Nos. 19-840 & 19-1019

In the Supreme Court of the United States

CALIFORNIA, et al.,	TEXAS, et al.,
Petitioners,	*Petitioners*,
v.	v.
TEXAS, et al.,	CALIFORNIA, et al.,
Respondents.	*Respondents*.

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF PUBLIC HEALTH EXPERTS, THE AMERICAN PUBLIC HEALTH ASSOCIATION, AND THE AMERICAN ACADEMY OF NURSING AS *AMICI CURIAE* IN SUPPORT OF THE CALIFORNIA PARTIES AND SEVERING THE INDIVIDUAL MANDATE

H. GUY COLLIER
MICHAEL B. KIMBERLY
Counsel of Record
MATTHEW A. WARING
McDermott Will & Emery LLP
500 North Capitol St. NW
Washington, DC 20001
(202) 756-8000
mkimberly@mwe.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Statutes—continued

Other authorities

Other authorities—continued

Other authorities—continued

Other authorities—continued

INTEREST OF THE *AMICI CURIAE* AND SUMMARY OF ARGUMENT *

One of the greatest legacies of the Affordable Care Act (ACA) is the strong and lasting foundation it laid for effective national public health initiatives. The importance of the ACA to public health policy is especially apparent today, in light of its pivotal role in facilitating federal and state governments' response to the novel coronavirus pandemic.

More generally, the ACA's expansion of Americans' access to health insurance and health care has contributed significantly to the Nation's well-being. It has had a transformative impact on the American health insurance market. By expanding the Medicaid program to more lower-income individuals and creating robust individual insurance exchanges, the ACA helped millions of Americans obtain insurance. It also improved the quality of health insurance coverage by ensuring that all plans cover essential preventive and diagnostic services and that no one is denied treatment for preexisting conditions or because of a cap on benefits.

The ACA's health insurance reforms have had tremendous and positive impacts on a range of public health metrics. Thanks to the ACA, more than 90% of Americans now have some form of health insurance—a fact that Congress has capitalized on by directing Medicare, Medicaid, and private health insurance plans to provide coverage, without cost sharing, for COVID-19 testing. As a result, Americans are now more likely to get care when they need it and to seek preventive care

---

* No counsel for a party authored this brief in whole or part, and no party other than *amici* or their counsel made a monetary contribution to the preparation or submission of the brief. All parties have consented to the filing of this brief.

rather than waiting until health problems manifest themselves and become more difficult and costly to treat.

These issues are deeply important to *amici curiae*, who are deans, departmental chairs, and faculty members of the leading schools of public health in the United States. *Amici* are engaged every day in the science and policy of protecting and improving the health of communities through education, promotion of healthy lifestyles and health care, and research to reduce disease and prevent injury. A list of the individual *amici* and their institutional affiliations is appended to this brief.

Amici also include the American Public Health Association (APHA) and American Academy of Nursing (AAN). APHA's mission is to champion the health of all people and all communities and to strengthen the profession of public health. It advocates before both lawmakers and judges for public health issues and policies, grounded in research and science. APHA is the only national health organization that combines a nearly 150-year perspective, a broad member community working to improve the public's health, and the ability to influence federal policy to improve the public's health.

AAN serves the public and the nursing profession by advancing health policy, practice, and science through organizational excellence and effective nursing leadership. The Academy and its more than 2,700 members, known as Fellows, create and execute knowledge-driving and policy-related initiates to promote reform of America's health system.

Amici file this brief to emphasize how essential the ACA has been to American public health over the past decade and how devastating the loss of the ACA would

be for public health moving forward. They take no position on the question whether the individual mandate is constitutional. Their position is only that, if it is unlawful, it should be severed from the statute.

Were the ACA struck down in its entirety, millions of Americans would lose the health coverage that they currently receive through federal and state exchanges or expanded Medicaid programs. Billions of dollars in federal funding for community health centers, state and local public health and disease prevention activities, and state Medicaid programs would be lost. Health insurers would be free to re-impose health penalties, such as exclusions for preexisting conditions and yearly and lifetime caps on benefits—a calamitous prospect in the midst of a global pandemic. Senior citizens receiving Medicare Part D benefits would have to pay thousands of dollars more each year for prescription drugs. And in the event of a future pandemic, Congress's options for providing health benefits to Americans would be severely limited. In short, the ACA has become an essential component of America's health care system.

For its part, Congress has *affirmed* the ACA's core policies by building upon them when addressing new public health challenges. And it has conspicuously declined to repeal the ACA in its entirety, despite repeated opportunities and campaigns to do so. Any decision to wholly unwind the ACA must continue to be "entrusted to the Nation's elected leaders." *National Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 532 (2012). This Court, comprised of unelected judges, should "take care not to undo" the repeatedly expressed will of the political branches on so important a matter as this. *King* v. *Burwell*, 135 S. Ct. 2480, 2496 (2015).

ARGUMENT

This is not the ACA's first appearance before this Court, but it may well be the most consequential. The ACA, at ten years old, has become an integral component of national public health policy. The Nation could ill afford to see it struck down now.

I. THE ACA HAS ADVANCED THE PUBLIC HEALTH IN IMMEASURABLE WAYS

Congress enacted the ACA to "improve national health-insurance markets and extend coverage to millions of people without adequate (or any) health insurance." *Maine Community Health Options* v. *United States*, 590 U.S. __, __ (2020). The Act has led to significant advances on both fronts and thereby improved the resilience of our health care system. The ACA's insurance reforms have also had a measurable impact on public health itself. The value of those reforms has been underscored by research showing "a significant decrease in mortality during a 5-year follow-up period," especially among minorities and in poor counties. Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 New Eng. J. Med. 1025, 1029 (2012). The Act has improved many other public health metrics as well.

A. The ACA transformed the individual health insurance market

The ACA was, first and foremost, Congress's response to the troubling fact that many Americans lacked access to affordable, quality health insurance. Prior to the ACA's passage, 44 million Americans—almost 15% of the U.S. population—were completely uninsured. Nat'l Council of Econ. Advisers, *The Economic Record of the Obama Administration: Reforming the Health Care System* 3 (Dec. 2016), perma.cc/KV23-KQ62. Many of these Americans were low-income indi-

viduals who could not afford any kind of coverage. Many more had preexisting conditions that prevented them from purchasing an affordable plan. Indeed, nearly 36% of all applicants in the individual market during the pre-ACA years were rejected or were charged more due to preexisting conditions. Michelle Doty, et al., The Commonwealth Fund, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* (July 21, 2009), perma.cc/RML5-S6EZ.

Even for Americans who had employer-provided or individual health insurance coverage, the market simply was not working. Health insurance policies were often riddled with limits, exclusions, and other gaps in coverage, leaving premium-paying Americans "vulnerable to financial catastrophe" if they became seriously ill. *Reforming the Health Care System*, *supra*, at 3. Many policies failed to cover preventive care adequately, making it less likely that policyholders would get the screenings and examinations that could catch serious medical issues before they became life-threatening and costly to treat. And the price tag for this inferior coverage was astounding: For a family of four with an income level below 200% of the poverty line in 2008, the average premium for employer-sponsored coverage represented 30% of family income—an utterly unrealistic burden without substantial employer subsidies. *Id.* at 8.

The ACA took on these problems by "adopt[ing] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King*, 135 S. Ct. at 2485. These reforms fell roughly into four categories:

First, the Act removed numerous barriers that prevented individuals from obtaining health insurance. It

prohibited the use of preexisting condition exclusions or other means of discrimination based on health status, medical history, or genetic information (42 U.S.C. 300gg-3, 300gg-4) and required premium structures that are non-discriminatory (*id.* 300gg). It guaranteed that every American would be accepted for coverage (*id.* 300gg-1) and able to renew that coverage during open enrollment (*id.* 300gg-2). It also prohibited insurers from rescinding coverage once issued (*id.* 300gg-12). The ACA further prohibited insurers from applying waiting periods longer than 90 days before coverage begins. *Id.* 300gg-7. And it mandated that large employers offer full-time employees and their dependents the opportunity to enroll in minimum essential coverage (and penalized employers with a tax if they failed to comply). 26 U.S.C. 4980H.

