No. 11-398

IN THE
Supreme Court of the United States

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners,

v.

STATE OF FLORIDA, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF 104 HEALTH LAW PROFESSORS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

(Minimum Coverage Provision)

GREGORY G. RAPAWY
KELLOGG, HUBER, HANSEN, TODD, EVANS & FIGEL, P.L.L.C.
1615 M Street, N.W.
Suite 400
Washington, D.C. 20036
(202) 326-7900

CHARLES FRIED
Counsel of Record
1563 Massachusetts Avenue
Cambridge, MA 02138
(617) 495-4636
(fried@law.harvard.edu)

ABBE R. GLUCK
435 West 116th Street
New York, NY 10027
(212) 854-0679

January 13, 2012

TABLE OF CONTENTS

TABLE OF AUTHORITIES

ADMINISTRATIVE MATERIALS

OTHER MATERIALS

INTEREST OF *AMICI CURIAE*[1]

Amici are 104 professors of law who teach in schools of law, medicine, public health, and management.[2] They specialize in the field of health law and are familiar with the organization, financing, and delivery of health care. They are a diverse group and include some who generally favor market-based and some who generally favor government solutions to health policy issues. The Patient Protection and Affordable Care Act ("PPACA") is a major development in the field of health law; *amici* have spent much of their careers analyzing the health care field and the policy problems addressed by PPACA. *Amici* have a professional interest in the Court's disposition of the challenges to PPACA presented in this case – and, in particular, feel strongly that the Court should reach its conclusion based on accurate information about the market for health care and the role that health insurance plays in that market.

Amici are not generally professors of constitutional law, although some also study and teach constitutional issues. The purpose of this brief is therefore not to add to the many pages of doctrinal argument before this Court. Instead, it is to document facts about health care that should inform the Court's

---

[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that, in consultation with *amici*, they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amici* or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Counsel for *amici* also represent that all parties have consented to the filing of this brief. Counsel for petitioners and respondents have filed letters with the Clerk granting blanket consent to the filing of *amicus* briefs.

[2] A full list of *amici*, including their institutional affiliations, is set forth in the Appendix to this brief.

deliberation. *Amici* believe that their perspective supports the position of the Solicitor General that, "[b]ecause of human susceptibility to disease and accident, we are all potentially never more than an instant from the 'point of consumption' of health care (Pet. App. 118a), yet it is impossible to predict which of us will need it during any period of time." U.S. Br. 43 (No. 11-398). *Amici* have therefore filed this brief in support of the United States and the constitutionality of PPACA.

INTRODUCTION AND SUMMARY

I. The market for health care in the United States operates on a national level. It is a very large part of the economy – in 2010, 17.9% of national gross domestic product ("GDP"). Almost everyone in the United States uses health care on a regular or semi-regular basis throughout their lives. Only 3.1% of Americans go longer than 5 years without seeing a health professional, and only 1% never see one in their lives. In any given year, however, the majority of health care costs go towards treating a minority of the population – those who become seriously ill or gravely injured. It is not possible to predict in advance who will fall into that category in any given year, and, when injury or illness does strike, it is very difficult for the affected individuals to estimate or control the costs of their care. The average bill for a hospitalization of an uninsured patient has recently been estimated at $22,200. That far exceeds the savings of the typical uninsured patient or family.

Nevertheless, the fact that uninsured individuals can rarely pay for urgently needed care seldom prevents them from receiving it. On the contrary, medical ethics, federal law, state law, and simple human nature all push (and sometimes require)

hospitals and physicians to provide lifesaving care without regard to ability to pay. American health policy therefore takes as a starting point that people in need *will* receive care – which is to say, they will participate in the market for health services. The hard question is how best to pay the resulting, unavoidable costs.

No other part of the national economy, and certainly none remotely as large, has features that resemble the market for health care. Virtually every person in society during a given period will enter one or more segments of that market – for hospital care, outpatient care, prescription drugs, or medical devices. Not only are urgent medical costs unpredictable and uncontrollable, but patients also are not ordinary consumers. Because their lives and well-being are at stake, patients are much less sensitive to price than are other consumers, and they rarely make decisions contrary to medical advice. The result has been a set of complex regulatory challenges particular to the health care market – especially the longstanding problem of dealing with the costs that individual patients incur, but cannot and do not pay.

II. Insurance, public and private, is the principal way that the costs of health care are financed in the United States. Health insurance performs a function that is very different from that of other types of insurance. Ordinary insurance protects assets acquired with other funds. In contrast, health insurance is a financing mechanism to pay for the original purchase of services that almost everyone consumes regularly. About 86% of total personal health expenditures are paid directly by either public or private health insurance.

Many Americans, however, spend at least some part of their lives without health insurance. Usually, this is not a voluntary choice; it is more typically a result of being unable to qualify for coverage or to afford coverage on an individual basis, combined with job loss or some other reason for lack of employer coverage.

Those who do not have insurance generally receive less health care than they need. This makes the uninsured prone to avoidable illness and premature death. The care that uninsured individuals and families receive also tends to be poorly timed. For example, illnesses such as asthma or diabetes that might have been treated in more effective and less costly ways instead result in hospitalization.

III. PPACA is a comprehensive regulatory effort to improve the functioning of the national market for health care in the United States by providing all Americans with the means of access to essential care. Its requirement that individuals obtain and maintain minimum coverage is one means that PPACA employs to ensure that the health care costs that practically everyone will incur (but in unpredictable amounts) are financed in advance. Many of PPACA's other provisions are designed to serve the same goal of improving access to care and ensuring that health care costs are financed in advance. These provisions include expansions of the two major public programs – Medicaid and Medicare – that finance health care for about a third of the population and new regulations of insurers and employers who provide health insurance to their employees.

By increasing insurance coverage and providing other means to secure financing of care in advance, PPACA will improve health outcomes nationwide.

By subsidizing coverage and requiring insurers to sell it at average community rates, PPACA also will make coverage more affordable and care more accessible. It also will protect individuals by eliminating the possibility that bad luck will render them "uninsurable" – that is, unable to obtain coverage at any reasonable price. Underlying all these provisions is an understanding that health insurance is both a means of protecting individuals by spreading the risk of unpredictable illness and injury and an important structural mechanism that ensures stable and reliable payment for services that virtually all Americans use.

