Nos. 19-840, 19-1019

In the Supreme Court of the United States

THE STATE OF CALIFORNIA, ET AL., PETITIONERS
v.
THE STATE OF TEXAS, ET AL.

THE STATE OF TEXAS, ET AL., CROSS-PETITIONERS
v.
THE STATE OF CALIFORNIA, ET AL.

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

BRIEF FOR LAMBDA LEGAL DEFENSE & EDUCATION FUND, INC., ET AL. AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICI CURIAE[1]

Amici are nonprofit organizations that undertake litigation, public policy, and advocacy efforts on behalf of people living with HIV, who rely on the myriad provisions of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended), to obtain and maintain access to affordable health insurance. Following the ACA's enactment, the percentage of non-elderly people living with HIV who were uninsured fell from 18% in 2012 to 11% in 2015. See Lindsey Dawson & Jennifer Kates, *An Update on Insurance Coverage Among People with HIV in the United States* (May 20, 2019) (*Insurance Coverage*), https://www.kff.org/report-section/an-update-on-insurance-coverage-among-people-with-hiv-in-the-united-states-findings/. The ACA's changes to the private and public health insurance markets—most notably its expansion of Medicaid—is directly responsible for this improvement. Amici therefore share a strong interest in ensuring the continued vitality of the entirety of the ACA, especially those provisions that make health insurance accessible and affordable.

Amici will focus on the deleterious impact that invalidation of any of these ACA provisions will have on people living with HIV by reversing recent progress in terms of increased health insurance coverage and im-

[1] A full list of amici organizations is included in the Appendix, *infra*. All parties have consented to the filing of this brief. No counsel for any party authored this brief in whole or in part, and no person or entity, other than amici curiae or their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

proved health outcomes. These provisions work in tandem with other legislation aimed at combatting HIV/AIDS. Congress's continued support of both conclusively demonstrates that it did not intend its reduction of the individual mandate's shared responsibility payment to effect a repeal of the ACA in its entirety.

SUMMARY OF THE ARGUMENT

In accordance with Congress's intent, the Court should uphold the constitutionality of the ACA's (currently inoperative) individual mandate. Alternatively, if the Court decides the mandate is now unconstitutional, it should sever that provision and uphold the remainder of the ACA, which operates independently of the mandate. In the decade since it passed the ACA, Congress has consistently preserved the law's core tenets and rejected efforts at wholesale or widespread repeal. In particular, in 2017, after multiple unsuccessful attempts to repeal the ACA, Congress settled on amending just one provision, lowering the amount of the shared responsibility payment tethered to the individual mandate to $0. Having expressed a clear intention at that time that the remainder of the law remain operative, Congress has continued to legislate with an understanding that the ACA remains alive and well. Specifically, Congress continues to support the ACA's overarching goal of ensuring that all Americans, including people living with HIV, are able to access quality, affordable health insurance.

The ACA's key reforms, none of which hinges on the operation of the individual mandate, have had the intended result of increasing the percentage of Americans who have health insurance. This is especially sig-

nificant for people living with HIV, who, prior to the ACA, often either were denied access to coverage due to the pre-existing condition of HIV or could not afford the astronomical premiums charged because of that pre-existing condition. The Medicaid expansion has been particularly important, as people living with HIV in the United States are disproportionately low-income. Disparities in insurance coverage rates and in the rate of new HIV diagnoses also have improved under the ACA. Congress did not intend to undo this progress when it reduced the amount of the shared responsibility payment to zero.

Concurrent with the expansion of access to health insurance, advances in HIV treatment and prevention have vastly improved the quality of life for people living with HIV and significantly reduced the risk of HIV transmission. These advances depend, however, on continued access to affordable health care, as life-saving medications continue to be prohibitively expensive without insurance, and regular monitoring of care is necessary for their use as either treatment or prevention. Here too, Congress did not intend to undo the progress made under the ACA, which has complemented the federal and state governments' efforts to fight the HIV epidemic.

The Court should reject efforts to use the judicial system to override the lawful policy decisions of the legislative branch, particularly in a case such as this where a decision in favor of the state and individual respondents would upend the lives and settled expectations of so many. The Court should uphold the ACA.

ARGUMENT

I. Congress Passed The ACA To Expand Access To Health Insurance, Including For People Living With HIV, And Has Maintained That Objective In Subsequent Legislation

Congress enacted the ACA to "increase the number of Americans covered by health insurance and decrease the cost of healthcare." *National Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 538 (2012) (*NFIB*); see *Maine Cmty. Health Options* v. *United States*, 590 U.S. ---, No. 18-1023, 2020 WL 1978706, at *3 (Apr. 27, 2020) (in passing the ACA, Congress sought "to improve national health-insurance markets and extend coverage to millions of people without adequate (or any) health insurance"). The ACA has largely achieved its purpose for the general population, and has been essential to accomplishing those objectives for many people living with HIV.

Before the ACA, two key obstacles blocked people living with HIV from obtaining proper medical care: (1) insurers could shut individuals with preexisting conditions out of the market, and (2) low-income people—who comprise a significant portion of the people living with HIV—could not afford insurance. The ACA solved these problems by adopting a series of major reforms designed to expand access to private and public health insurance. These reforms have dramatically improved outcomes for individuals living with HIV.

Congress has preserved and expanded upon the ACA's successes in subsequent legislation. In so doing, Congress has signaled a clear intent to maintain the

ACA's vitality, including the provisions particularly beneficial to people living with HIV.

A. The ACA Enables Near-Universal Access To Health Insurance, And Any Holding That Invalidates The Provisions Furthering This Would Be Particularly Damaging To People Living With HIV

Congress passed the ACA to increase access to affordable health care for all Americans, particularly those against whom insurers historically discriminated. The ACA accomplished these objectives by prohibiting insurers from declining coverage and from charging rates above the community rates to individuals with preexisting conditions (the "guaranteed issue" and "community rating" provisions). See 42 U.S.C. 300gg(a), 300gg-1, 300gg-3, 300gg-4. Additionally, the ACA extended healthcare coverage to tens of millions of Americans by providing federal tax subsidies to low-income individuals to purchase health insurance, see 26 U.S.C. 36B, and by allowing states to expand Medicaid to all individuals with a household income below 138% of the federal poverty line (FPL), see 42 U.S.C. 1396a(a)(10)(A)(i), 1396d(y).