Second, the ACA improved the quality of private insurance coverage. It eliminated annual and lifetime limits on coverage for "essential health benefits," including ambulatory care, emergency services, hospitalizations, and maternity care. 42 U.S.C. 300gg-11. It required that plans sold in the individual and small employer group markets cover essential health benefits (*id.* 300gg-6) and that *all* plans, regardless of size, cover preventive health services for children and adults—including immunizations, preventive screening and treatment, well baby and well child care, and screening and preventive care for women—without patient cost-sharing (*id.* 300gg-13). It allowed young adults to remain on their parents' health plans until they reach age 26. *Id.* 300gg-14. It guaranteed that insurance plans would cover emergency hospital care without the need for prior authorization and regardless of the network status of the hospital provider. *Id.* 300gg-19a(b). It closed the "donut hole" coverage gap in Medicare Part D, which required Medicare beneficiaries who re-

ceived a certain threshold of prescription drugs each year to pay something akin to a $3,500 mid-stream deductible. *Reforming the Health Care System*, *supra*, at 26. And for individuals receiving premium tax credits, it guaranteed a grace period of three months before an insurer could discontinue coverage for nonpayment of premiums—a critical feature in times of national economic stress. 42 U.S.C. 18082(c)(2)(B)(iv)(II).

Third, the ACA made insurance more affordable for low and moderate-income individuals. It established refundable tax credits to help lower-income Americans purchase health plans offering essential health benefits and comprehensive preventive coverage. 26 U.S.C. 36B. It established cost-sharing assistance to reduce the burden of patient cost-sharing for lower-income individuals and families. 42 U.S.C. 18071. And the Act expanded Medicaid to cover adults and children with family incomes up to 133% of the federal poverty level who would not have qualified for coverage under Medicare or traditional Medicaid eligibility rules. 42 U.S.C. 1396a(a)(10)(A)(i)(IV), (VIII).

Finally, the ACA simplified the process of enrolling in health insurance for those not covered through their employers. It established a nationwide system of health benefit exchanges on which individuals could easily compare and select qualified health plans and, if qualified, secure advance premium tax credits and cost-sharing assistance. 42 U.S.C. 18031. It streamlined enrollment and renewal procedures across subsidized insurance markets (including those for Medicaid and the Children's Health Insurance Program (CHIP)), in order to encourage and simplify enrollment and renewal of coverage among needy populations. *Id.* 1396w-3. And it created a system of presumptive, temporary Medicaid eligibility based at participating hos-

pitals as a means of promoting Medicaid enrollment at times when access to care is most urgently needed. *Id.* 1396a(a)(47).

Together, these comprehensive and interlocking insurance reforms—which do not depend on the individual mandate—helped bring *millions* of Americans onto insurance rolls, by making coverage more comprehensive, more affordable, and easier to purchase. Healthcare became accessible to these new enrollees like never before.

B. The ACA implemented vital public health reforms

The ACA didn't just reform health insurance for individuals and families; it also included initiatives designed to promote the broader public health.

In particular, the ACA targeted additional healthcare resources at underserved communities and at-risk populations. The Act established an $11 billion Community Health Center Fund to support community health centers, which provide primary and preventive care services in underserved and low-income communities. See Health Res. & Servs. Admin, *The Affordable Care Act and Health Centers*, perma.cc/H7C3-8QCV. Among other things, the fund helped support an expansion of the National Health Service Corps, which provides loan repayment and scholarships to health care providers who work in communities where there is great need for medical professionals. See Dep't of Health & Human Servs., Press Release, Affordable Care Act Helps National Health Service Corps Increase Access to Primary Care, Nov. 26, 2013, perma.cc/EZ9Q-NPHU. Without the ACA on the books, the fund—and the programs that depend on it—would end.

The ACA also established the Prevention and Public Health Fund (PPHF), which established a mandato-

ry funding stream for "investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." 42 U.S.C. 300u-11(a). This fund, which supports prevention, wellness, and public health activities, is the first mandatory federal spending program of its kind. A ruling for Texas would terminate it.

In order to promote smarter delivery of health care services, the Act established the Center for Medicare & Medicaid Innovation (CMMI). 42 U.S.C. 1315a(a). CMMI "test[s] innovative payment and service delivery models" with the aim of reducing health care expenditures "while preserving or enhancing the quality of care." *Id.* 1315a(a)(1). CMMI has evaluated numerous initiatives in trials including nearly a million health care providers (see CMMI, *2018 Report to Congress* at 4 (2018), perma.cc/JMU8-LT79), and many of these initiatives have shown the ability to reduce health care costs while maintaining quality (*id.* at 2). A refusal to sever the mandate would spell the Center's demise.

Lastly, the ACA recruited tax-exempt hospitals as partners in improving public health. It amended the Internal Revenue Code to require that hospitals seeking tax-exemption status undertake and publish community health needs assessments that take into account the broad interests of their communities. 26 U.S.C. 501(r). A hospital must also adopt an implementation strategy to meet the needs identified in this assessment. *Id.* 501(r)(3)(A)(ii).

Each of the ACA's infusions of federal resources has helped to strengthen the health infrastructure that keeps Americans well and their communities safe. Collectively, these initiatives represent one of the most significant federal investments in public health apart from the pandemic response.

II. STRIKING DOWN THE ACA NOW WOULD DO LASTING DAMAGE TO THE PUBLIC HEALTH

Given all of the advances in public health that the ACA has made possible, the Nation can ill afford to do away with the ACA now. Eliminating the ACA would end programs, terminate funds, eliminate insurance protections, and—on the whole—destroy many of the gains that the country has made since 2010. The damage to public health would be incalculable.

A. The ACA is irreversibly entwined with the American healthcare system

1. To begin with, without the ACA, millions of Americans who have obtained health insurance in recent years would lose their coverage. Coverage would become unaffordable for 11.4 million individuals who are covered through plans purchased with subsidies on ACA exchanges and 12 million adults who obtained insurance through the expanded Medicaid program. Reed Abelson et al., *What Happens if Obamacare Is Struck Down?*, N.Y. Times (Mar. 26, 2019), perma.cc/RG53-75FJ. Three million children who obtained Medicaid or CHIP coverage when their parents qualified for expanded Medicaid coverage would also become uninsured. *Ibid.* And at least two million young adults who rely on their parents' insurance for coverage would face a loss of insurance without the ACA provision requiring employers to cover their employees' children through the age of 26. Namrata Uberoi et al., *Health Insurance Coverage and the Affordable Care Act, 2010–2016*, at 2 (Mar. 3, 2016), perma.cc/B256-UAKX.

Many individuals with coverage through their employers would also lose it. Up to 133 million Americans who have pre-existing medical conditions could be disqualified from their health insurance, or face prohibitive premium increases. Dep't of Health & Human

Servs., *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Jan. 5, 2017), perma.cc/A9K5-GPY6.

Individuals who remained insured could find themselves saddled with the kind of flawed plans that were common prior to the ACA. Prior to the ACA's passage, many plans did not cover important preventive services. Seventy-five percent of health plans in the individual market did not cover maternity services, 45% did not cover substance use disorder treatment, and 38% did not cover mental health treatment. Kaiser Family Found., *Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act* (Jan. 03, 2020), perma.cc/6XQL-YCJK. Twenty-nine percent of employer-based plans had waiting periods of at least 3 months before coverage began. *Ibid.* Fifty-nine percent of workers using employer-sponsored plans were subject to lifetime limits, and 19% had no limits on their out-of-pocket expenses. *Ibid.* Insurers would be free to adopt all of these limitations again, increasing enrollees' out-of-pocket costs.

Americans would also be paying more for their medical benefits. About five million Medicare enrollees would once again be subject to the Medicare Part D "donut hole" deductible for prescription drug costs, which the ACA eliminated. Abelson et al., *supra*. Some 55 million Medicare enrollees could experience premium increases, because the ACA's cuts in the government's payment rates to providers and Medicare Advantage plans would be reversed. *Ibid.* And *all* insured Americans could face higher premiums, or lower-quality service, because the ACA's "medical loss ratio" provision, which requires insurance plans to spend at least 85% of premiums on medical care or rebate the

shortfall to consumers, would be no more. See 42 U.S.C. 300gg-18(b)(1).