ARGUMENT

I. THE NATIONAL MARKET FOR HEALTH CARE IS IMMENSE, INTERDEPENDENT, AND UNIQUE

A. Almost Everyone in the United States Uses Health Care Throughout Their Lives

Health care accounts for nearly a fifth of the national economy. In 2010, national spending on health care was approximately $2.6 trillion, which is 17.9% of national GDP.[3] A 2004 study estimated that the average American incurs more than $300,000 in costs for health care services over a lifetime.[4] These costs are spread over all phases of the average individual's life: 7.8% before the age of 20, 12.5% from ages 20 to 39, 31.0% from ages 40 to

---

[3] *See* Anne B. Martin et al., *Growth In US Health Spending Remained Slow In 2010; Health Share Of Gross Domestic Product Was Unchanged From 2009*, 31 Health Aff. 208, 208-09 & exh. 1 (Jan. 2012).

[4] *See* Berhanu Alemayehu & Kenneth E. Warner, *The Lifetime Distribution of Health Care Costs*, 39 Health Serv. Res. 627, 635 (June 2004).

64, 36.5% from ages 65 to 84, and 12.1% after the age of 85.[5]

All but a very few Americans use health care on a regular or recurring basis, and only a miniscule number do not use it at all. A 2010 survey by the National Center for Health Statistics ("NCHS") found that 82.5% of adults in the United States had visited a health care professional within the last year, and 95.9% had done so within the past five years.[6] Only 1% of all adults had never visited a doctor or other health care professional.[7] In addition, about half of non-elderly adults use at least one prescription drug every month.[8] Children use health care even more regularly: NCHS found that three-quarters of all children had visited a health care professional within the last six months.[9]

---

[5] *See id.* at 637.

[6] *See* National Ctr. for Health Statistics, U.S. Dep't of Health & Human Services, *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009*, Vital & Health Stat., Series 10, Number 249, at 124 tbl. 37 (Dec. 2010), *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_249.pdf.

[7] *See id.* Only 0.4% to 0.7% of insured adults ages 18 to 65 had never visited a health care professional; 2.9% of uninsured adults had not. *See id.* at 125 tbl. 37. That percentage diminishes by age, confirming that virtually everyone uses health services at some point. Of all adults under age 45, 1.3% reported never using health services; of those aged 65-74, only 0.4%. *See id.* at 124 tbl. 37.

[8] *See* National Ctr. for Health Statistics, U.S. Dep't of Health & Human Services, *Health, United States, 2010*, at 318 tbl. 94 (Feb. 2011), *available at* http://www.cdc.gov/nchs/data/hus/hus10.pdf.

[9] *See* National Ctr. for Health Statistics, U.S. Dep't of Health & Human Services, *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2009*, Vital & Health

B. Health Care Costs for Individuals Are Expensive, Unpredictable, and Difficult To Control

1. Though it is practically certain that everyone in the United States will incur a substantial amount of health care costs distributed over the course of a lifetime, it is not at all certain whether a particular individual will incur major costs in a particular year. The distribution of health care costs in any given year is highly concentrated. It follows a rough "80-20 rule": 80% of costs each year fall upon 20% of the population, and the remaining 20% of costs are spread over the remaining 80% of the population.[10] Costs are even more concentrated at the very top of the distribution. In 2005, 22.7% of health care costs fell upon only 1% of the population, each of whom incurred more than $43,000 in costs.[11]

This concentration occurs because care other than routine preventive visits is often extremely expensive. The average bill for a hospital visit by an uninsured patient is more than $22,000.[12] For the most

---

Stat., Series 10, Number 247, at 6 (Dec. 2010), *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_247.pdf.

[10] *See* Statement of Mark A. Hall Before the U.S. Senate Committee on Finance, Hearing on "47 Million and Counting: Why the Health Care Marketplace is Broken," at 3 (June 10, 2008) (citing Kaiser Family Foundation's calculations), *available at* http://finance.senate.gov/imo/media/doc/061008MHTest.pdf.

[11] *See id.* at 3-4.

[12] *See* Office of the Ass't Secretary for Planning and Evaluation, U.S. Dep't of Health & Human Services, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources To Pay Potential Hospital Bills* 8 (May 2011), *available at* http://aspe.hhs.gov/health/reports/2011/valueofinsurance/rb.pdf. This figure does not count "physician fees, ambulance fees, post-

common types of cancer, treatment for the first year after diagnosis costs Medicare an average of $27,693 (breast cancer) and $23,652 (prostate cancer).[13] The cost of an organ transplant ranges from a quarter-million to more than a million dollars.[14] A recent private study using data from 2004 and 2005 calculated average private insurance payments for coronary artery bypass graft surgery in 2005 at $86,914.[15]

These figures, high as they are, reflect payments by private insurers or Medicare. An uninsured patient would likely be billed a substantially greater amount for one of these procedures, because uninsured patients do not receive the benefit of negotiated discounts that average roughly 50% for hospital and specialist care.[16] Most American families

---

acute care expenses, or the possibility of multiple hospitalizations." *Id.*

[13] *See* Angela B. Mariotto et al., *Projections of the Cost of Cancer Care in the United States: 2010-2020*, 103 J. Nat'l Cancer Inst. 117, 125 tbl. 4 (Jan. 19, 2011) (cost of care); *see also id.* at 124 & tbl. 3 (cancer prevalence). The figures are estimates for 2010.

[14] *See* Milliman, *2011 U.S. Organ and Tissue Transplant Cost Estimates and Discussion* 3 tbl. 1 (Apr. 2011) ($262,900 for a kidney; $577,100 for a liver; $997,700 for a heart; more for multiple organs), *available at* http://www.publications.milliman.com/research/health-rr/pdfs/2011-us-organ-tissue.pdf.

[15] *See* Zhenxiang Zhao & Melissa Winget, *Economic Burden of Illness of Acute Coronary Syndromes: Medical and Productivity Costs*, 11 BMC Health Servs. Res. 35, 35 (Feb. 2011), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3042911/pdf/1472-6963-11-35.pdf.

[16] *See* Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 Mich. L. Rev. 643, 662-63 (2008); *see also* America's Health Insurance Plans, *The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs:*

without health insurance confront these costs without any substantial savings.[17] Indeed, most Americans would not have the ability to pay out of pocket for an expensive medical episode even by selling everything they owned.[18] As a result, the costs of a significant injury or illness that is not covered by insurance can simply be impossible to pay.

2. Individuals routinely need regular preventive care, but their use of other types of care is highly unpredictable. Even with expert analysis, only about one-quarter of the variation in annual health care spending per person is predictable from one year to the next.[19]

The costs of health care also are difficult for individuals to predict or control even once an injury or illness has occurred, for several reasons. For one

---

A Survey of Charges Billed by Out-of-Network Physicians (Aug. 2009) (documenting list prices many times greater than those paid by Medicare), *available at* http://www.ahipresearch.org/PDFs/ValueSurvey/AllStatesReport.pdf.

