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 education. 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.

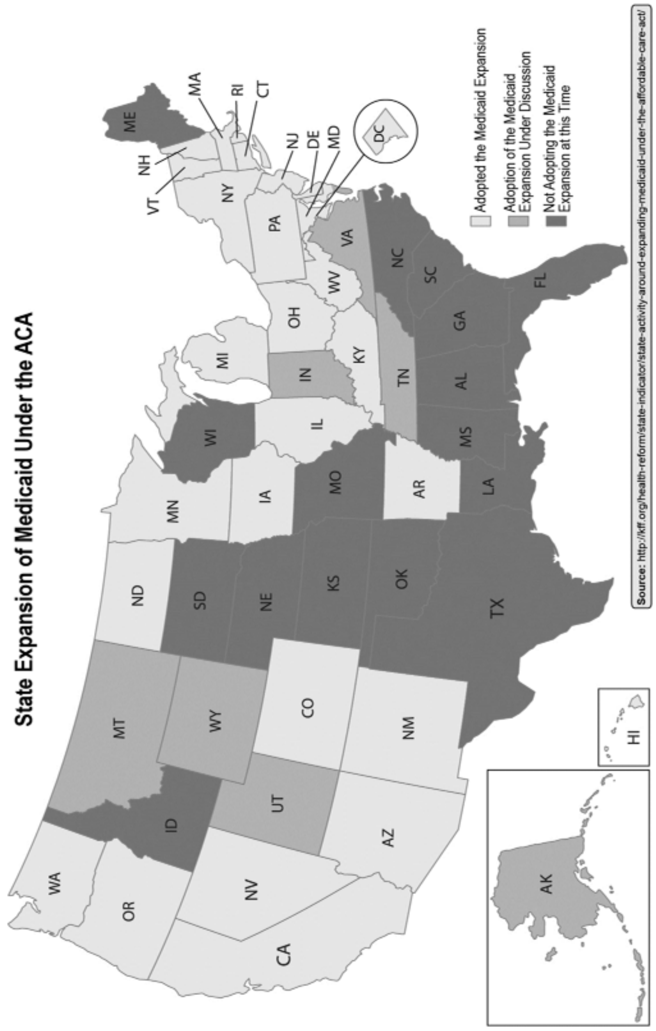
The National Black Justice Coalition (NBJC) is a civil rights organization dedicated to empowering Black lesbian, gay, bisexual and transgender (LGBT) people. NBJC's mission is to end racism and homophobia. Part of NBJC's efforts is public education work to highlight that African Americans are disproportionately 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]



State Expansion of Medicaid Under the ACA

Source: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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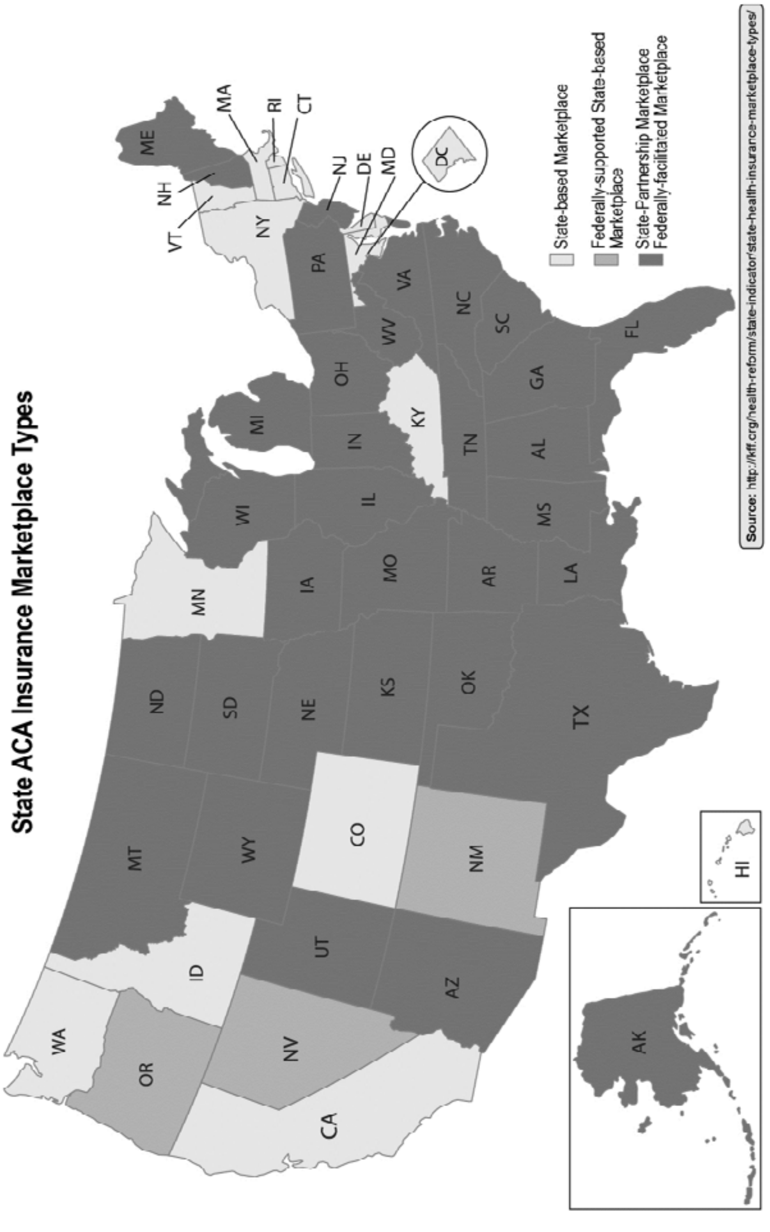
[1] This map does not reflect the Medicaid expansion announced by Indiana on January 27, 2015.