Insured Americans would lose important legal protections under the ACA as well. For example, the ACA currently prohibits insurers from rescinding coverage or denying payment based on errors or technical mistakes in insurance applications (42 U.S.C. 300gg-12); its removal would permit these rescissions again. Consumers would also lose the benefit of the ACA's requirement that insurance plans provide internal appeal processes for coverage determinations and claims. *Id.* 300gg-19(a).

2. Eliminating the ACA would harm not only consumers, but also healthcare providers, who would lose critical revenues through increases in uncompensated care. The ACA sought to reduce the amount of uncompensated care by bringing more individuals onto insurance plans and prohibiting coverage limits, and it succeeded in doing so. One study estimates that States that expanded Medicaid under the ACA saw a 40% drop in the share of medical costs that were uncompensated, generating more than $6 billion in savings for hospitals in those States. David Dranove et al., The Commonwealth Fund, *The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal* 1-2 (May 2017), perma.cc/J72H-F5AL. If the ACA were eliminated and the number of uninsured Americans rose again, uncompensated care costs would also rise, to hospitals' detriment. Certain providers and programs that received increased or dedicated funding under the ACA, including rural health care providers and the U.S. Indian Health Service, would also lose resources.

The impact on community health centers would be particularly acute. Federal funding accounts for rough-

ly 20% of community health centers' revenue, and the bulk of federal funding to these centers comes from the ACA's Community Health Center Fund. Kaiser Family Found., *Community Health Centers Prepare for Funding Uncertainty* (Sept. 4, 2019), perma.cc/SE8L-LC74. The loss of the Community Health Center Fund would make it impossible for community health centers to maintain their current level of service and likely necessitate hiring freezes, staff layoffs or hour reductions, reduced operating hours, closures, or other cost-cutting measures. *Ibid.* Indeed, federal officials estimated in 2016 that the loss of the Community Health Center Fund would result in the closure of one out of every four sites, a commensurate layoff of staff, and a nine-million-person reduction in patient capacity. Sara Rosenbaum, *The Community Health Center Fund: What's At Risk?*, 95 MILBANK QUARTERLY 706 (Dec. 2017). The loss of ACA funding devoted to training, scholarships, and loan repayments for primary care doctors and nurses who work in underserved areas would also make it harder for community health centers to attract and retain an adequate workforce.

3. State and federal governments would also experience increased costs. In particular, States that wanted to maintain their expanded Medicaid programs would have to come up with funding to cover the 90% of the cost of the Medicaid expansion that the federal government currently pays—a daunting prospect. Abelson et al., *supra*. States and the federal government could also see an increase in waste, fraud, and abuse with the removal of the provider screening procedures that the ACA put in place for Medicare, Medicaid, and CHIP. See, *e.g.*, Sarah Clemente et al., *Medicare and the Affordable Care Act: Fraud Control Efforts and Results* 2, Int'l J. of Healthcare Mgmt. (2017), perma.cc/MK26-HGUZ.

4. Lastly, all of these changes in the scope and quality of individuals' health insurance would restrict Americans' access to care and lead to worse health outcomes. The ACA caused measurable improvements in Americans' ability to get medical treatment: Between 2010 and 2018, there was a 27% drop in the number of nonelderly adults who did not fill prescriptions, a 24% drop in the number who skipped tests or treatment, and a 19% drop in the number who did not visit a provider despite needing care. Ctr. on Budget & Pol'y Priorities, *Chart Book: Accomplishments of Affordable Care Act* (Mar. 19, 2019), perma.cc/A3ZR-LCPL. With better medical treatment, Americans' health improved. Studies have shown that the ACA's Medicaid expansion led to improved reported health among women of reproductive age,[1] lower rates of preventable hospitalizations,[2] lower cardiovascular mortality,[3] increased lung transplant listings,[4] and lower mortality rates for individuals with end-stage renal disease.[5] These welcome trends, and many others, would almost certainly reverse if the ACA were invalidated.

---

[1] Claire Margerison, et al., *Impacts of Medicaid Expansion on Health Among Women of Reproductive Age*, 58 AMERICAN JOURNAL OF PREVENTIVE MEDICINE 1 (2019).

[2] Heifei Wen, et al., *Medicaid Expansion Associated With Reductions In Preventable Hospitalizations*, 38 HEALTH AFFAIRS 1845 (2019).

[3] Sameed Khatana et al., *Association of Medicaid Expansion With Cardiovascular Mortality*, 4 JAMA CARDIOLOGY 671 (2019).

[4] J. Hayanga, et al., *Lung transplantation and Affordable Care Act Medicaid expansion in the era of lung allocation score–a retrospective study*, 32 TRANSPLANT INTERNATIONAL 762 (2019).

[5] Shailender Swaminathan, et al., *Association of Medicaid Expansion With 1-Year Mortality Among Patients With End-Stage Renal Disease*, 320 JAMA 2242 (2018).

B. Without the ACA, the government's ability to respond to COVID-19 and other global pandemics would be hobbled

Wholesale invalidation of the ACA would be extremely damaging to public health even in the best of circumstances. With the COVID-19 pandemic threatening communities across the country, the risk to public health is amplified by orders of magnitude. In this way, the pandemic underscores the vital role that the ACA plays in promoting and protecting public health.

1. By reforming America's private health insurance markets and bringing millions of additional Americans onto insurance plans, the ACA created a robust, nationwide health insurance infrastructure. That infrastructure has served as the scaffolding for many of the actions that Congress has taken in response to the COVID-19 pandemic.

Most notably, the ACA set the precedent for the nationwide system of health care financing for universal testing. As discussed above, one of the ACA's key reforms was the requirement that all insurance plans cover for preventive and diagnostic services essential to individual and public health. This requirement enabled Congress to use insurance plans as the vehicle for delivering universal testing coverage to Americans. In the Families First Coronavirus Response Act (FFCRA), Congress required that health insurers provide coverage without cost sharing for COVID-19 testing and assessment-related treatment. Pub. L. No. 116-127, § 6001(a), 134 Stat. 178, 201 (2020). This requirement sweeps broadly, applying to grandfathered health plans that are otherwise exempt from certain ACA coverage mandates. In all, the private insurance plans subject to this testing requirement cover 67.3% of the U.S. population. Edward R. Berchick et al., U.S. Cen-

sus Bureau, *Health Insurance Coverage in the United States: 2018* at 2 (Nov. 2019), perma.cc/H9ZP-ZTSW. The FFCRA also makes testing available without cost sharing for Medicare and Medicaid beneficiaries (§§ 6002-6004, 134 Stat. at 202-207), who account for 34.4% of the population. Berchick et al., *supra*, at 2.[6]

The ACA also provided Congress with a template for extending testing to the uninsured population. Just as the ACA expanded Medicaid to cover previously uninsured people who were ineligible for Medicaid under traditional criteria, the FFCRA gives states the option to expand Medicaid to cover COVID-19 testing for otherwise uninsured individuals. § 6004(a)(3), 134 Stat. at 205-206. Together, these provisions of the FFCRA leverage the near-universal insurance coverage achieved by the ACA to make testing widely available—an essential component of the Nation's pandemic response. Moreover, the ACA's essential health benefits will likely give most Americans coverage without cost-sharing for any COVID-19 vaccine. See 42 U.S.C. 300gg-13(a)(2).

The health insurance exchanges that the ACA created for individuals not covered by employer plans have also proved vitally important in the current crisis. COVID-19 has had a devastating effect on the economy: In April 2020 alone, the unemployment rate skyrocketed from roughly 4% to nearly 15%. U.S. Bureau of Labor Statistics, *Employment Situation Summary* (May 8, 2020), perma.cc/8EE9-MGRG.