[17] A recent study calculated that, using 2006-2007 data, median financial assets for an uninsured family were $20. *See Value of Health Insurance*, *supra* note 12, at 4 tbl. 2. Even the wealthiest segment of the uninsured population within that study – those with incomes above 400% of the federal poverty line, which were only 11% of the population – had median financial assets of only $4,100, completely inadequate to pay a $22,200 hospital bill.

[18] Median net worth for all Americans (including the insured and the uninsured) in 2010 was nearly $120,000. *See* U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, at 6 tbl. 1 (Sept. 2011), *available at* http://www.census.gov/prod/2011pubs/p60-239.pdf.

[19] *See* Joseph P. Newhouse, Melinda Beeuwkes Buntin & John D. Chapman, *Risk Adjustment And Medicare: Taking A Closer Look*, 16 Health Aff. 26, 32-33 (Sept./Oct. 1997), *available at* http://content.healthaffairs.org/content/16/5/26.full.pdf+html.

thing, once "individuals . . . or their loved ones are sick," they are likely to seek any possible care that might help.[20] For another, as this Court has noted, the health care market is "characterized by striking disparities between the information available to the professional and the patient." *California Dental Ass'n v. FTC*, 526 U.S. 756, 771 (1999). Patients rely heavily on doctors and other health care professionals in determining what care they need. They rarely reject doctors' recommendations.[21] Doctors, for their part, generally put patients' health over costs,[22] and there is considerable evidence that doctors are unaware of or tend to minimize issues of cost or ability to pay in recommending treatments.[23]

---

[20] Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. Contemp. Health L. & Pol'y 1, 32 n.107 (1998); *see id.* (discussing the "wealth of literature debating the causes of, and possible solutions to, increasing demand for medical care").

[21] *See* Hall & Schneider, 106 Mich. L. Rev. at 652.

[22] *See*, *e.g.*, Norman G. Levinsky, *The Doctor's Master*, 311 New Eng. J. Med. 1573, 1573 (Dec. 13, 1984) (arguing that the proper role of doctors is "to do everything that they believe may benefit each patient without regard to costs or other societal considerations").

[23] *See* Uwe E. Reinhardt, *The Economist's Model of Physician Behavior*, 281 J. Am. Med. Ass'n 462, 464 (1999) (finding "tentative support" for the hypothesis that, rather than maximizing revenue from each patient, "the typical physician will have settled on a preferred practice style that is applied to all patients, regardless of their insurance status"); Elliott Fischer et al., *The Implications of Regional Variations in Medicare Spending – Part 2: Health Outcomes and Satisfaction with Care*, 138 Annals of Internal Med. 288 (Feb. 18, 2003), *available at* http://www.annals.org/content/138/4/288.full.pdf+html; Yungie Song et al., *Regional Variations in Diagnostic Practices*, 363 New Eng. J. Med. 45 (July 1, 2010), *available at* http://tdi.dartmouth.edu/

C. Individuals Often Receive Health Care Even When They Cannot Pay

Individuals who desperately need health care often receive it even if they cannot afford to pay. In 2008, uninsured patients in the United States used emergency rooms more than 19 million times.[24] Beyond emergency care, our country has more than 8,000 community health centers that provide a wide range of basic health services to all patients in need, regardless of their ability to pay.[25]

Indeed, the medical profession has long considered it ethically improper to refuse emergency treatment for any reason, including inability to pay.[26] This professional "rescue ethic"[27] tracks a broader social

---

documents/publications/Song%20Y%20Regional%20Variations.pdf.

[24] *See* National Ctr. for Health Statistics, U.S. Dep't of Health & Human Services, *National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables* tbl. 6 (Jan. 2011), *available at* http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/nhamcsed2008.pdf.

[25] *See* Eli Y. Adashi et al., *Health Care Reform and Primary Care – The Growing Importance of the Community Health Center*, 362 New Eng. J. Med. 2047, 2047 (June 3, 2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1003729.

[26] *See* AMA Council on Ethical and Judicial Affairs, Opinion 8.11 – *Neglect of Patient* (June 1996) ("The physician should . . . respond to the best of his or her ability in cases of emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient."), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion811.page?

[27] MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 32 (Oxford Univ. Press 1997); *see id.* ("[O]ur society will care for people in serious and obvious distress regardless of whether they can pay."); David C. Hadorn, *Setting Health Care Priorities*

norm: we "value in a different way, not just quantitatively but qualitatively," the "worth of saving an *identified* individual's life" as compared to the "statistical lives" that are lost or saved as "the incidence of death among a mass of unknown human beings" rises or falls.[28] Researchers have labeled this sociological phenomenon the "identifiable victim effect": people are consistently unwilling to let a named or visible person die for lack of money, even though they might not act to save a larger group of anonymous people under otherwise similar circumstances.[29]

Hospitals also have legal obligations to provide emergency care without regard to ability to pay. The

---

in Oregon: Cost-Effectiveness Meets the Rule of Rescue, 265 J. Am. Med. Ass'n 2218, 2219 (1991) (arguing that "any plan to distribute health care services must take human nature into account if the plan is to be acceptable to society," including the inability of people to "stand idly by when an identified person's life is visibly threatened if effective rescue measures are available").

[28] Thomas C. Schelling, *The Life You Save May Be Your Own*, *in* PROBLEMS IN PUBLIC EXPENDITURE ANALYSIS 127, 129-30 (Samuel B. Chase, Jr. ed., 1968); *see also* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 21 (1978) (discussing the problem of "why, for instance, the United States will spend a million dollars to rescue a single, downed balloonist but will not appropriate a similar sum to provide shore patrols"); CHARLES FRIED, AN ANATOMY OF VALUES: PROBLEMS OF PERSONAL AND SOCIAL CHOICE 207-10 (Harvard Univ. Press 1970) (analyzing "the apparent anomaly" between preferences for saving identifiable as opposed to statistical lives).