These policies have greatly benefited people living with HIV, who no longer have to worry about being denied, priced out of, or dropped from insurance due to their status, and, as a result, have access to new, affordable insurance options. See pp. 9-18, *infra*. In addition, the ancillary health benefits the ACA has engendered have been particularly significant for people living with HIV. Because of the ACA, those living with HIV are more likely to know their status and to have

access to antiretroviral therapies that will dramatically improve their health and reduce their viral load to non-infectious levels. See pp. 18-25, *infra*. Additionally, individuals at risk of HIV are now more likely to have access to pre-exposure prophylaxis medication—one of the most effective methods of HIV prevention. See pp. 21-22, *infra*. Were the ACA's protections suddenly to disappear, the resulting setback would be devastating for people living with and at higher risk for HIV.

B. Congress Has Demonstrated A Consistent Intent That The ACA's Key Provisions Expanding Access To Health Insurance Remain In Effect

As evidenced by multiple unsuccessful attempts, Congress understood how to repeal the ACA, but each time *declined* to do so. These attempts are well documented by the principal briefs in support of petitioners and need not be recounted here. See State Pet. Br. 9; House Resp. Br. 6.

Following renewed and unsuccessful repeal efforts in 2017, Congress passed the Tax Cuts and Jobs Act, Pub. L. No. 115-97, 131 Stat. 2054 (2017) (TCJA). In contrast to the repeal efforts, Congress this time traded its sledgehammer for a scalpel and surgically amended the ACA by setting the penalty for those who do not obtain health insurance, dubbed the "[s]hared responsibility payment," to $0. § 11081, 131 Stat. 2092; see also 26 U.S.C. 5000A(c). Congress was explicit that it was amending *only* the amount of the penalty assessed for forgoing health insurance and making *no other changes* to the statute. See State Pet. Br. 47; House Resp. Br. 41-42. In other words, Congress

demonstrated that its limited intervention meant to preserve the ACA.

Legislation passed since the TCJA only bolsters this conclusion, as Congress has continued to support the ACA's initiatives. This includes efforts to expand access to health care and to improve outcomes for people living with HIV. In its most recent appropriations bill for FY2020, for example, Congress extended funding for programs—including Community Health Centers and the National Health Service Corps—pursuant to the ACA. Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Div. N, Title I, § 401(a)-(b), 133 Stat. 3133 (2019). Community health centers benefit people living with HIV as "important partners in implementing the National HIV/AIDS Strategy and expand[ing] the opportunities for integrating HIV testing, prevention, care, and treatment services into primary care." HIV.gov, *The Affordable Care Act and HIV/AIDS* (last updated Dec. 19, 2019), https://www.hiv.gov/federal-response/policies-issues/the-affordable-care-act-and-hiv-aids. And, "[t]hanks to the ACA, the National Health Service Corps [provides] loans and scholarships to more doctors, nurses, and other healthcare providers, a critical healthcare workforce expansion to better serve vulnerable populations." *Ibid.*

The law contains several other provisions specifically contemplating the ACA's continuation. For example, it requires the HHS Secretary to provide reports on monthly enrollment figures for the ACA's health insurance exchanges; publish information pertaining to the employment of full-time federal employees or contractors carrying out the ACA's provisions;

and publish information detailing the historical and prospective "uses of all funds used by the Centers for Medicare & Medicaid Services specifically for Health Insurance Exchanges." Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Div. A, Title II, §§ 219, 220, 226, 133 Stat. 2581-2583 (2019).[2] This language demonstrates that Congress did not intend the remainder of the ACA's provisions to cease operation when it zeroed out the shared responsibility payment.[3]

Most recently, on March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) provided additional funds for HIV-related issues while also continuing to support the ACA. Congress allocated additional funds to the Ryan White HIV/AIDS Program[4] and the Housing Opportunities for Persons with

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[2] The omnibus appropriations bill for FY2018—passed on March 23, 2018 by the same Congress that just months earlier passed the TCJA—contained virtually identical provisions. See Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, Title II, §§ 219-221, 132 Stat. 739-740.

[3] Cf. *Maine Cmty.*, 2020 WL 1978706, at *10 (observing that "repeals by implication are not favored," and that, "[p]resented with two statutes, the Court will 'regard each as effective'—unless Congress' intention to repeal is 'clear and manifest' or the two laws are 'irreconcilable' " (quoting *Morton* v. *Mancari*, 417 U.S. 535, 549-551 (1974))). Here, not only has Congress not indicated a desire to repeal the ACA through lack of appropriations or other means, but it has affirmatively and repeatedly extended funding for ACA programs and even added a requirement that the Secretary create an automatic reenrollment process for individuals enrolled in ACA exchange plans. See Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Div. N, Title I, § 608, 133 Stat. 3130 (2019).

[4] The Ryan White HIV/AIDS Program is a federal program that provides grants to state and local governments and certain

AIDS program to help combat the coronavirus pandemic. CARES Act, Pub. L. 116-136, Div. B, Titles VIII, XII, 134 Stat. 553-575, 595-614 (2020). At the same time, Congress allocated additional funds to support multiple aspects of the ACA. Div. A, Title III, § 3831(a)-(b), 134 Stat. 433 (amending the ACA to increase funding for Community Health Centers and the National Health Service Corps through November 2020). This increased funding further demonstrates Congress's continued support of the ACA's goals.