"[M]any Americans who lose their jobs during this health and economic crisis could also lose their health

---

[6] Individuals can be covered by both a public and a private plan. In total, 91.5% of Americans currently have some form of health insurance. Berchick et al., *supra*, at 2.

insurance," if it was provided through their former employers. Anuj Gangopadhyaya and Bowen Garrett, Urban Inst., *Unemployment, Health Insurance, and the COVID-19 Recession* 1, Apr. 2020, perma.cc/6LGF-MCS9. In response to that problem, at least eleven States have used their authority over their health insurance exchanges to establish special enrollment periods to help individuals who lose their jobs find new individual health insurance, with the help of the subsidies and tax credits available through the ACA. Margot Sanger-Katz and Reed Abelson, *Eleven States Now Letting Uninsured Sign Up for Obamacare*, N.Y. Times, Apr. 6, 2020, perma.cc/NVH5-2QCT. In States that have adopted it, the ACA's expanded Medicaid program also provides a backstop for workers who lose their jobs and health insurance coverage. In all, studies estimate that in expansion States, the ACA will provide financial assistance to anywhere from 66% to 75% of laid-off workers in the industries most vulnerable to pandemic-related unemployment. See Linda J. Blumberg et al., Urban Inst., *Potential Eligibility for Medicaid, CHIP, and Marketplace Subsidies among Workers Losing Jobs in Industries Vulnerable to High Levels of COVID-19- Related Unemployment* 2 (Apr. 2020), perma.cc/XM44-XA4Z.

These enrollment periods also afford individuals who previously chose not to purchase insurance for 2020 to make a new election and obtain coverage. Blumberg et al., *supra* at 2. Tens of thousands of Americans have already obtained coverage through these special enrollment periods in California alone. See, *e.g.*, Covered Cal., News Release, *Covered California Enrolls Tens of Thousands as Impacts of COVID-19 Pandemic Hits [sic] California Households*, Apr. 14, 2020, perma.cc/GT7X-YE33. Without the infrastructure of the ACA's health exchanges, this expansion of enroll-

ment opportunity for the uninsured would not have been feasible.

2. The ACA's financial investments in public health have also been critical to the response to COVID-19. The ACA strengthened community health centers into a nationwide network capable of putting resources to use quickly, where they are needed most, and those community health centers have been on the front lines of the fight against the pandemic. To assist in these efforts, Congress has taken action to give these centers additional resources: It provided community health centers an additional $100 million in the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. No. 116-123, 134 Stat. 146, 149 (2020)), an additional $1.32 billion in the subsequent CARES Act (Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020)), which also extended the life of the Community Health Center Fund (*id.* § 3831), and $600 million more in the Paycheck Protection Program and Health Care Enhancement Act (Pub. L. No. 116-139, 134 Stat. 620, 626 (2020)). This funding will help community health centers "detect coronavirus; prevent, diagnose, and treat COVID-19; and maintain or increase health capacity and staffing levels to address this public health emergency." Dep't of Health & Human Servs., Press Release, HHS Awards $1.3 Billion to Health Centers in Historic U.S. Response to COVID-19, Apr. 8, 2020, perma.cc/9TKN-Y7C2.

The ACA's establishment of the PPHF was also instrumental in the pandemic response. The PPHF provides more than 12% of the program funding for the Centers for Disease Control and Prevention, the agency at the forefront of the government's efforts to contain the pandemic. See Ctrs. for Disease Control & Prevention, *Accomplishing CDC's Mission with In-*

vestments from Prevention & Public Health Fund, FY 2010-FY 2016, perma.cc/N8P6-TUED. This funding supports a range of CDC activities, including several that are essential in a pandemic, such as immunization programs and grants to states to increase laboratory capacity. *Id.* at 1-2; see also Am. Public Health Ass'n, *Prevention and Public Health Fund* 2, perma.cc/7626-VMN6.

Lastly, the ACA's investment in health care innovation has paid great dividends during the pandemic. In particular, CMMI has funded a number of initiatives in the area of telehealth, and those initiatives have been "generating evidence on telehealth access, cost, and quality." Victoria L. Elliott, Cong. Research Serv., R44437, *Telehealth and Telemedicine: Description and Issues* 14 (2016), perma.cc/NFT6-2SU9. With demand for telehealth services exploding during the pandemic—and likely to remain high even after the COVID-19 outbreak recedes—the resources that the ACA has made available are proving to be critical to public health. See Wall St. J., *The Doctor Will Zoom You Now*, Apr. 26, 2020.

Without the ACA, the country would be grievously ill equipped to address a future pandemic. Congress's legislative toolbox would be emptier. It could not, for example, address a health crisis through insurance regulation as effectively, because fewer Americans would have health insurance, and the ACA exchanges that allow Americans without insurance to obtain coverage would be weakened or even eliminated. Likewise, without the resources provided by the ACA, the CDC, community health centers, and other health care providers would be less equipped to assist in pandemic response.

COVID-19 has made clear that a population-wide means of delivering preventive and diagnostic medical treatment is essential to the health of Americans—and to the health of the American economy. The ACA is the only legislation that fills that important void right now, and it cannot lightly be discarded.

III. WHETHER TO RETAIN A STATUTE LIKE THE ACA, WITH FAR REACHING CONSEQUENCES FOR PUBLIC HEALTH POLICY, IS AN ISSUE FOR THE POLITICAL BRANCHES

Given the daunting magnitude of both immediate and future consequences of eliminating the ACA, the courts should hesitate before holding that the entire statute rises and falls with the constitutionality of the individual mandate.

The ACA, as we have shown, reaches into every corner of the health care system and affects virtually every aspect of federal public health policy. A decision to strike down the entire statute would have immeasurable, unknowable ripple effects throughout the American healthcare system and economy. Millions of Americans would become uninsured and thereby become unable to access health care services that they need, and billions of dollars in funding for public health initiatives would evaporate.

The Court must be mindful of these consequences. As it explained in *King* v. *Burwell*, "the power to make the law rests with those chosen by the people." 135 S. Ct. at 2496. Congress's accountability to the people makes it uniquely qualified to address policy "question[s] of deep economic and political significance" (*id.* at 2489 (internal quotation marks omitted)), such as whether the ACA's numerous insurance and public health reforms should remain in place.

To be sure, courts retain the responsibility to "say what the law is" and to invalidate legislation that violates the Constitution. *King*, 135 S. Ct. at 2496 (quoting *Marbury* v. *Madison*, 5 U.S. (1 Cranch) 137, 177 (1803)). But in discharging that responsibility, courts must strive "not to nullify more of a legislature's work than is necessary," lest they "'frustrate[] the intent of the elected representatives of the people.'" *Ayotte* v. *Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006) (quoting *Regan* v. *Time, Inc.*, 468 U.S. 641, 652 (1984)). That is especially true here, where the consequences of striking down the entire statute would be profound and sweeping.

The question whether to eliminate the entire ACA, with all the disruption to insurance markets and all the harm to public health it would entail, "is a matter of high policy for resolution within the legislative process after the kind of investigation, examination, and study that legislative bodies can provide and courts cannot." *Diamond* v. *Chakrabarty*, 447 U.S. 303, 317 (1980). The Court should therefore leave the decision whether to repeal the ACA to Congress and not assume responsibility for setting health care policy for the Nation.

CONCLUSION

The Court should hold that the individual mandate, if unlawful, is severable.

Respectfully submitted.

H. GUY COLLIER
MICHAEL B. KIMBERLY
Counsel of Record
MATTHEW A. WARING
McDermott Will & Emery LLP
500 North Capitol St. NW
Washington, DC 20001
(202) 756-8000
mkimberly@mwe.com

Counsel for Amici Curiae

APPENDIX

APPENDIX

Amici curiae, whose affiliations are listed for identification purposes only, are as follows.