[29] *See generally* PAUL SLOVIC, THE FEELING OF RISK: NEW PERSPECTIVES ON RISK PERCEPTION 73 (2010); Karen E. Jenni & George Loewenstein, *Explaining the "Identifiable Victim Effect,"* 14 J. Risk & Uncertainty 235 (1997), *available at* http://www.andrew.cmu.edu/user/gl20/GeorgeLoewenstein/Papers_files/pdf/identifiable-victim.pdf.

federal Emergency Medical Treatment and Active Labor Act ("EMTALA") is perhaps the best-known example: it prohibits denial of certain emergency care and transfers on the basis of inability to pay and mandates screening and other procedures to ensure that such denials do not occur. *See* 42 U.S.C. § 1395dd. Moreover, EMTALA is neither innovative nor unique. Similar obligations existed before it was enacted, and continue to exist today, under state statutes[30] or judicial decisions.[31]

As a result of these ethical and legal commitments, our emergency departments and clinics take in a steady stream of patients who lack the means to pay (through insurance or otherwise) but who will suffer grave harm if denied urgent or essential care. The phenomenon of unpaid care creates several problems. From the patient's perspective, health care delivered on an emergency basis is often not as effective or as cost-efficient. Uninsured care also commonly forces patients into bankruptcy: a 2009 study by Harvard researchers estimated that "[i]llness or medical bills

---

[30] *See*, *e.g.*, Cal. Health & Safety Code § 1317; Fla. Stat. Ann. § 401.45; 210 Ill. Comp. Stat. Ann. 70/1; *see generally* Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action To Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 Am. U. L. Rev. 173, 187-88 nn.72-74 (2002) (collecting statutes).

[31] *See*, *e.g.*, *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961) (recognizing "liability on the part of a hospital . . . predicated on the refusal of service to a patient in case of an unmistakable emergency, if the patient has relied upon a well-established custom of the hospital to render aid in such a case"); *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329, 1331 (Ariz. 1975) (deriving from a state hospital licensing statute a "public policy" under which a licensed "hospital may not deny emergency care to any patient without cause").

contributed to 62.1% of all bankruptcies in 2007."[32] From the providers' perspective, these bankruptcies and other failures to pay medical bills cause substantial financial losses. Hospitals nationwide report tens of billions of dollars in bad debt each year.[33]

In sum, as a society we devote substantial resources to make urgent and essential medical care available to practically everyone, whether or not they have made provisions through insurance coverage to pay for the required costs. The real question is not whether people will receive care: it is who will pay the cost of that care, and how.

D. No Other Part of the Economy Shares the Key Characteristics of the Health Care Market

No other economic activity in which Americans engage shares the characteristics of health care – its size, its ubiquity in touching every American, its unpredictable imposition of immense costs on individuals, and its intertwinement with moral and psychological imperatives about our responsibilities to each other. Other industries or economic activities have some of these characteristics, but not all. For example, Americans spent about $1.19 trillion (8.4% of GDP) on food and food services in 2009, and about

---

[32] David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 Am. J. Med. 741, 743 (Aug. 2009), *available at* http://download.journals.elsevierhealth.com/pdfs/journals/0002-9343/PIIS0002934309004045.pdf.

[33] *See* American Hospital Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* (Nov. 2008), *available at* http://www.aha.org/content/00-10/08-uncompensated-care.pdf.

$1.58 trillion (11.2% of GDP) on housing in 2009.[34] Those industries touch every American, and serve basic human needs, but the costs of both food and shelter are much more predictable, stable, and evenly spread compared to health care.

The Eleventh Circuit used the example of catastrophic flooding as an area in which Congress confronted problems somewhat analogous to those that affect the health care market: the "unpredictability of flooding, the inevitability that floods will strike flood plains, and the cost shifting inherent in uninsured property owners seeking disaster relief funds." Pet. App. 108a (No. 11-398). But the comparison simply does not work; instead, the obvious contrasts illustrate just how distinctive health care really is.

The scale of the flood insurance problem is much smaller. Only a small portion of the population needs flood insurance, and floods affect only a tiny portion of those people every year[35] – compared to the entire population of the country that uses health care. The character of the problem also is fundamentally different. Large floods are major disasters that imperil life as well as property, but flood insurance (unlike health insurance) ultimately provides funds to rebuild homes and businesses after the fact.

---

[34] *See* U.S. Census Bureau, *Statistical Abstract of the United States* 442 tbl. 677 (2012), *available at* http://www.census.gov/compendia/statab/2012edition.html.

[35] Total flood losses in the United States averaged $7.56 billion annually from 1980 to 2009 – about 0.3% of the $2.6 trillion Americans spent in 2010 on health care. *See* National Weather Service, *United States Flood Loss Report – Water Year 2010*, *available at* http://www.nws.noaa.gov/hic/flood_stats/Summaries/WY2010.pdf; *see also supra* p. 5 & note 3 (providing figures and sources for total health care spending).

Human life is not directly in the balance when society makes the decision whether to pay for that rebuilding.

In addition, as we explain in more detail in Part II, health insurance plays a very different role from other types of insurance, flood insurance included. Other types of insurance pay for losses to existing property that a buyer has purchased with separate funds. Health insurance pays for the original purchase of health care services at the outset, not for losses to independently acquired assets. Moreover, while health insurance does protect individuals against the cost of care after catastrophic health events, unlike other forms of insurance, it also finances the direct provision of ongoing necessary health care that – to varying degrees – virtually everyone receives.

II. LACK OF HEALTH INSURANCE COVERAGE DRAMATICALLY AFFECTS THE NATIONAL HEALTH CARE MARKET

A. Private and Public Insurance Pay for Most Personal Health Care Expenditures

Over time – and, in particular, as technological advances have made health care more expensive – various forms of private and public health insurance have become the dominant means of payment for care in the national economy.[36] Public and private

---

[36] The market for private health insurance is, moreover, dominated by multi-state and national firms. *See* James C. Robinson, *Consolidation And The Transformation Of Competition In Health Insurance*, 23 Health Aff. 11 (Nov./Dec. 2004), *available at* http://content.healthaffairs.org/content/23/6/11.full.pdf+html; American Medical Ass'n, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets – 2010 Update* (2010). Eighty percent of the 442 health insurers active in each state in

insurance paid for 85.7% of personal health care expenditures in 2009.[37] Only 14.3% – including retail sales of over-the-counter medications, as well as deductibles and co-payments – was paid out of pocket.[38]

As the Institute of Medicine concluded in a 2009 report, "health insurance coverage is integral to health care access and health."[39] It is not surprising that insurance has come to play this role, because insurance mechanisms are necessary to address the risk that an individual or family member will need expensive, unforeseen care. With regard to catastrophic care in particular, any method of financing health care is, at least in part, a means of spreading risk over the population, a traditional function of insurance. In addition, health insurance also serves

---

2009 were part of larger companies, and on average each insurer was active in 4.5 states. *See* Office of Consumer Information & Insurance Oversight, Interim Final Rule for Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act, Regulatory Impact Analysis Technical Appendix 20 tbl. 12 (Nov. 2010), *available at* http://cciio.cms.gov/resources/files/mlr_20101122_technical_appendix.pdf.