II. The ACA Has Resulted In An Increase In The Number Of People Living With HIV Who Have Access To Health Insurance, And Congress Did Not Intend To Impair That Progress

An estimated 1.1 million people in the United States have HIV. See CDC, *Basic Statistics* (last reviewed Mar. 20, 2020), https://www.cdc.gov/hiv/basics/statistics.html. Before the ACA's enactment, it was impossible for many of them to access affordable, quality health insurance. Today, nearly 40 years after the discovery of HIV, the ACA has changed that reality by eliminating barriers to access, ensuring that treatments and prophylactics are both available and affordable. As a result, people living with HIV are now better positioned to exercise control over their conditions and to live long, healthy lives. There is no evidence that Congress intended to arrest this progress when it lowered the shared responsibility payment.

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nonprofit organizations to provide treatment and medication to people living with HIV who have no alternative health coverage. See pp. 26-30, *infra*.

A. People Living With HIV Historically Faced Numerous Obstacles To Obtaining Access To Health Insurance

Prior to the ACA, people living with HIV had difficulty accessing both public and private individual insurance plans. In most states, insurers were allowed to consider health status and history when deciding whether to issue individual policies and in determining premiums. See Lindsey Dawson & Jennifer Kates, *What is at Stake in ACA Repeal and Replace for People with HIV?*, Issue Brief 3 (2017) (*What is at Stake*), http://files.kff.org/attachment/Issue-Brief-What-is-at-Stake-in-ACA-Repeal-and-Replace-for-People-with-HIV. People with HIV shopping in the private insurance market were considered "uninsurable" and either were denied coverage altogether or were offered a plan with unaffordable rates and sweeping exclusions. *Ibid.*; see Institute of Medicine, *Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White* 108 (2005), https://doi.org/10.17226/10995.

Under federal law, individuals could not qualify for Medicaid based on income alone, and had to show both financial need and inclusion in another category, such as disability, pregnancy, or being a parent (categorical eligibility). *What is at Stake* 2. This restriction excluded many low-income, childless adults from coverage until they were so sick that they became disabled, despite the availability of medications that could have prevented disease progression. *Ibid.*

As a result, between 2009 and 2012, almost 18% of people who were actively engaged in HIV medical care lacked any form of health insurance. Heather Bradley

et al., *Ryan White HIV/AIDS Program Assistance and HIV Treatment Outcomes*, 62 Clinical Infectious Diseases 90, 91 (2015), https://academic.oup.com/cid/article/62/1/90/2462646.

B. The Guaranteed Issue, Community Rating, Tax Subsidy, And Nondiscrimination Provisions Of The ACA, None Of Which Relies On The Individual Mandate To Achieve Its Goals, Have Been Critical In Expanding Access To Private Health Insurance Plans

The ACA's protective provisions have enabled people living with HIV to obtain health insurance coverage as individuals in the private market.

First, under the statute's "guaranteed issue" provision, insurers cannot deny access to health insurance based on a person's HIV-positive status or any resulting deterioration in health. Dori Molozanov, *Celebrating 10 Years of the Affordable Care Act*, NASTAD.org (Mar. 23, 2020) (*Celebrating 10 Years*), https://www.nastad.org/blog/celebrating-10-years-affordable-care-act. Second, under the statute's "community rating" provision, insurers cannot engage in price discrimination by setting unaffordable premiums for those who are HIV-positive. 42 U.S.C. 300gg. Third, under the ACA's federal tax subsidies ("premium assistance credits") provision, people living with HIV whose household incomes range between 100% and 400% of the FPL receive financial assistance to purchase insurance on marketplace exchanges. 26 U.S.C. 36B.

In addition, the ACA contains a pivotal nondiscrimination provision (Section 1557)—the first major civil rights law enacted by Congress in decades—that spe-

cifically prohibits discrimination on the basis of race, color, national origin, sex, and disability in healthcare programs and services. 42 U.S.C. 18116; see also *Celebrating 10 Years*. Equal access to health insurance is particularly important because, as discussed in more detail on pages 31-33, *infra*, historically marginalized groups face disproportionately higher rates of HIV diagnoses. These groups also have faced pervasive discrimination by providers and in the health insurance market, making it more difficult for them to access health care. See, *e.g.*, Nat'l Women's Law Ctr., *Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS* (May 2014), https://nwlc.org/wp-content/uploads/2015/08/lgbt_refusals_factsheet_05-09-14.pdf; Lambda Legal, *When Health Care Isn't Caring* (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whic-report_when-health-care-isnt-caring.pdf. Section 1557 is thus an important mechanism for addressing such discrimination. Indeed, Section 1557 has proven helpful in protecting access to health care for people living with HIV. See Dep't of Health & Human Servs., *National HIV/AIDS Strategy for the United States: 2017 Progress Report* 27 (2018), https://files.hiv.gov/s3fs-public/NHAS_Progress_Report_2017.pdf (discussing a Voluntary Resolution Agreement between HHS and an Oklahoma nursing home resulting from discrimination based on disability (HIV-positive status) in violation of Section 1557); *East* v. *Blue Cross & Blue Shield of Louisiana*, No. 3:14-CV-00115-BAJ, 2014 WL 8332136 (M.D. La. Feb. 24, 2014) (temporarily restraining insurers from refusing to accept federally funded third-party premium payments on behalf of

lower-income Louisianans living with HIV in case asserting violations of Section 1557, among other laws). The collective result of these provisions is that health insurance is *available* and *affordable* to individuals with HIV, allowing them to make meaningful gains in accessing private plans.

The result has been a measurable increase in coverage. An analysis of prescription drug data in 2015 showed that a significantly higher percentage of enrollees in marketplace plans used HIV treatments than people in employer-sponsored plans, indicating that persons with HIV were able to obtain marketplace plans—after being either uninsured or publicly insured—as soon as they became available. Julie M. Donohue et al., *Early Marketplace Enrollees Were Older and Used More Medication than Later Enrollees; Marketplaces Pooled Risk*, 34 Health Affairs 1049, 1054 (2015). CDC survey data also showed that, of the population at highest risk for HIV—gay and bisexual men—the percentage who reported being uninsured dropped from 31% in 2011 to 21% in 2014.[5] These gains are repeated at the state level. In Louisiana, more than 2,300 people living with HIV received new coverage in a marketplace plan. Louisiana HIV Planning Grp., *Loui-*

[5] Compare CDC, *HIV Risk, Prevention, and Testing Behaviors Among Men Who Have Sex with Men—National HIV Behavioral Surveillance System: 20 U.S. Cities, 2014*, 11 (2016), https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-15.pdf with CDC, *HIV Risk, Prevention, and Testing Behaviors National HIV Behavioral Surveillance System Men Who Have Sex With Men: 20 U.S. Cities, 2011*, 16 (2014), https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-8.pdf.

siana HIV/AIDS Strategy - For Prevention, Treatment and Care Services 2017-2021, 69 (2016), https://www.louisianahealthhub.org/wp-content/uploads/2018/10/LouisianaHIVAIDSStrategy.pdf.