APPENDIX III

MAP OF STATE ACA INSURANCE MARKETPLACE TYPES



State ACA Insurance Marketplace Types

□ State-based Marketplace

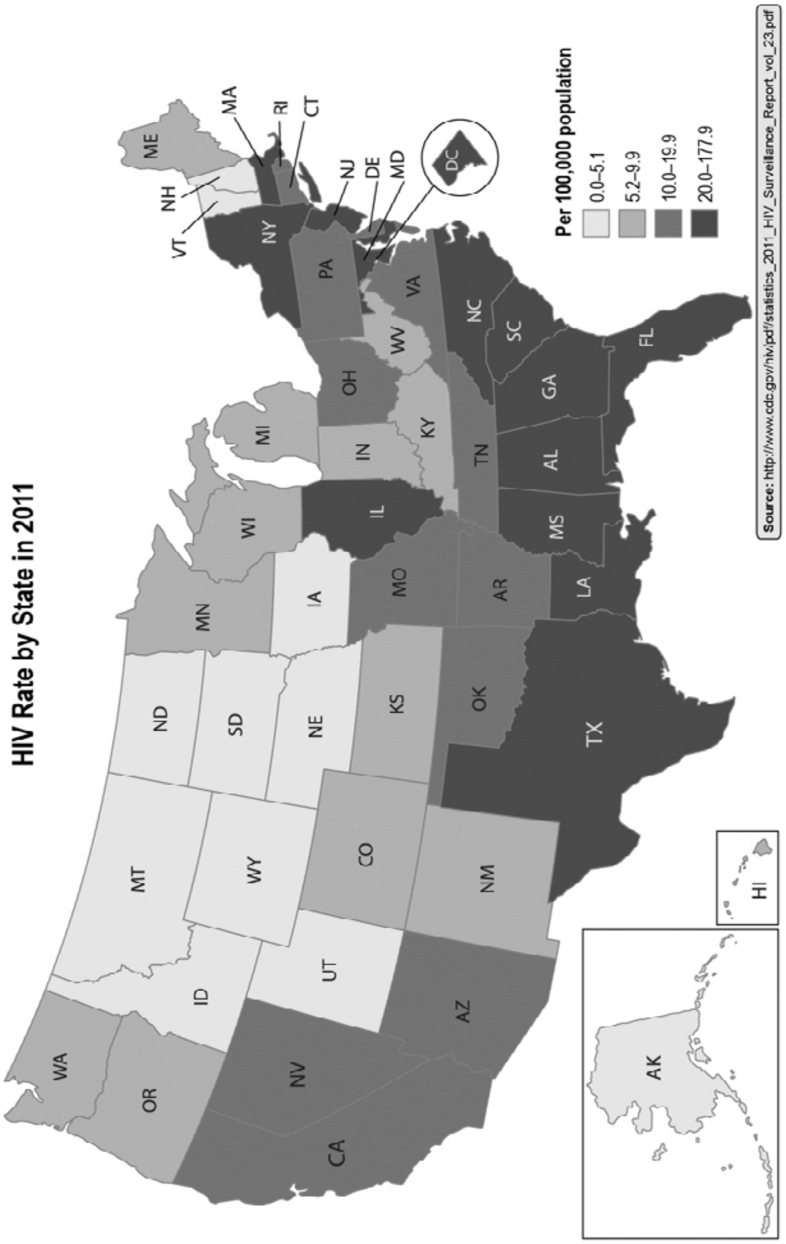
▨ Federally-supported State-based Marketplace

■ State-Partnership Marketplace Federally-facilitated Marketplace

Source: http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/

APPENDIX IV

MAP OF HIV RATES BY STATE IN 2011



Source: http://www.cdc.gov/hiv/pdf/statistics_2011_HIV_Surveillance_Report_vol_23.pdf