[37] *See* Centers for Medicare & Medicaid Services, U.S. Dep't of Health & Human Services, *National Health Expenditures by Type of Service and Source of Funds*, *CY1960-2009*, *available at* http://www.cms.gov/nationalhealthexpenddata/02_nationalhealthaccountshistorical.asp.

[38] *See id.*; *see also* Centers for Medicare & Medicaid Services, U.S. Dep't of Health & Human Services, *National Health Expenditures Accounts: Definitions, Sources, and Methods, 2009*, *available at* http://www.cms.gov/nationalhealthexpenddata/downloads/dsm-09.pdf.

[39] INSTITUTE OF MEDICINE, AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 49 (2009), *available at* http://www.nap.edu/catalog.php?record_id=12511.

to finance the costs of health care generally – including, for some medical conditions such as cancer or diabetes, treatment that may remain unaffordable even after the condition is known and the costs are predictable.[40]

In 2010, 58.7% of non-elderly Americans had health insurance coverage through an employer; 7.1% purchased coverage individually; and 21.6% were covered by non-employment-based federal programs, including Medicare (which covers certain disabled non-elderly beneficiaries), Medicaid, and the Department of Veterans Affairs.[41] The uninsured made up 18.5% of the total non-elderly population; 21.9% of non-elderly adults; and 9.8% of children.[42]

B. Many Americans Spend Time Without Insurance

On average, Americans spend about 12 years of their life without health insurance and report at least some health problems during 40% of those uninsured years.[43] It is common for people to "cycle

---

[40] *See* Wendy K. Mariner, *Health Reform: What's Insurance Got to Do With It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 Am. J. L. & Med. 436, 444 (2010) ("[H]ealth plans . . . perform two distinct financial functions: risk spreading for unanticipated health problems; and paying for routine or regular health services.").

[41] *See* Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey*, EBRI Issue Brief No. 362, at 5 fig. 1 (Sept. 2011), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2011_No362_Uninsured1.pdf. Percentages sum to more than 100 because some people have two sources of coverage.

[42] *See id.* at 5 fig. 1, 7 figs. 2-3.

[43] *See* James B. Kirby & Toshiko Kaneda, *Unhealthy and Uninsured: Exploring Racial Differences in Health and Health*

in and out of coverage over a short period of time."[44] A third of Americans were uninsured for at least part of the two-year period 2007-2008.[45] Only 20.6% of the non-elderly uninsured have never had insurance, while 25.9% have been uninsured less than a year, and an additional 22.6% have been uninsured from 1 to 3 years.[46] People also shift between private and Medicaid coverage as their incomes and job status change.[47]

Insurance Coverage Using a Life Table Approach, 47 Demography 1035, 1047 (Nov. 2010).

[44] Ken Jacobs et al., *Maximizing Health Care Enrollment through Seamless Coverage for Families in Transition: Current Trends and Policy Implications* 2 (Univ. of Calif., Berkeley, Ctr. for Labor Research & Educ., Mar. 2011), *available at* http://laborcenter.berkeley.edu/healthcare/seamless_coverage11.pdf.

[45] *See* Families USA, *Americans At Risk: One in Three Uninsured* 1 (Mar. 2009) (Lewin Group analysis of Census Bureau survey data), *available at* http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf.

[46] *See* National Ctr. for Health Statistics, U.S. Dep't of Health & Human Services, *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2010*, Vital & Health Stat., Series 10, Number 251, at 69 tbl. 23 (Dec. 2011), *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_251.pdf; *see also* Pamela Farley Short & Deborah R. Graefe, *Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured*, 22 Health Aff. 244, 248 (Nov./Dec. 2003) (finding that, in a four-year study period, 24% of the non-elderly uninsured were uninsured for 1 to 4 months; 22%, for 5 to 12 months; 19%, for 13 to 24 months; and 35%, for longer), *available at* http://content.healthaffairs.org/content/22/6/244.full.pdf+html.

[47] *See* Benjamin D. Sommers & Sara Rosenbaum, *Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges*, 30 Health Aff. 228 (Feb. 2011).

When Americans go without insurance, it is usually not a voluntary choice. A 2010 NCHS survey of the non-elderly uninsured found that the high cost of premiums was the most commonly cited reason for lack of coverage (by 48.1% of respondents), followed by loss of one's job (27.6%), lack of employer coverage or refusal by an insurance company (12.4%), and loss of Medicaid coverage (12.1%).[48] "[D]id not want or need coverage" was listed in a footnote as not receiving enough responses to warrant its own category.[49] As one recent analysis put it:

- "most uninsured people – more than 60 percent – disagreed with the view that they do not need health insurance coverage, with more than 40 percent strongly disagreeing";
- "even among groups with relatively low need, such as younger people or those without chronic conditions or access problems, most believe they need health insurance";
- "cost and affordability influence the decision not to purchase coverage for most uninsured people rather than perceptions that health insurance coverage isn't necessary";
- "the perception among some that most uninsured people do not value coverage and

---

[48] *See* National Ctr. for Health Statistics, U.S. Dep't of Health & Human Services, *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2009*, Vital & Health Stat., Series 10, Number 248, at 71 tbl. 25 (Dec. 2010), *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_248.pdf.

[49] *Id.* at 72 n.2; *see also* Jacobs, *supra* note 44, at 2-3 ("[F]or many individuals uninsurance is a condition precipitated by a work or life change such as loss of job, reduction in work hours, job change, divorce, early retirement, or graduation.").

> are willing to risk incurring catastrophic costs is overstated."[50]

In addition, about 10 million of the non-elderly uninsured have one or more preexisting conditions that typically result in denial of wanted coverage or higher premiums that make coverage unaffordable.[51]

C. Lack of Health Insurance Coverage Leads to Worse Outcomes and Unpaid Bills

Lack of health insurance coverage has well-established negative effects on health care. Those without insurance on average receive less health care relative to their needs than those with insurance.[52] A higher number of people who lack insurance in a particular community "result[s] in a lower probability of having a usual source of care, having an office-based visit, having any medical expenditures, and reporting being satisfied with the quality of care provided by the usual source of care" and "a higher

---

[50] Peter J. Cunningham, Center for Studying Health System Change, *Who Are the Uninsured Eligible for Premium Subsidies in the Health Insurance Exchanges?* 5-6 (Dec. 2010), *available at* http://www.rwjf.org/files/research/71572.pdf.