Notably, none of these provisions relies on the individual mandate to achieve its goals. The difficulties faced by people living with HIV stem not from an unwillingness to purchase insurance, but from an inability to access insurance. Moreover, Congress's zeroing of the shared responsibility payment is not expected to destabilize the insurance markets on which people with HIV rely for coverage.[6]

C. Independent From The Individual Mandate, The ACA's Expansion Of Medicaid Has Resulted In Significant Improvements In Coverage Of Low-Income People Living With HIV

The ACA also has been crucial in increasing access to Medicaid, the largest source of coverage for people with HIV in the United States. *What is at Stake* 1. The ACA's expansion of Medicaid to individuals with incomes up to 138% of the FPL directly impacted people living with HIV.[7] As of 2014, more than 60% of non-

[6] See America's Health Insurance Plans Amicus Br. 23 ("the individual markets have demonstrated a continued resiliency—and, in many instances, have shown signs of increasing steadiness" since the adjustment).

[7] The ACA also ensures that enrollees in expanded Medicaid plans receive services that fall into "essential health benefits" categories, many of which are particularly important to those living with HIV. Kaiser Family Found., *Medicaid and HIV* (2019), https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/ (listing categories including laboratory services, preventive services and

elderly adults with HIV had incomes at or below 138% of the FPL, with more than four in ten below 100% of the FPL. Jennifer Kates et al., *Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV* 6, Kaiser Family Found. (Jan. 7, 2014), https://www.kff.org/wp-content/uploads/2013/12/8535-assessing-the-impact-of-the-affordable-care-act-on-health-insurance-coverage.pdf. Of equal importance, the statute removed the categorical eligibility requirement, meaning people with HIV no longer have to wait until they are disabled by their condition to receive coverage. Kaiser Family Found., *Medicaid and HIV* (2019) (*Medicaid and HIV*), https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

In *NFIB*, this Court upheld the ACA's expansion of Medicaid, but held that states could choose whether to expand their Medicaid programs. 567 U.S. at 625. Since that decision, nearly three-quarters of the states have opted to expand. See *Medicaid and HIV* ("As of July 2019, 36 states and Washington, D.C. have adopted the ACA Medicaid expansion."). Nearly two-thirds (64%) of the population living with HIV reside in these jurisdictions. *Ibid.* Here too, measurable gains have been made. In one illustrative example, as of 2016, at least 12,000 people living with HIV in Illinois—one-third of the HIV-positive population in the state—had newly gained health care through the ACA. AIDS Found. of Chicago, *The American Health Care Act (AHCA) Will Devastate Health Care for People with HIV in Illinois*, https://www.aidschicago.org/resources

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chronic disease management, and mental health and substance use disorder services).

/content/9/3/3/documents/ahca-passed-house.pdf. The state's Medicaid expansion in particular covered 9,000 people with HIV—25% of the HIV-positive population. *Ibid.* Accordingly, Medicaid enrollees achieved gains in access to services. In Michigan, a survey conducted by the Public Health Institute showed that 44% of providers statewide had experienced an increase in the demand for services by those living with HIV following the state's expansion of Medicaid. See Michigan Dep't of Health & Human Servs., *Michigan Coordinated HIV/AIDS Needs Assessment* 103 (June 2015), https://www.michigan.gov/documents/mdhhs/Michigan_HIV_Needs_Assessment_504007_7.pdf.

In June 2015, the CDC required jurisdictions that receive Ryan White funding to submit plans that identify HIV prevention and care needs, and to outline strategies to address existing barriers. CDC, *Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017-2021*, 4 (2015) https://hab.hrsa.gov/sites/default/files/hab/Global/hivpreventionplan062015.pdf. The resulting plans widely acknowledged that increasing access to health insurance through Medicaid would help end the HIV epidemic.

In Washington, the state's End AIDS initiative explicitly acknowledges the importance of health insurance coverage, and includes a plan to identify and notify individuals who are eligible for Medicaid to ensure that no one is left without coverage for necessary medications and medical care. Washington State Dep't of Health, *Integrated HIV Prevention and Care Plan 2017-2021*, 26 (Oct. 2016), https://www.doh.wa.gov/Portals/1/Documents/Pubs/150-093-HIVPreventionAnd

CarePlan.pdf. Similarly, New York's Blueprint to End the AIDS Epidemic includes providing expanded Medicaid coverage to those who are uninsured or underinsured and considered at higher risk for HIV. N.Y. State Dep't of Health, *New York State's Blueprint to End the AIDS Epidemic* 31 (2015), https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf.

D. In Zeroing The Shared Responsibility Payment, Congress Did Not Intend To Reverse The Gains That People Living With HIV Have Made In Obtaining Access To Health Insurance

As described on pages 6-9, *supra*, Congress has remained committed to combatting the HIV epidemic. In zeroing the shared responsibility payment, Congress did not signal any intention to repeal provisions that have so effectively increased the ability of people living with HIV to access health insurance. In 2017, an analysis of the effects of eliminating the ACA's expansion of Medicaid alone found that such elimination would result in an estimated 19 million people losing Medicaid coverage by 2026. Congressional Budget Office, *H.R. 1628, Obamacare Repeal Reconciliation Act of 2017*, 8, 10 (July 19, 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf. That would be devastating for people living with HIV, particularly if coupled with elimination of the guaranteed issue and community rating provisions that provide individuals the opportunity to purchase insurance in the private market. The reduction of the shared responsibility payment has had no material effect on the functionality of these provisions. The Court

should allow them to continue to operate as Congress intended.