Organizations

- **American Public Health Association**
- **American Academy of Nursing**

Deans

- **Adnan A. Hyder**, MD, MPH, PhD, Senior Associate Dean for Research, Professor of Global Health, Milken Institute School of Public Health, The George Washington University
- **Audrey Lyndon**, PhD, RNC, FAAN, Professor of Nursing and Medicine, Assistant Dean for Clinical Research, NYU Rory Meyers College of Nursing
- **Barbara K. Rimer**, DrPH, MPH, Dean and Alumni Distinguished Professor, UNC Gillings School of Global Public Health
- **Bess Marcus**, PhD, Dean, Brown University School of Public Health
- **Craig H. Blakely**, PhD, MPH, Professor and Dean, School of Public Health and Information Sciences, University of Louisville
- **Donna M. Nickitas**, PhD, RN, NEA-BC, FNAP, FAAN, Dean and Professor, Rutgers School of Nursing – Camden
- **Edith A. Parker**, DrPH, Dean and Professor of Community and Behavioral Health, University of Iowa College of Public Health
- **Elizabeth Cohn**, PhD, RN, Rudin Professor of Nursing, Associate Dean for Research, Director,

Center for Nursing Research, Hunter-Bellevue School of Nursing

- **Eric A. Feldman**, JD, PhD, Heimbold Professor of International Law, Deputy Dean for International Programs, Professor of Medical Ethics and Health Policy, University of Pennsylvania Law School
- **James G. Gurney**, PhD, Dean, Hardin Endowed Professor of Public Health, Professor of Epidemiology, University of Memphis School of Public Health
- **Jane Hyatt Thorpe**, JD, Sr. Associate Dean for Academic, Student & Faculty Affairs, Professor of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Jane Kim**, PhD, Dean for Academic Affairs, Professor of Health Decision Science, Department of Health Policy and Management, Harvard T.H. Chan School of Public Health
- **Jean Wactawski-Wende**, PhD, Dean, School of Public Health and Health Professions, SUNY Distinguished Professor, University at Buffalo
- **Jill R. Horwitz**, PhD, JD, MPP, Vice Dean for Faculty and Intellectual Life and Professor of Law, UCLA School of Law, Professor of Public Affairs, UCLA Luskin School of Public Affairs
- **Laura A. Siminoff**, PhD, Dean, Laura H. Carnell Professor of Public Health, Temple University College of Public Health
- **Linda D. Scott**, PhD, RN, NEA-BC, FAAN, Dean and Professor, School of Nursing, University of Wisconsin-Madison
- **Lisa de Saxe Zerden**, MSW, PhD, Senior Associate Dean for MSW Education, John A. Tate Early Ca-

reer Scholar for Children in Need, UNC Chapel Hill School of Social Work

- **Lorien Abroms**, ScD, Professor, Associate Dean for PhD/MS Studies, Director, MPH in Public Health Communication & Marketing, Milken Institute School of Public Health, The George Washington University
- **Lynn R. Goldman**, MD, MS, MPH, Michael and Lori Milken Dean, Milken Institute School of Public Health, Professor of Environmental and Occupational Health, The George Washington University
- **Mark L. Williams**, PhD, Joycelyn Elders Professor & Dean, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences
- **Michael C. Lu**, MD, MS, MPH, Dean, University of California, Berkeley School of Public Health
- **Michael G. Perri**, PhD, ABPP, Dean, College of Public Health and Health Professions, The Robert G. Frank Endowed Professor of Clinical and Health, Psychology, University of Florida
- **Mimi V. Chapman**, PhD, Associate Dean for Doctoral Education, Professor, UNC at Chapel Hill School of Social Work
- **Paula Lantz**, PhD, Associate Dean for Academic Affairs, James B. Hudak Professor of Health Policy, Professor of Public Policy, Gerald R. Ford School of Public Policy, Professor of Health Management and Policy, School of Public Health, University of Michigan
- **Susan Ettner**, PhD, Professor, Division of General Internal Medicine and Health Services Research, UCLA Department of Medicine, Professor, Department of Health Policy and Management, Field-

ing UCLA School of Public Health, Associate Dean, UCLA Graduate Division

- **Susan W. Salmond**, RN, EdD, ANEF, FAAN, Executive Vice Dean & Professor, Rutgers University School of Nursing
- **Susan Weber Buchholz**, PhD, RN, FAANP, FAAN, Professor, Acting Chairperson, Adult Health and Gerontological Nursing, Rush University College of Nursing
- **Thomas A. LaVeist**, PhD, Dean & Weatherhead Presidential Chair, School of Public Health & Tropical Medicine, Tulane University
- **Thomas E. Burroughs**, PhD, MS, MA, Dean and Professor, SLU College for Public Health and Social Justice, Saint Louis University

Departmental Chairs

- **Aaron B. Caughey**, MD, MPH, PhD, Professor and Chair, Department of Obstetrics & Gynecology, Associate Dean for Women's Health Research & Policy, Oregon Health & Science University
- **Alan G. Wasserman**, MD, Eugene Meyer Professor of Medicine, Chair, Department of Medicine, President, Medical Faculty Associates, The George Washington University
- **Amanda S. Birnbaum**, PhD, MPH, Professor and Chair, Department of Public Health, Montclair State University
- **Anne R. Pebley**, PhD, Distinguished Professor and Fred H. Bixby Chair, Chair, Bixby Center on Population and Reproductive Health, UCLA Fielding School of Public Health
- **Claire D. Brindis**, DrPH, Caldwell B. Eselystyn Chair in Health Policy, Director, Philip R. Lee, In-

stitute for Health Policy Studies, Distinguished Professor of Pediatrics, Division of Adolescent and Young Adult Health and Department of Obstetrics, Gynecology, and Reproductive Health Sciences, University of California, San Francisco

- **Donald Moynihan**, PhD, McCourt Chair of Public Policy, Georgetown University McCourt School of Public Policy
- **Elizabeth J. Mayer-Davis**, PhD, Cary C. Boshamer Distinguished Professor of Nutrition and Medicine, Chair, Department of Nutrition, UNC Chapel Hill Gillings School of Global Public Health and School of Medicine
- **Gary L. Simon**, MD, PhD, MACP, Walter G. Ross Professor of Clinical Science, Director, Division of Infectious Diseases, Vice Chairman, Department of Medicine, The George Washington University SOM and HS
- **Jack Needleman**, PhD, FAAN, Fred W. and Pamela K. Wasserman Professor, Chair, Department of Health Policy and Management, UCLA Fielding School of Public Health
- **James M. Tielsch**, PhD, Professor and Chair, Department of Global Health, Milken Institute School of Public Health, The George Washington University
- **J. Zoe Beckerman**, JD, MPH, Teaching Professor Interim Vice Chair, Health Policy and Management, Practicum Director, MPH@GW, Academic Program Director, Geiger Gibson Program in Community Health Policy, Milken Institute School of Public Health, The George Washington University

- **Jonathan Oberlander**, PhD, Professor and Chair, Department of Social Medicine, Professor, Department of Health Policy & Management, University of North Carolina at Chapel Hill
- **Laury Oaks**, PhD, Professor and Chair, Department of Feminist Studies, University of California, Santa Barbara
- **Manya Magnus**, PhD, MPH, Professor and Associate Chair, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University
- **Michael W. Neft**, DNP, MHA, RN, CRNA, FNAP, FAAN, LTC, US Army, ret., Associate Professor and Vice Chair, Department of Nurse Anesthesia, Assistant Director, Nurse Anesthesia Program, Clinical Education Coordinator, MSN-DNP Coordinator, University of Pittsburgh School of Nursing
- **Morris Weinberger**, PhD, Vergil N. Slee Distinguished Professor of Healthcare Quality Management, Chair, Department of Health Policy and Management, UNC Gillings School of Global Public Health
- **Rebecca Slifkin**, PhD, Professor and Associate Chair, Health Policy and Management, UNC Gillings School of Public Health

Public Health Scholars

- **Abbey Hardy-Fairbanks**, MD, FACOG, Associate Clinical Professor, Department of Obstetrics and Gynecology, University of Iowa Health Care
- **Aileen Gariepy**, MD, MPH, MS, Associate Professor, Section of Family Planning, Director, Yale Fellowship in Family Planning, Department of Obstetrics, Gynecology, and Reproductive Sciences, Yale School of Medicine

- **Alan B. Cohen**, ScD, Research Professor, Markets, Public Policy, and Law, Boston University Questrom School of Business
- **Allison Squires**, PhD, RN, FAAN, Associate Professor of Nursing, Rory Meyers College of Nursing, Research Associate Professor of Medicine, Grossman School of Medicine, New York University
- **Alson Burke**, MD, Assistant Professor, UEW Medicine Department of Obstetrics & Gynecology
- **Andrea Kalfoglou**, PhD, Associate Professor, Health Administration and Policy Program, Department of Sociology, Anthropology, & Health Admin and Policy, University of Maryland Baltimore County
- **Antwan Jones**, PhD, Associate Professor of Sociology, Department of Epidemiology, The George Washington University
- **Anushree Vichare**, MBBS, MPH, PhD, Assistant Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Anu Manchikanti Gomez**, PhD, Associate Professor, School of Social Welfare, Director, Sexual Health and Reproductive Equity Program, University of California, Berkley
- **Barbara Shaw**, DNP, APRN, FNP-BC, Assistant Professor, Department of Community, Systems & Mental Health Nursing, College of Nursing, Rush University
- **Benjamin Mason Meier**, JD, LLM, PhD, Associate Professor of Global Health Policy, Department of Public Policy, University of North Carolina at Chapel Hill