[51] *See* The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, Staff Working Paper #11, at 6 (June 2010) (based on national Medical Expenditures Panel Survey), *available at* http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

[52] *See* Anita Soni & Marc Roemer, *Characteristics of Those Without Any Ambulatory Care Visits in 2008: Estimates for the U.S. Civilian Noninstitutionalized Adult Population*, Agency for Healthcare Research & Quality Statistical Brief #334, at 1 (July 2011) (finding that the most important variable in determining individuals' number of ambulatory care visits was insurance coverage), *available at* http://www.meps.ahrq.gov/mepsweb/data_files/publications/st334/stat334.pdf.

probability of reporting difficulty obtaining needed care."[53] Although it is more difficult to draw direct connections from lack of coverage to adverse outcomes, studies have estimated that widespread lack of health insurance causes more than 20,000 people to die each year.[54]

Nevertheless, that those without insurance receive *less* care does not mean that they receive *no* care. *See supra* pp. 11-14. The bills for much of that care, moreover, go unpaid. In the aggregate, those without insurance receive about $60 billion a year in uncompensated care.[55] People who go without insurance for an entire year on average receive more than $1,600 in care that year, of which they pay for about one-third themselves.[56] Among all hospitalizations

---

[53] Carole Roan Gresenz & José J. Escarce, *Spillover Effects of Community Uninsurance on Working-age Adults and Seniors: An Instrumental Variables Analysis*, 49 Med. Care e14, e14 (Sept. 2011), *available at* http://www.rwjf.org/files/research/72828fullmedicalcarespillovereffects20110920.pdf.

[54] *See* Stan Dorn, Urban Institute, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* 3 (Jan. 2008) (estimating 22,000 such deaths in 2006, "an average of one death every 24 minutes"), *available at* http://www.urban.org/uploadedPDF/411588_uninsured_dying.pdf. These figures are "reasonable indicators of the general magnitude of excess mortality that results from uninsurance" rather than "precise 'body counts.'" *Id.* at 4.

[55] *See* Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured* 3 (June 2005) (projected costs for 2010), *available at* http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf.

[56] *See* Jack Hadley et al., *Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs*, 27 Health Aff. 399, 401 (Aug. 2008), *available at* http://content.healthaffairs.org/content/27/5/w399.full.pdf+html.

by the uninsured, on average only 12% are by uninsured people who have sufficient assets to pay their bill in full.[57] Even the wealthiest 10% of the uninsured have sufficient assets, on average, to pay for only about half of their hospitalizations in full.[58]

The unpaid portion is absorbed by hospitals (an estimated $35 billion in 2008), clinics ($14.6 billion), and physicians ($7.8 billion).[59] Those costs are in turn passed on (known as "cost-shifting" in the literature) to public and private insurers, as well as targeted charity and government programs. Overall, experts estimate that, in 2008, unpaid care increased federal spending by $25.6 billion, state spending by $17.2 billion, and private spending by $14.5 billion.[60]

Further, the care received by those without insurance tends to be provided in ways that are not only less effective but more costly. According to a 2004 report by the Institute of Medicine, the "lack of timely screening services and preventive care" for the uninsured population leads to "delayed diagnoses and failure to control treatable conditions," so that, "[w]hen they finally receive treatment, those without health insurance are more likely to require more expensive services because of deteriorating health."[61] For example, conditions such as "hypertension"; "asthma; ear, nose, and throat infections; pneumonia; [and] diabetes," which might be successfully (and

---

[57] *See Value of Health Insurance*, *supra* note 12, at 6 & tbl. 4a.

[58] *See id.*

[59] *See* Hadley, 27 Health Aff. at 403-06.

[60] *See id.*

[61] INSTITUTE OF MEDICINE, INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS 43 (2004), *available at* http://www.nap.edu/catalog.php?record_id=10874.

inexpensively) treated through outpatient care for an insured patient, can result in "unnecessary hospitalizations" for an uninsured patient who does not have access to nonemergency care.[62] A follow-up report by the Institute in 2009 cited "fewer avoidable hospitalizations" as a benefit of extending insurance to children in particular.[63]

III. REQUIRING INDIVIDUALS TO BE INSURED STABILIZES THE NATIONAL HEALTH CARE MARKET

A. The Individual Mandate Advances PPACA's Purpose of Guaranteeing Access

Although PPACA has many purposes as a regulatory intervention in the health care market, one dominates the others, especially for purposes of this case. That purpose is to give all Americans reliable, affordable access to health care, ensuring that they do not suffer the poorer health outcomes or the higher costs of later care that come from being uninsurable or facing unaffordable premiums.

Mandating that individuals maintain or obtain minimum coverage – whether through public or private sources[64] – is a logical means for advancing

---

[62] *Id.* at 44.

[63] AMERICA'S UNINSURED CRISIS, *supra* note 39, at 5, 8, 49, 71.

[64] The mandate is sometimes described, including by the court of appeals, as a "mandate . . . to purchase insurance from a private company." Pet. App. 155a (No. 11-398). This is inaccurate because, as the court of appeals elsewhere acknowledged, the mandate as applied to some individuals requires them only to "maintain" insurance they have previously purchased, and does not require any purchase by those individuals who can obtain coverage for free through an employer or through a federal program such as Medicaid or the Department of Veterans Affairs. *Id.* at 2a-3a & n.3; *see* 26 U.S.C. § 5000A(f).

PPACA's purposes of guaranteeing access and reducing costs in light of the basic facts discussed in Parts I and II about the health care market and health insurance. Everyone in America is practically certain to use a significant amount of health care prospectively, whether or not there is a mechanism in place to finance the costs of that care. Some – we often do not know who, in advance – will use a great deal of costly health care because they will experience unexpected illness or injury. Once that illness or injury actually occurs, the affected individuals will in many cases be unable to pay for the care they need. Accordingly, while they will still *use* health care (as everyone does), the costs of that care will be paid by other participants in the health care market. The mandate is one of several ways that PPACA aims to solve these problems by ensuring in advance that individuals have made provisions to pay for the care that, in aggregate, they will predictably need.

Finally, the individual mandate, which has become the most contentious aspect of PPACA, must be seen in the context of the legislation and indeed the system of financing health care as a whole. As has been pointed out, there are a variety of more or less well-coordinated financing mechanisms in the health care market, a market in which virtually everyone participates. Congress, eschewing a total government takeover of the financing of health care, chose instead to incorporate existing private health insurance mechanisms as an important payment mechanism in the health care market. The mandate is a part of the PPACA regulatory scheme, but by no means the only part. PPACA also expands the public insurance programs that currently cover about a third of all Americans. It greatly expands Medicaid, which is

the public health insurance program for low income individuals, and enhances prescription drug coverage under Medicare, the public health insurance program for the elderly and disabled. And it makes additional changes to existing regulation of the private insurance market and employer-provided plans.