III. Since The ACA's Enactment, Clear Progress Has Been Made In Treating And Preventing HIV, And Eliminating The ACA In Part Or In Its Entirety Could Result In Devastating Public Health Consequences That Congress Did Not Intend

Since its enactment, the ACA has significantly improved the well-being of people living with or at higher risk for HIV. These improvements result both from the protections afforded by the ACA and from the programs the ACA has complemented and strengthened. Congress expressly preserved these benefits by continuing to support a multi-pronged approach—of which the ACA is a key part—to fighting the HIV/AIDS epidemic.

A. The ACA's Coverage of Preventive Health Services Has Increased The Likelihood Of HIV Testing And Preventive Treatments, Which Benefit HIV-Positive And HIV-Negative Individuals Alike

In addition to expanding access to health insurance, the ACA has been instrumental in limiting the spread of HIV by requiring group and individual health insurance plans to provide certain preventive health services without requiring cost sharing (*i.e.*, co-payments or deductibles) on the part of beneficiaries. See 42 U.S.C. 300gg-13(a). These services include those that have received an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF). 42 U.S.C. 300gg-13(a)(1). Included in that group are HIV screening

services for pregnant persons and for adolescents and adults between the ages of 15 and 65. USPSTF, *USPSTF A and B Recommendations* (*USPSTF Recommendations*), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations?PAGE=2 (last visited May 12, 2020). Eligible insured individuals are thus entitled to HIV screening services at no out-of-pocket cost. According to one early study, the combined effect of this provision and Medicaid expansion would "result in an additional half a million people getting tested for HIV and the identification of 2,598 new cases of HIV by 2017, accompanied by a 22% decrease in the population that is unaware that they are HIV infected." Winston Abara & Harry Heiman, *The Affordable Care Act and Low-Income People Living with HIV: Looking Forward in 2014 and Beyond*, 25 J. Assoc. Nurses AIDS Care 476, 478 (2014) (citation omitted). And indeed, data show that from 2008 to 2020, the number of people living with HIV who were unaware of their status dropped from 20% to 14%—a 30% decrease. Compare Richard Knox, *Many Americans With HIV Don't Know They Have It*, NPR (Nov. 24, 2008) with Dep't of Health & Human Servs., U.S. Statistics (last updated Jan. 16, 2020), https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.

Access to HIV testing services is paramount in the fight against HIV/AIDS, because knowledge is power in preventing new cases. This is why one of the Administration's key strategies is to "diagnose all people with HIV as early as possible." See Dep't of Health & Human Servs., *Ending the HIV Epidemic: A Plan for America: Key Strategies* (2019), https://www.hiv.gov/

federal-response/ending-the-hiv-epidemic/overview. The importance of knowing one's status is two-fold: first, such knowledge allows the person to begin obtaining treatment, thereby increasing the chance of successfully managing their HIV and achieving desirable health outcomes; and second, it empowers informed decisions that minimize the risk of HIV transmission. See Kaiser Family Found., *HIV Testing in the United States* (June 25, 2019), https://www.kff.org/hivaids/fact-sheet/hiv-testing-in-the-united-states/ (noting studies showing that "those who learn they are HIV positive modify their behavior to reduce the risk of HIV" and "[e]arly knowledge of HIV status is critical for linkage to medical care and treatment that can reduce morbidity and mortality and improve quality of life"). Importantly, even when individuals at higher risk test negative for HIV, they are able to explore the full range of preventive options with their providers, which benefits them and their partners. Abigail H. Viall et al., *Current and (Potential) Future Effects of the Affordable Care Act on HIV Prevention*, 13 Current HIV/AIDS Rep. 95, 98 (2016).

Available data confirm that the ACA has increased the prevalence of HIV testing. One study, focused on the effect of Medicaid expansion, found that between 2010 and 2017, Medicaid expansion states "experienced a significant increase of 3.22 percentage points in ever having an HIV test and an increase of 2.31 percentage points in having a test in the last [three] years." Jaime Rosenberg, *Medicaid Expansion Linked to Increased HIV Testing*, Am. J. Pub. Health (Aug. 24, 2019). Increases in testing rates were highest for non-Hispanic Black individuals. *Ibid.* Other studies likewise con-

firmed an increase in HIV testing following the ACA's implementation. See Greg Carter et al., *HIV Screening and the Affordable Care Act*, 11 Am. J. of Men's Health 233, 238 (2017) (finding men were 2.3 times more likely to be prescribed HIV screening in 2012 compared with 2009).

In addition to HIV screening services, the USPTF recently added to its list of "A" recommendations the provision of pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy (ART) to "persons at high risk of HIV acquisition."[8] *USPSTF Recommendations*. PrEP is the repurposing of antiretroviral medications developed to treat HIV as a prophylactic medication for HIV-negative individuals who are at a higher risk of acquiring HIV. When taken daily, PrEP can significantly lower a person's risk of contracting HIV. See CDC, *PrEP*, https://www.cdc.gov/hiv/basics/prep.html (last visited May 12, 2020) (studies have demonstrated 99% and 74% reduction in risk of contracting HIV through sex and through injection drug use, respectively, when taken daily). To date, the U.S. Food and Drug Administration has approved two

[8] The USPSTF recommends that certain types of persons at heightened risk for HIV be offered PrEP, including sexually active men who have sex with men and heterosexually active women and men who meet certain criteria (*e.g.*, are in a sexual relationship with a person living with HIV, engage in inconsistent condom use with a high-risk sexual partner, or have had certain sexually transmitted infections (STIs) within the past six months), and persons who inject drugs and either share use of drug injection equipment or are at risk of sexual acquisition of HIV. USPSTF, *Preexposure Prophylaxis for the Prevention of HIV Infection Recommendation Statement*, 321 J. Am. Med. Ass'n 2203, 2205-2206 (June 11, 2019).

drugs—Truvada in 2012 and Descovy in 2019—as PrEP regimens. Press Release, FDA, FDA Approves Second Drug to Prevent HIV Infection as Part of Ongoing Efforts to End the HIV Epidemic (Oct. 3, 2019).