- **Benjamin D. Sommers**, MD, PhD, Professor of Health Policy & Economics, Harvard T.H. Chan School of Public Health, Brigham & Women's Hospital
- **Bernadette Dunham**, DVM, PhD, Professorial Lecturer, Environment and Occupational Health, Milken Institute School of Public Health, The George Washington University
- **Beth Bolick**, DNP, APRN, PPCNP-BC, CPNP-AC, FAAN, Professor and Director Acute Care Pediatric Nurse Practitioner Program, Department of Women, Children, and Family Nursing, Rush University College of Nursing
- **Beth Doyle**, DNP, RN, WHCNP, ANP, GCPH, Assistant Professor of Clinical Nursing, Oregon Health & Science University
- **Beverly Winikoff**, MD, MPH, President Gynuity Health Projects and Professor of Clinical Population and Family Health, Mailman School of Public Health, Columbia University
- **Bruce J. Fried**, PhD, Associate Professor, Department of Health Policy & Management, University of North Carolina at Chapel Hill
- **Bruce E. Landon**, MD, MBA, MSc, Professor of Health Care Policy, Harvard Medical School, Professor of Medicine, Beth Israel Deaconess Medical Center
- **Carl Theodore Ficken**, PhD, CPHQ, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Carlos E. Rodriguez-Diaz**, PhD, MPHE, MCHES, Associate Professor, Director, Community-Oriented Primary Care Program, Department of

Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

- **Carol M. Mangione**, MD, Professor of Medicine and Public Health, Department of Medicine, David Geffen School of Medicine at UCLA, Department of Health Policy and Management, UCLA Fielding School of Public Health
- **Carole Joffe**, PhD, Professor of Obstetrics, Gynecology and Reproductive Sciences, University of California San Francisco
- **Carrie Cwiak**, MD, MPH, Professor, Chief, Obstetrics and Gynecology Inpatient Service Line, Department of Gynecology and Obstetrics, Emory University School of Medicine
- **Catherine A. Chesla**, RN, PhD, FAAN, Professor Emeritus, Family Health Care Nursing, University of California, San Francisco
- **Chandra L. Ford**, PhD, MPH, MLIS, Associate Professor, Department of Community Health Sciences, Founding Director, Center for the Study of Racism, Social Justice & Health, Jonathan & Karin Fielding School of Public Health, UCLA
- **Christopher N. Mores**, SM, ScD, Director, BSL-3 Containment Facility, Milken Institute School of Public Health, The George Washington University
- **Constance A. Nathanson**, PhD, Professor, Departments of Sociomedical Sciences and Population and Family Health, Mailman School of Public Health, Columbia University
- **Cynthia C. Harper**, PhD, Professor, Obstetrics, Gynecology & Reproductive Services, Director, UCSF-Kaiser Permanente Building Interdisciplinary Research, Careers in Women's Health

(BIRCWH) Program, University of California, San Francisco

- **C.W. Burton**, PhD, RN, AFN-BC, AGN-BC, FNAP, Assistant Professor, Sue & Bill Gross School of Nursing, UCI
- **Daniel C. Ehlke**, PhD, Associate Professor, Department of Health Policy and Management, SUNY Health Sciences University
- **Daniel Grossman**, MD, FACOG, Professor, Department of Obstetrics, Gynecology & Reproductive Science, Director, Advancing New Standards in Reproductive Health (AMSIRH), Bixby Center for Global Reproductive Health, University of California, San Francisco
- **David M. Frankford**, JD, Professor of Law, Rutgers University School of Law
- **David M. Huebner**, PhD, MPH, Associate Professor, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University
- **David M. Keepnews**, PhD, JD, RN, NEA-BC-FAAN, ANEF, Professor and Director, DNP Health Policy option and Certificate Program in Health Policy & Media Management, The George Washington University School of Nursing
- **David Jones**, PhD, Associate Professor, Department of Health Law, Policy and Management, Boston University School of Public Health
- **David Michaels**, PhD, MPH, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, The George Washington University
- **David Vlahov**, PhD, RN, Professor of Nursing, Yale School of Nursing

- **Debora Goetz Goldberg**, PhD, MHA, MBA, Associate Professor, Department of Health Administration and Policy, George Mason University
- **Deborah Dean**, MD, MPH, FAAM, Director, Children's Global Health Initiative, Professor of Medicine, Pediatrics and Global Health, UCSF School of Medicine, Affiliate Faculty, the UC Berkeley – the UCSF Graduate Program in Bioengineering, UCSF
- **Diana J. Mason**, PhD, RN, FAAN, Senior Policy Service Professor, The George Washington University School of Nursing, Professor Emerita, Hunter College, City University of New York
- **Diana Taylor**, PhD, RNP, FAAN, Professor of Emerita, School of Nursing, University of California, San Francisco
- **Dominika Seidman**, MD, MAS, Assistant Professor, University of California San Francisco
- **Donald H. Taylor, Jr.**, PhD, Professor of Public Policy, Sanford School of Public Policy, Director, Social Science Research Institute, Duke University
- **Donald M. Berwick**, MD, MPP, Lecturer, Department of Health Care Policy, Harvard Medical School
- **Donna L. Schminkey**, PhD, MPH, MSN, CNM, RN, Assistant Professor, Department of Nursing, College of Health and Behavioral Studies, James Madison University
- **Dora L. Hughes**, MD, MPH, Associate Research Professor, Department of Health Policy and Management, The George Washington University
- **Eileen Boris**, PhD, MA, Hull Professor and Distinguished Professor of Feminist Studies, Professor of History, Black Studies, and Global Studies, University of California, Santa Barbara

- **Eleanor Bimla Schwarz**, MD, MS, Professor of Medicine, University of California, Davis
- **Eliot Sorel**, MD, Chair, Access to Care Committee of the American Psychiatric Association, Clinical Professor of Global Health, Department of Health Policy and Management, Milken Institute School of Public Health, Professor of Psychiatry & Behavioral Sciences, School of Medicine, The George Washington University
- **Elizabeth Dickson**, PhD, RN, Assistant Professor, University of New Mexico, College of Nursing, College of Population Health, Center for Participatory Research Emily R. Smith, ScD, MPH, Assistant Professor, Departments of Global Health and of Exercise and Nutrition Sciences, Milken Institute School of Public Health, The George Washington University
- **Elizabeth B. Erbaugh**, MA, MA, PhD, Assistant Professor of Sociology, Stockton University
- **Emmeline Chuang**, PhD, Associate Professor of Health Policy and Management, UCLA Fielding School of Public Health
- **Eugenia Eng**, DrPH, MPH, Professor of Health Behavior, University of North Carolina at Chapel Hill Gillings School of Public Health
- **Eve Rittenberg**, MD, Primary Care Physician, Brigham and Women's Hospital, Assistant Professor, Harvard Medical School
- **George H. Pink**, PhD, Humana Distinguished Professor, Department of Health Policy and Management, UNC Chapel Hill
- **Gerald F. Kominski**, PhD, Professor of Health Policy and Management, UCLA

- **Heidi L. Allen**, PhD, Associate Professor, Columbia University School of Social Work
- **Herman Gibb**, PhD, Professorial Lecturer, Milken Institute School of Public Health, The George Washington University
- **Ifeyinwa V. Asiodu**, PhD, RN, IBCLC, Assistant Professor, UCSF School of Nursing
- **Jamila K. Stockman**, PhD, MPH, Vice Chief, Global Public Health Section, Associate Professor, Director, CFAR Disparities Care, Division of Infectious Diseases & Global Public Health, Department of Medicine, University of California, San Diego
- **Janet Heinrich**, DrPH, RN, FAAN, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Janice Bowie**, PhD, MPH, Professor, Director, Schoolwide DrPH Program, Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health
- **Jeffrey Levi**, PhD, Professor of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Jennifer Cooper**, DNP, RN, PHNA-BC, CNE, Assistant Professor of Nursing, Department of Nursing, Hood College
- **Jennifer Muz**, PhD, Assistant Professor, Department of Global Health, Milken Institute School of Public Health, The George Washington University
- **Jennifer Rousseau**, DNP, WHNP, Assistant Professor/Nurse Practitioner, Rush University College of Nursing