B. PPACA Provides Nationwide and Individual Benefits to All Americans Participating in the Market for Health Care

The Congressional Budget Office has projected that PPACA will reduce the number of uninsured Americans by 60% (32 million).[65] A majority of the remaining 23 million uninsured would be those exempt from the individual mandate for one reason or another, such as individuals who would have to pay more than 8% of their income in premiums to obtain coverage.[66] Because insurance coverage affects health outcomes, *see supra* pp. 21-24, the increased coverage secured by PPACA should lead to an overall improvement in health outcomes as well. PPACA is also expected to decrease significantly the systemic costs of uncompensated care: a study by the Urban Institute estimated that, if PPACA had been implemented in 2010, the cost of uncompensated care would have "decline[d] by 60 percent, resulting in savings of $42.3 billion" to the government and health care providers who currently bear those costs.[67]

---

[65] *See* Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation, 2009-2010*, at 11, 23 tbl. 4 (Dec. 2010), *available at* http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf.

[66] *See id.* at 71.

[67] Matthew Buettgens et al., Urban Institute, *America Under the Affordable Care Act* 11 (Dec. 1, 2010), *available at* http://www.urban.org/UploadedPDF/412267-america-under-aca.pdf.

In addition to these broad effects, PPACA also provides an individual benefit to all Americans, including those who may be healthy and may not currently be using health care. Before PPACA's enactment, every individual and family, regardless of their current health or insurance coverage, has faced the risk that illness or injury will render them "uninsurable" by increasing their likely future costs for health care far beyond their ability to pay or their insurer's willingness to cover.[68]

PPACA eliminates this possibility through its guaranteed-issue and community-rating provisions. Those measures require insurers to accept and keep all applicants, at average rates that do not vary by individual health care characteristics. PPACA also prohibits insurers from limiting coverage based on preexisting conditions.

In economic terms, these provisions create the equivalent of a contractual option to buy health insurance at market rates from any insurer at any future time, regardless of one's health status. That option has real economic value. A 2005 study estimated that, under conservative assumptions, a guaranteed option to renew an individual health policy with the same insurer at a constant rate would be worth $1,084 *annually* to the average man and

---

[68] According to a recent estimate by the Department of Health and Human Services, "50 to 129 million (19 to 50 percent of) non-elderly Americans have some type of pre-existing health condition" that threatens their ability to obtain or afford health insurance. HealthCare.gov, *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*, http://www.healthcare.gov/law/resources/reports/preexisting.html (last visited Jan. 9, 2012).

$1,891 to the average woman.[69] The value of an option to purchase from *any* insurer, which is the effect of PPACA's guaranteed-issue provision, would presumably be higher.

Congress coupled this protection of insurability with the individual mandate for obvious reasons. If individuals do not have a general obligation to obtain coverage, a guaranteed-issue option at community rates with no limits on preexisting conditions becomes much more expensive because it removes most of the incentive to obtain coverage before injury or illness occurs. The increased expense would threaten PPACA's regulatory goal of stabilizing health care financing. The mandate thus helps to correct distortions in the health care market in which a significant number of uninsured Americans have consumed significant quantities of health care for which they have not been able pay.

CONCLUSION

For the reasons given above and in the brief of the United States, the judgment of the court of appeals should be reversed.

---

[69] *See* Bradley Herring & Mark V. Pauly, *Incentive-Compatible Guaranteed Renewable Health Insurance Premiums*, 25 J. Health Econ. 395, 415 (2006). The numbers quoted in text assume a 10% real discount rate; a lower 5% discount rate would increase the estimate for men to $3,937, and the estimate for women to $3,333. *See id.*

Respectfully submitted,

GREGORY G. RAPAWY
KELLOGG, HUBER, HANSEN, TODD, EVANS & FIGEL, P.L.L.C.
1615 M Street, N.W.
Suite 400
Washington, D.C. 20036
(202) 326-7900

CHARLES FRIED
Counsel of Record
1563 Massachusetts Avenue
Cambridge, MA 02138
(617) 495-4636
(fried@law.harvard.edu)

ABBE R. GLUCK
435 West 116th Street
New York, NY 10027
(212) 854-0679

January 13, 2012

APPENDIX

List of Amici
(Titles and institutional affiliations are provided for identification purposes only)

Mark A. Hall, JD
Fred D. & Elizabeth L. Turnage Professor of Law
Wake Forest University School of Law

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

Lori B. Andrews, JD
Distinguished Professor of Law; Director of the Institute for Science, Law and Technology; and Associate Vice President
Chicago-Kent College of Law, Illinois Institute of Technology

George J. Annas, JD, MPH
William Fairfield Warren Distinguished Professor
Chair and Professor of Health Law, Bioethics & Human Rights
Boston University School of Public Health
Professor of Law
Boston University School of Law

Paul G. Arshagouni, MD, JD, MPH
Associate Professor of Law
Michigan State University College of Law

W. Eugene Basanta
Southern Illinois Healthcare Professor of Law and Director, Center for Health Law and Policy
Southern Illinois University School of Law

Hazel Glenn Beh, PhD, JD
Professor of Law and Director, Health Law Policy Center
University of Hawai'i at Manoa, William J. Richardson School of Law

Peter Bell, JD
Professor of Law
Syracuse University College of Law

Kimberly Cogdell Boies, JD, MPH
Assistant Professor and Director, Biotechnology and Pharmaceutical Law Institute
North Carolina Central University School of Law

Richard J. Bonnie, JD
Harrison Foundation Professor of Law and Medicine
Professor of Public Policy, and Director, Institute of Law, Psychiatry and Public Policy
University of Virginia

Kathleen M. Boozang, JD, LLM
Professor of Law
Seton Hall School of Law

Scott C. Burris, JD
Professor and Director, Center for Health Law, Policy and Practice
Temple University Beasley School of Law

Steve Calandrillo, JD
Charles I. Stone Professor of Law
University of Washington School of Law

Kathy L. Cerminara, JD, LLM, JSD
Professor of Law
Nova Southeastern University Shepard Broad
Law Center

Marguerite Chapman, JD
Director, Health Law Certificate
University of Tulsa College of Law

Glenn Cohen, JD
Assistant Professor
Harvard Law School

Carl H. Coleman, JD
Professor of Law
Seton Hall University School of Law

Kenneth De Ville, PhD, JD
Professor, Department of Bioethics &
Interdisciplinary Studies
Brody School of Medicine at East Carolina University