With its new category "A" status, PrEP is better positioned than ever before to help bring an end to the HIV epidemic. Under the ACA, this categorization requires most health insurance plans to cover PrEP at no out-of-pocket cost to the individual, which is important considering the high cost of these medications. Although a recent study found there exists a relatively small number of persons with indications for PrEP who were "not insured, not eligible for ACA insurance, and ineligible for" a drug manufacturer-provided cost assistance program,[9] the same study cautioned that "*[i]f the eligibility for different types of insurance * * * changes substantially in coming years*, it will impact the feasibility of scaling up PrEP use to the many who would benefit from its use." Dawn K. Smith et al., *Estimated Coverage to Address Financial Barriers to HIV Preexposure Prophylaxis Among Persons with Indications for Its Use, United States, 2015*, 76 J. Acquired Immune Deficiency Syndrome 465, 471 (2017) (emphasis added). This is precisely the result that would ensue should the Court decide to do away with the various ACA provisions—including the mandatory coverage of no-cost-sharing preventive services—that provide affordable access to such treatment.

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[9] Despite their existence, manufacturer-provided cost assistance programs presuppose that patients have knowledge of their existence, a prescription, and regular medical monitoring, all of which underscores the need for reliable access to a healthcare professional.

B. Access To Antiretroviral Therapy, Made Available By The ACA, Is Necessary To Reduce HIV Transmission

Because a lack of regular medical care is strongly correlated with a higher rate of HIV transmission, the ACA's success in expanding insurance coverage has helped turn the tide. For example, in 2009—the year before the ACA's enactment—individuals who were diagnosed with HIV but not receiving regular care accounted for 61% of the estimated 45,000 HIV transmissions in the United States. Jacek Skarbinski et al., *Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States*, 175 JAMA Internal Med. 588, 590 (2015). An additional 30% of transmissions were correlated with people who had HIV but were undiagnosed. *Ibid.* Undoubtedly, these rates would have been lower had these individuals had regular access to ART, as is now the norm under the ACA. And indeed, as of 2016, it was estimated that fewer than 39,000 new HIV transmissions occurred in the United States. Zihao Li et al., *Vital Signs: HIV Transmission Along the Continuum of Care—United States, 2016*, 68 Morbidity & Mortality Weekly Rep. 267, 267 (Mar. 22, 2019).

Since its introduction in the mid-1990s, ART has transformed HIV from an invariably fatal diagnosis into a treatable, manageable condition with few, if any, effects on a person's overall health, daily life or life expectancy. See Panel on Antiretroviral Guidelines for Adults & Adolescents, Dep't of Health & Human Servs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV* E-1 (July 10, 2019) (*Guidelines*), http://www.aidsinfo.nih.gov/ContentFiles

/AdultandAdolescentGL.pdf. ART functions by reducing an individual's viral load, *i.e.*, the amount of HIV in blood plasma. Taken as prescribed, ART sufficiently lowers viral load to allow the immune system to function properly (a state termed "viral suppression"), and can even render an individual's viral load undetectable. CDC, *HIV Treatment as Prevention*, https://www.cdc.gov/hiv/risk/art/index.html (last visited May 12, 2020).

When people living with HIV commence and maintain an ART regimen, they substantially increase the likelihood of living healthy lives while simultaneously reducing the likelihood of transmission. See Viall, 13 Current HIV/AIDS Rep. at 98 ("Individuals who do not start antiretroviral therapy quickly or who are not adequately retained in care may experience delayed virologic suppression, higher cumulative viral load burden, poorer immunologic function and overall health, and increased risk of death."); *Guidelines* E-1 (starting ART immediately or as soon as possible after HIV diagnosis reduces risk of HIV transmission). Indeed, a series of studies analyzed by the CDC found ART to be nearly 100% effective in preventing transmission once the HIV-positive partner achieves viral suppression, which most patients do within six months. CDC, *Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV* (Dec. 2018), https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf.

Although it will take some time to determine the full extent of the ACA's effect, a clear relationship between increased access to ART and reduced rates of HIV transmission is beginning to emerge. Louisiana's evolution is illustrative. In 2018, two years after the

state accepted the Medicaid expansion, fewer than 1,000 new HIV cases were diagnosed—the lowest in at least a decade and a 12% drop over the previous three years. Emily Woodruff, *New HIV Cases in Louisiana Hit Decade Low in 2018; Health Officials Hopeful for Epidemic's End*, NOLA.com (July 3, 2019). State officials attributed the decrease to people having "more access to HIV medication that makes the virus undetectable and PrEP, * * * as well as increases in screening." *Ibid.* Similarly, an increase in access to comprehensive health insurance in Illinois contributed to a 25% drop in new HIV cases in that state from 2008 to 2017. See Illinois Dep't of Public Health, *Getting to Zero Illinois – 2019-2023 Plan* 9 (2019), https://gtzillinois.hiv/wp-content/uploads/2019/06/GTZ-IL-plan-English-06062019.pdf. And in Nebraska, a sample of people living with HIV who received new coverage under that state's Medicaid expansion in 2013-2014 were significantly more likely to achieve viral suppression compared to those who remained uninsured. Renae Furl et al., *Determinants of Facilitated Health Insurance Enrollment for Patients with HIV Disease, and Impact of Insurance Enrollment on Target Health Outcomes*, 18 BMC Infectious Diseases 6 (2018). The connection between increased adherence to ART brought on by the ACA and a reduction in the number of new HIV cases demonstrates part of the deleterious effect that invalidating the ACA would have on the progress made to date.