- **Jennifer Tang**, MD, MSCR, Associate Professor, UNC School of Medicine
- **Jennifer Templeton Dunn**, JD, Assistant Professor, Family Health Care Nursing, UCSF School of Nursing
- **Jillian Catalanotti**, MD, MPH, FACP, Associate Professor of Medicine, Associate Professor of Health Policy and Management, Director, Internal Medicine Residency Programs, The George Washington University
- **Joan Alker**, M.Phil, Research Professor, McCourt School of Public Policy, Georgetown University
- **Joanne Spetz**, PhD, Professor, Philip R. Lee Institute for Health Policy Studies, UCSF
- **Jonah Fleisher**, MD, MPH, Assistant Professor of Clinical Obstetrics and Gynecology, Department of Obstetrics and Gynecology, University of Illinois Chicago, College of Medicine
- **Joel Teitelbaum**, JD, LLM, Associate Professor and Director of the Hirsh Health Law and Policy Program, Department of Health Policy and Management, The George Washington University
- **Jon Kingsdale**, PhD, Associate Professor of the Practice, Health Law, Policy & Management, Boston University School of Public Health
- **Julia R. Steinberg**, PhD, Assistant Professor, Department of Family Science, School of Public Health, University of Maryland, College Park
- **Justin G. Trogdon**, PhD, Professor, Department of Health Policy and Management, Gillings School of Global Public Health, UNC at Chapel Hill
- **K. John McConnell**, PhD, Director, Center for Health Systems Effectiveness, Professor, Depart-

ment of Emergency Medicine, Oregon Health & Science University

- **Katherine Horton**, RN, MPH, JD, Research Professor in the Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Katrina Kimport**, PhD, Associate Professor, Department of Obstetrics, Gynecology & Reproductive Services, UCSF
- **Karen Meckstroth**, MD, MPH, Clinical Professor, UCSF, Director, Women's Options Center, Gyn Medical Director, Women's Community Clinic, Department of Obstetrics, Gynecology and Repro. Sci, UCSF & Zuckerberg San Francisco General
- **Kair White**, PhD, MPH, Associate Professor, Steve Hicks School of Social Work & Department of Sociology, University of Texas at Austin
- **Karin B. Yeatts**, PhD, Associate Professor, Department of Epidemiology, UNC Gillings School of Global Public Health
- **Kelly Karas-Hedrick**, DNP-FNP-BC, MSN, RN, Clinical Nurse Instructor and Lecturer, Rush University Medical Center, College of Nursing
- **Kelsey Holt**, ScD, Assistant Director, Person-Centered Reproductive Health Program, Assistant Professor, Department of Family & Community Medicine, University of California, San Francisco
- **Kerry W. Tripp**, JD, Director of Undergraduate Program & Senior Lecturer, Department of Family Science, School of Public Health, University of Maryland College Park
- **Kevin Kjell Olsen**, PhD, Adjunct Professor of Public Health, Montclair State University

- **Kevin Roy**, PhD, Associate Professor, Department of Family Science, School of Public Health, University of Maryland, College Park
- **Kirsten Warner**, MSN, APRN, AGCNS-BC, CNEcl, CNL, CMRSN, Instructor, Adult Health Nursing, Nursing Learning Lab, College of Nursing, Rush University
- **Krista M. Perreira**, PhD, Department of Social Medicine, UNC School of Medicine
- **Laura Mamo**, PhD, Professor, Health Equity Institute, San Francisco State University
- **Leonard H. Friedman**, PhD, MPH, FACHE, Professor and Director, MHA@GW Program, Milken Institute School of Public Health, The George Washington University
- **Linda James**, MSc, RN, Clinical Assistant Professor, School of Nursing, College of Health Sciences, Sam Houston State University
- **Lisa Bowleg**, MA, PhD, Professor of Applied Social Psychology, Department of Psychology, Director, Social and Behavioral Science Core, DC Center for AIDS Research, Founding Director, Intersectionality Training Institute, The George Washington University
- **Lisa Cacari Stone**, PhD, MS, MA, Associate Professor of Health & Social Policy, Department of Family & Community Medicine, College of Population Health, University of New Mexico
- **Lisa Liberman**, PhD, Professor, Department of Public Health, Montclair State University
- **Lois Lee**, MD, MPH, Senior Associate in Medicine, Division of Emergency Medicine, Boston Children's Hospital, Associate Professor of Pediatrics and Emergency Medicine, Harvard Medical School

- **Lois McCloskey**, DrPH, MPH, Associate Professor, Director, Center for Excellence in Maternal and Child Health Education, Science and Practice, Department of Community Health Sciences, Boston University School of Public Health
- **Lorie S. Goshin**, PhD, RN, Associate Professor, Hunter-Bellevue School of Nursing
- **Madga G. Peck**, ScD, Adjunct Professor of Pediatrics and Public Health, University of Nebraska Medical Center, Founding Dean, University of Wisconsin – Milwaukee Zilber School of Public Health
- **Marcos Perez-Losada**, PhD, Assistant Professor, Computational Biology Institute, Department of Biostatistics and Bioinformatics, Milken Institute School of Public Health, The George Washington University
- **Margarita Alegria**, PhD, Professor, Departments of Medicine & Psychiatry, Harvard Medical School, Chief, Disparities Research Unit, Department of Medicine, Massachusetts General Hospital
- **Margaret Wallhagen**, PhD, CNP-BC, ACSF, FGSA, FAAN, Professor, Department of Physiological Nursing, Director, UCSF Hartford Center of Gerontological Nursing Excellence, UCSF School of Nursing
- **Marisa Elena Domino**, PhD, Professor, Department of Health Policy & Management and The Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill
- **Mark A. Peterson**, PhD, Professor of Public Policy, Political Science, and Law, Department of Public Policy, UCLA Meyer and Renee Luskin School of Public Affairs

- **Mark Edberg**, PhD, MA, Associate Professor, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University
- **Marla E. Salmon**, ScD, RN, FAAN, Professor, Nursing and Global Health, Adjunct Professor, Public Policy and Governance, University of Washington
- **Marsha Lillie-Blanton**, DrPH, Associate Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Marsha Regenstein**, PhD, Professor in the Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Mary Hunter**, RN, PhD, Assistant Professor, Department of Psychological Nursing, University of California, San Francisco
- **Maureen Byrnes**, MPA, Lead Research Scientist/Lecturer, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Maya Manian**, JD, PhD(c), Visiting Professor, Howard University School of Law
- **Megan B. Cole**, PhD, MPH, Assistant Professor, Department of Health Law, Policy & Management, Boston University School of Public Health
- **Melissa M. Goldstein**, JD, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Melissa McCarthy**, ScD, Professor, Department of Health Policy and Management & Emergency

Medicine, Milken Institute School of Public Health, The George Washington University

- **Meredith Minkler**, DrPH, MPH, Professor Emerita/Professor in the Graduate Group, Community Health Sciences, UC Berkeley School of Public Health
- **Merlin Chowkwanyun**, PhD, MPH, Donald H. Gemson Assistant Professor, Sociomedical Sciences, Mailman School of Public Health, Columbia University
- **Michael K. Gusmano**, PhD, Associate Professor of Health Policy, Rutgers, The State University of New Jersey
- **Mimi Ghosh**, PhD, MS, Associate Professor, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University
- **Monica R. McLemore**, RN, MPH, PhD, FAAN, Associate Professor, Family Health Care Nursing Department, Clinician-Scientist, ANSIRH, Affiliated Faculty, Center for Vulnerable Populations, UCSF
- **Nadereh Pourat**, PhD, Professor, Department of Health Policy and Management, UCLA Fielding School of Public Health, Professor, UCLA School of Dentistry, Associate Director, UCLA Center for Health Policy Research, Director of Health Economics and Evaluation Research Program
- **Nancy L. Keating**, MD, MPH, Professor of Health Care Policy and Medicine, Harvard Medical School
- **Nancy Krieger**, PhD, Professor of Social Epidemiology, American Cancer Society Clinical Research Professor, Department of Social and Behavioral