C. The ACA Has Allowed The Ryan White HIV/AIDS Program To Develop Into The Safety Net That Was Intended At Its Inception

Enacted in 1990 at the height of the HIV/AIDS crisis, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, 42 U.S.C. 300ff *et seq.*, established the federal government as the payer of last resort for people living with HIV (Ryan White Program). Under the Ryan White Program, the federal government provides grants to states, cities, and nonprofit organizations to provide treatment and medication to people with HIV who have no alternative coverage. The program does not provide health insurance. Among the grants provided is the AIDS Drug Assistance Program (ADAP), a program administered by states and territories that provides medications to low-income people living with HIV who have limited or no health coverage from private or public insurance. Over approximately the past decade, ADAP has also been used to purchase health insurance for eligible individuals. See Health Res. & Servs. Admin., *Part B: AIDS Drug Assistance Program* (last reviewed Oct. 2019), https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-b-aids-drug-assistance-program.

Prior to the ACA, Ryan White funding proved simply inadequate to satisfy the full range of healthcare needs of people living with HIV. See Kaiser Family Found., *Financing HIV/AIDS Care: A Quilt with Many Holes*, HIV/AIDS Policy Issue Brief 14 (May 2004) (noting that, due to mismatches between annual appropriations and the need for services, "several state ADAP[] programs have had to place clients on waiting

lists to access prescription drugs, or limit such access in other ways," and that "CARE Act programs and services vary across the country"). Moreover, because the program generally limits eligibility to people already living with HIV, Ryan White funding still cannot be used to assist those who are HIV-negative in obtaining access to PrEP. See Letter from Dep't of Health & Human Servs. to Ryan White HIV/AIDS Program Colleagues (June 22, 2016), https://hab.hrsa.gov/sites/default/files/hab/Global/prepletter062216.pdf (Ryan White Program legislation "prohibit[s] the use of RWHAP funds for PrEP medications and the related medical services such as physician visits and laboratory costs").

The ACA has changed the landscape in profound ways, allowing the Ryan White Program to serve as the safety net that Congress originally intended. Specifically, "[t]he ACA has allowed RWHAP Part B programs and ADAPs to repurpose expenditures associated with paying full cost for clients for medications by migrating clients toward Medicaid * * * or enrolling them in less costly and more comprehensive insurance coverage within the federal or state Marketplaces." NASTAD, *2019 National RWHAP Part B and ADAP Monitoring Project Annual Report* (May 2019) (*Monitoring Project*), https://publications.partbadap-2019.nastad.org/. Indeed, one analysis showed that 60% of people living with HIV who have marketplace coverage relied on Ryan White, compared to 31% of those with employer-sponsored insurance, "potentially reflecting the role of Ryan White in helping clients purchase insurance, especially among a group likely to have lower incomes relative to those with employer coverage." *Insurance Coverage*. By relieving pressure on the Ryan

White Program to fund expensive medications for the uninsured and underinsured, the ACA has made it possible for the program to shift funds toward "wrap-around" services that make it easier for people to access care and adhere to medication regimens, including mental health, housing, and medical transportation services.[10] *Ibid.*; see *Monitoring Project.*

The experience of individual states confirms the effect of the ACA in bolstering the Ryan White Program's reach. Washington State's ADAP program, for example, has reportedly experienced cost savings as a result of people living with HIV obtaining insurance coverage under expanded Medicaid; in turn, this has reduced the program's client load, allowing it to engage in increased outreach. Washington State Dep't of Health, *Integrated HIV Prevention and Care Plan 2017-2021*, 26 (Oct. 2016), https://www.doh.wa.gov/Portals/1/Documents/Pubs/150-093-HIVPreventionAndCarePlan.pdf. By contrast, in 2012, the year before Arizona expanded its Medicaid program under the ACA, healthcare providers in Maricopa County—a locality with HIV infection rates among the highest in the country[11]—struggled to meet demand for care as HIV

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[10] In addition to providing wrap-around support services, the Ryan White Program continues to fill insurance coverage gaps by providing ART to people living with HIV in states that have not expanded their Medicaid programs under the ACA. See Tamar Ginossar et al., *The Ryan White HIV/AIDS Program After the Patient Protection and Affordable Care Act Full Implementation: A Critical Review of Predictions, Evidence, and Future Directions*, 27 Topics in Antiviral Med. 91, 96 (2019).

[11] Marc A. Pitasi et al., *HIV Testing in 50 Local Jurisdictions Accounting for the Majority of New HIV Diagnoses and Seven*

diagnoses occurred primarily in communities with no health insurance coverage. The result was "increasing[] relian[ce] on Ryan White funded services for HIV primary medical and specialty care, making Ryan White funding essential to supporting the fragile health care system." Phoenix EMA Ryan White Planning Council, *3-Year Comprehensive HIV Services Plan of the Phoenix EMA Ryan White Planning Council* 40 (2012), https://www.maricopa.gov/ArchiveCenter/ViewFile/Item/1908. However, following Medicaid expansion, a study assessing the needs of people living with HIV showed that 43% of respondents in Maricopa and Pinal counties newly enrolled in Medicaid or private health insurance after being contacted by their medical provider or case manager, resulting in 45% of overall respondents being enrolled in Medicaid. See Phoenix EMA Ryan White Planning Council, *Arizona Statewide Needs Assessment for People Living with HIV/AIDS* 32-33, 35-36 (May 2019), https://www.maricopa.gov/ArchiveCenter/ViewFile/Item/1902.

Congress's continued funding of the ACA (see pp. 7-9, *supra*) alongside its funding of the Ryan White Program indicates its intent for the two systems to work in concert to address the health care needs of people living with HIV. The Ryan White Program is designed to provide additional support for people receiving care through the regular health care system, particularly those who are not being fully served by that system. This remains true following the adjustment to the shared responsibility payment. Substan-

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States with Disproportionate Occurrence of HIV in Rural Areas, 2016–2017, 68 MMWR Weekly 561, 563 (2019).

tially increasing the level of dependence on the Ryan White Program by eliminating the ACA would erase the considerable advances made in the fight against HIV in recent years.

Preventing this outcome is especially important in the age of COVID-19. The economic fallout from the ongoing pandemic, which already has significantly increased the number of unemployed Americans, will result in millions of people losing their private employer-provided health insurance. See Karen Pollitz & Gary Claxton, *Changes in Income and Health Coverage Eligibility After Job Loss Due to COVID-19*, Kaiser Family Found. (Apr. 14, 2020), https://www.kff.org/health-reform/issue-brief/changes-in-income-and-health-coverage-eligibility-after-job-loss-due-to-covid-19/. Many of these individuals thus likely will seek subsidized health coverage through ACA exchanges or through Medicaid, depending on their qualifications and states of residence. *Ibid.* This includes people living with HIV, many of whom are immunocompromised and may be at higher risk of serious illness from COVID-19. See CDC, *What to Know About HIV and COVID-19* (Mar. 18, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/hiv.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fspecific-groups%2Fhiv.html (noting potential risk for people living with HIV who have low CD4 cell counts or are not on ART). It is critical that people living with HIV maintain their ability to access affordable health insurance—and the access to comprehensive health care it enables—in such an uncertain and dangerous time.

D. Striking Down The ACA In Whole Or In Part Would Undo Substantial Progress And Exacerbate Disparities In Health Care For People Living With HIV

In addition to expanding access to coverage and treatment options for all people living with HIV, the ACA has demonstrably aided in reducing racial disparities in coverage rates. Reviewing data from 2013 to the present, researchers determined that Blacks and Hispanics, despite having had the highest uninsured rates prior to the ACA's passage, have made the largest gains in coverage. See Jesse C. Baumgartner et al., *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care*, The Commonwealth Fund (Jan. 16, 2020), https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access. Disparities narrowed both in states that opted to expand Medicaid and in states that opted not to expand Medicaid, although the change was smaller in the latter group. *Ibid.* Overall, the "gap between black and white adult uninsured rates dropped by 4.1 percentage points, while the difference between Hispanic and white uninsured rates fell 9.4 points." *Ibid.* See also Ajay Chaudry et al., *Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?*, The Commonwealth Fund (Aug. 21, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/did-ACA-reduce-racial-ethnic-disparities-coverage (finding that the "ACA had an equalizing effect" and that "[a]ll groups gained from the ACA's expansions of public insurance coverage and private insurance coverage"); Samantha Artiga et al., *Changes in Health Cov-*

erage by Race and Ethnicity since the ACA, 2010–2018, Kaiser Family Found. (Mar. 5, 2020), http://files.kff.org/attachment/Issue-Brief-Changes-in-Health-Coverage-by-Race-and-Ethnicity-since-the-ACA-2010-2018.pdf (similar).

Despite the progress made under the ACA, significant disparities in the prevalence of HIV and in coverage rates remain. The majority of annual new HIV cases nationwide (51%) originate in the South, and of those, Black people are disproportionately represented across all risk groups, accounting for 53% of new infections (of which 67% were Black women) in 2017. CDC, *HIV in the Southern United States*, Issue Brief 1 (Sept. 2019), https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-in-the-south-issue-brief.pdf. Disparities also exist with respect to trend rates, with new HIV diagnoses among Hispanic/Latino gay and bisexual men increasing by 27% since 2012, while new diagnoses among White gay and bisexual men decreased by nine percent in the same period. *Ibid.* Nationwide, HIV disproportionately impacts transgender people; transgender women in general and transgender women of color in particular are at a much higher risk. CDC, *HIV and Transgender Communities*, Issue Brief 1 (Apr. 2019), https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf (mean HIV prevalence was 44.2% among Black transgender women and 25.8% among Hispanic/Latina transgender women, compared to 6.7% among White transgender women). And Hispanics/Latinos have the highest uninsured rate of any racial or ethnic group in the United States at 17.8% as of 2018. Edward R. Berchick et al., *Health Insurance Coverage in the United States: 2018*, 14, Census Bureau (Nov. 2019), https://

www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

If the Court were to invalidate all or part of the ACA, it would erase the progress made to date in reducing disparities in coverage for people living with HIV. Likewise, such a decision would significantly exacerbate the disparities in coverage and HIV prevalence that remain. By consigning people living with HIV once again to the ranks of the uninsured, the Court would severely impede, if not completely hobble, efforts to halt HIV and end AIDS.

E. Congress Did Not Intend These Unconscionable Public Health Consequences When It Lowered The Shared Responsibility Payment

"Congress passed the [ACA] to improve health insurance markets, not to destroy them." *King* v. *Burwell*, 135 S. Ct. 2480, 2496 (2015). As explained (see pp. 6-9, *supra*), Congress's actions throughout the decade since the ACA's passage preclude the conclusion that it intended to unleash a wave of economic and public health uncertainty when it lowered the shared responsibility payment to zero. To the contrary, Congress has repeatedly rejected efforts to repeal the main pillars of the ACA, and has continued to provide funding for programs supported by the law, including programs that have made real differences in the lives of people living with HIV. It is imperative that the millions of Americans who rely on the ACA's protections—including those living with such chronic conditions as HIV—maintain the advances the law has afforded them.

CONCLUSION

For the foregoing reasons, the judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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MAY 2020

APPENDIX

APPENDIX

LIST OF AMICI CURIAE

- **Lambda Legal Defense and Education Fund, Inc.** (Lambda Legal)
- **AIDS United**
- **American Academy of HIV Medicine** (AAHIVM)
- **Black AIDS Institute**
- **Center for Health Law and Policy Innovation** of Harvard Law School (CHLPI)
- **GLBTQ Legal Advocates & Defenders** (GLAD)
- **Housing Works**
- **Human Rights Campaign** (HRC)
- **Latino Commission on AIDS**
- **National Alliance of State & Territorial AIDS Directors** (NASTAD)
- **National Black Justice Coalition** (NBJC)
- **National Center for Transgender Equality** (NCTE)
- **National Minority AIDS Council** (NMAC)
- **Positive Women's Network – USA** (PWN-USA)
- **The AIDS Institute**
- **Whitman-Walker Health** (legal name Whitman-Walker Clinic, Inc.) and **Whitman-Walker Institute**