Sciences, Harvard T.H. Chan School of Public Health

- **Neal Halfon**, MD, MPH, Professor of Pediatrics, Public Health and Public Policy, Director, UCLA Center for Healthier Children, Families & Communities, UCLA
- **Nina Wallerstein**, DrPH, Professor, Public Health, Director, Center for Participatory Research, College of Population Health, University of New Mexico
- **Ninez A. Ponce**, MPP, PhD, Professor, Department of Health Policy and Management, Director, UCLA Center for Health Policy Research, UCLA Fielding School of Public Health
- **Olga Acosta Price**, PhD, Associate Professor, Department of Prevent & Community Health, Milken Institute School of Public Health, The George Washington University
- **Pam Silberman**, JD, DrPH, Professor, Director, Executive Doctoral Program in Health Leadership, Department of Health Policy and Management, UNC Gillings School of Global Public Health
- **Pamela Herd**, PhD, Professor of Public Policy, Georgetown University
- **Pamela Murnane**, PhD, MPH, Assistant Professor, Department of Epidemiology and Biostatistics, University of California, San Francisco
- **Paul Lanier**, PhD, Associate Professor, School of Social Work, Kuralt Early Career Distinguished Professor, UNC Chapel Hill School of Social Work
- **Paul Ndebele**, PhD, Professorial Lecturer, Department of Global Health, Milken Institute School of Public Health, The George Washington University

- **Paul R. Shafer**, PhD, Assistant Professor, Department of Health Law, Policy and Management, Boston University School of Public Health
- **Paula Tavrow**, PhD, Associate Adjunct Professor, Department of Community Health Sciences, Fielding School of Public Health, University of California at Los Angeles
- **Peter LaPuma**, PhD, CIH, PE, Associate Professor, Department of Environmental & Occupational Health, The George Washington University
- **Peter Shin**, PhD, MPH, Associate Professor, Department of Health Policy and Management, The George Washington University
- **Philip Rocco**, PhD, Assistant Professor of Political Science, Marquette University
- **Rachel Bender Ignacio**, MD, MPH, Assistant Professor, Assistant Professor, Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington
- **Rachel K. Walker**, PhD, RN, Associate Professor & PhD Program Director, Associate Director, IALS Center for Health & Human Performance, College of Nursing, University of Massachusetts Amherst
- **Rand E. Rosenblatt**, JD, Professor Emeritus of Law, Rutgers University School of Law
- **Randy Goldberg**, MD, MPH, FACP, Assistant Professor of Clinical Medicine, Chair, WMC Ethics Committee, Chair, WMC Health Information Management Committee, New York Medical College
- **Rebecca Berman**, MD, FACP, Internal Medicine Residency Program Director, Associate Professor of Medicine, University of California, San Francisco

- **Rebecca Tyrrell Parkin**, PhD, MPH, Professional Lecturer, Department of Environmental and Occupational Health and of Epidemiology, Milken Institute School of Public, The George Washington University
- **Richard Riegelman**, MD, MPH, PhD, Professor of Epidemiology and Founding Dean, Milken Institute School of Public, The George Washington University
- **Robert W. Blum**, MD, MPH, PhD, Professor and Immediate Past William H Gates Sr. Chair, Department of Population, Family and Reproductive Health, Bloomberg School of Public Health, Johns Hopkins University
- **Robert I. Bonar, Jr.**, MA, MHA, DrHA, Professor and MHA Program Director, Milken Institute School of Public Health, The George Washington University
- **Robert G. Frank**, PhD, Professor, Population Health, Family and Community Medicine, & Psychology, University of New Mexico
- **Roxanne M. Landis**, JD, MPH, Assistant Director of Policy, Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco
- **Ruth E. Malone**, RN, PhD, Professor Emerita (recalled), Department of Social and Behavioral Science, School of Nursing, University of California, San Francisco
- **Sally Clark Stearns**, PhD, Professor, Department of Health Policy and Management, The University of North Carolina at Chapel Hill

- **Samuel J. Simmens**, PhD, Research Professor of Biostatistics and Bioinformatics, Milken Institute School of Public Health, The George Washington University
- **Sandra B. Greene**, DrPH, Professor, Health Policy and Management, UNC Gillings School of Global Public Health
- **Sara Rosenbaum**, JD, Harold and Jane Hirsh Professor of Health Law and Policy, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
- **Sarah Verbiest**, DrPH, MSW, MPH, Director, Jordan Institute for Families, UNC School of Social Work, Executive Director, Center for Maternal and Infant Health, UNC School of Medicine
- **Scott Evans**, PhD, Professor and Founding Chair, Department of Biostatistics and Bioinformatics, Director, Biostatistics Center, Milken Institute School of Public Health, The George Washington University
- **Shawn M. Kneipp**, PhD, RN, ANP, PHNA-BC, FAANP, Associate Professor, School of Nursing, Adjunct Associate Professor, UNC-CH Gillings School of Public Health, Chair, Public Health Nursing Section, American Public Health Association
- **Sheryl Zimmerman**, PhD, University Kenan Distinguished Professor, Co-Director, Program on Aging, Disability, and Long-Term Care, Cecil G. Sheps Center for Health Services Research, Director of Aging Research, School of Social Work, UNC Chapel Hill

- **Sidney D. Watson**, JD, Jane and Bruce Robert Professor of Law, Center for Health Law Studies, Saint Louis University School of Law
- **Steven D. Pizer**, PhD, Professor of Health Law, Policy & Management, Director, Doctoral Program in Health Services Research, Boston University School of Public Health
- **Steven P. Wallace**, PhD, Professor, Department of Community Health Sciences, Associate Director, UCLA Center for Health Policy Research, UCLA Fielding School of Public Health
- **Sonda Oppewal**, PhD, RN, Clinical Professor, UNC at Chapel Hill School of Nursing
- **Susan Helm-Murtagh**, DrPH, MM, Assistant Professor, Department of Health Policy & Management, UNC Chapel Hill Gillings School of Global Public Health
- **Susan M. Swider**, PhD, PHNA-BC, FAAN, Professor, Department of Community, Systems and Mental Health Nursing, Rush University
- **Suzanne Held**, PhD, Professor, Department of Health and Human Development, Montana State University
- **Sylvia A. Law**, JD, Elizabeth K. Dollard Professor of Law, Medicine, and Psychiatry Emerita, NYU Law School
- **Therese McGinn**, DrPH, Professor Emerita of Population and Family Health, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University
- **Thomas Rice**, PhD, Professor, UCLA Fielding School of Public Health

- **Thomas C. Ricketts**, PhD, MPH, Professor, University of North Carolina at Chapel Hill Gillings School of Global Public Health
- **Timothy M. Westmoreland**, JD, Professor from Practice, Georgetown University School of Law
- **Uriyoán Colón-Ramos**, ScD, MPA, Associate Professor of Nutrition & Global Health, Department of Exercise & Nutrition Sciences, Milken Institute School of Public Health, The George Washington University
- **W. Douglas Evans**, PhD, Professor of Prevention and Community Health & Global Health, Milken Institute School of Public Health, The George Washington University
- **Wendy K. Mariner**, JD, LLM, MPH, Edward R. Utley Professor of Health Law, Boston University School of Public Health, Professor of Law, Boston University School of Law, Professor of Medicine, Boston University School of Medicine
- **Wendy E. Parmet**, JD, Matthews Distinguished University Professor of Law and Director, Center for Health Policy and Law, Professor of Public Policy and Urban Affairs, Northeastern University School of Public Policy and Urban Affairs
- **William H. Dietz**, MD, PhD, Sumner M. Redstone Center Chair, Professor, Department of Prevention and Community Health, The George Washington University
- **Y. Tony Yang**, ScD, LLM, MPH, Professor and Executive Director, Center for Health Policy and Media Engagement, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University