Janet L. Dolgin, MA, PhD, JD
Jack and Freda Dicker Distinguished Professor
of Health Care Law
Hofstra University School of Law
Professor of Science Education
Hofstra University School of Medicine

Nancy Dubler, LL.B
Professor Emerita
Albert Einstein College of Medicine

Einer Elhauge, JD
Petrie Professor of Law
Harvard Law School

Cheryl Erwin, JD, PhD
Director, Medical Humanities Certificate Program
University of Texas Health Science Center
Visiting Law Professor
Texas Tech University School of Law

Linda C. Fentiman
James D. Hopkins Professor
Pace University Law School

Jacqueline Fox, JD, LLM
Associate Professor
University of South Carolina School of Law

David M. Frankford, JD
Professor of Law
Rutgers University School of Law – Camden

Barry Furrow, JD
Professor of Law and Director, The Health Law Program
The Earle Mack School of Law at Drexel University

Lance Gable, JD, MPH
Assistant Professor of Law
Wayne State University Law School

Amy Lewis Gilbert, JD, MPH
Visiting Assistant Professor of Pediatrics
Indiana University School of Medicine

Margaret Gilhooley, JD
Professor of Law Emeritus
Seton Hall Law Center

Leonard H. Glantz
Professor of Health Law, Bioethics & Human Rights
Associate Dean Emeritus, Academic Affairs
Boston University School of Public Health
Professor of Law
Boston University School of Law

Michele Bratcher Goodwin, JD, LLM
Everett Fraser Professor of Law and Professor of Medicine
University of Minnesota

Thomas (Tim) Greaney
Chester A. Meyers Professor and Co-Director, Center for Health Law Studies
Saint Louis University School of Law

Henry T. Greely, JD
Deane F. and Kate Edelman Johnson Professor of Law
Professor, by courtesy, of Genetics
Stanford University

Michael Greenberger, JD
Professor of Law
Founder and Director, University of Maryland Center for Health & Homeland Security
Francis King Carey School of Law, University of Maryland

Sofia Gruskin, JD, MIA
Professor of Preventive Medicine, Keck School of Medicine
Professor of Law and Preventive Medicine, Gould School of Law
University of Southern California

Dean M. Harris, JD
Clinical Associate Professor, Health Policy and Management
University of North Carolina at Chapel Hill Gillings School of Global Public Health

Dean Hashimoto, JD, MD
Associate Professor
Boston College Law School

Leslie Meltzer Henry, JD, MSc
Assistant Professor of Law
University of Maryland Carey School of Law

Laura Hermer, JD, LLM
Assistant Professor
University of Texas Medical Branch

Christina S. Ho, JD, MPP
Assistant Professor of Law
Rutgers School of Law, Newark

Allison K. Hoffman, JD
Acting Professor of Law
UCLA School of Law

Sharona Hoffman, JD, LLM
Professor of Law and Bioethics and Co-Director, Law-Medicine Center
Case Western Reserve University School of Law

Nicole L. Huberfeld, JD
Gallion & Baker Associate Professor of Law
University of Kentucky College of Law

Nan D. Hunter, JD
Associate Dean for Graduate Programs and
Professor of Law
Georgetown University Law Center

Peter D. Jacobson, JD, MPH
Professor of Health Law and Policy and Director,
Center for Law, Ethics, and Health
University of Michigan School of Public Health

Fazal R. Khan, MD, JD
Associate Professor of Law
University of Georgia School of Law

Nancy M. P. King, JD
Professor of Social Sciences and Health Policy
Wake Forest School of Medicine

Eleanor D. Kinney, JD, MPH
Hall Render Professor of Law Emeritus
Indiana University Robert H. McKinney School
of Law

Sylvia A. Law
Elizabeth K. Dollard Professor of Law, Medicine
and Psychiatry
New York University School of Law

Robert B. Leflar
Ben J. Altheimer Professor of Legal Advocacy
University of Arkansas School of Law

Elizabeth Weeks Leonard
Associate Professor
University of Georgia School of Law

Kristin Madison, JD, PhD
Professor of Law and Health Science
Northeastern University

Gwendolyn Roberts Majette, JD, LLM
Assistant Professor of Law
Cleveland-Marshall College of Law

Anna Mastroianni, JD, MPH
Professor of Law
University of Washington School of Law

Dayna Bowen Matthew
Professor of Law
University of Colorado Law School and
Colorado School of Public Health

Thomas Wm. Mayo, JD
Associate Professor
Southern Methodist University (SMU) Dedman
School of Law

Maxwell J. Mehlman
Arthur E.Petersilge Professor of Law and Director,
Law-Medicine Center
Case Western Reserve University School of Law
Professor of Bioethics
Case Western Reserve University School of Medicine

Alan Meisel, JD
Professor of Law and Dickie, McCamey & Chilcote
Professor of Bioethics
University of Pittsburgh

Michelle M. Mello, JD, PhD
Professor of Law and Public Health
Harvard School of Public Health

Kate Mewhinney
Clinical Professor
Wake Forest University School of Law

Frances H. Miller, JD
Professor of Law Emerita
Boston University School of Law

Michelle Oberman, JD, MPH
Professor of Law
Santa Clara University

David Orentlicher, MD, JD
Samuel R. Rosen Professor of Law and Co-Director,
Hall Center for Law and Health
Indiana University Robert J. Kinney School of Law

Efthimios Parasidis, JD, MBE
Assistant Professor of Law
Center for Health Law Studies, Saint Louis
University School of Law

Sallyann Payton, LLB
William W. Cook Professor of Law
University of Michigan Law School

Philip G. Peters, Jr., JD
Ruth L. Hulston Professor of Law
University of Missouri School of Law

Thaddeus Mason Pope, JD, PhD
Associate Professor of Law and Director,
Health Law Institute
Hamline University School of Law

Vernellia R. Randall
Professor of Law
The University of Dayton School of Law

Ben A. Rich, JD, PhD
Professor and School of Medicine Alumni Association
Endowed Chair of Bioethics
University of California, Davis School of Medicine

Edward P. Richards, III, JD, MPH
Clarence W. Edwards Professor of Law and Director,
Program in Law, Science and Public Health
Louisiana State University Law Center

Margaret Foster Riley, JD
Professor of Law
University of Virginia School of Law and School
of Medicine

Jessica L. Roberts
Assistant Professor of Law
University of Houston Law Center

Christopher T. Robertson
Associate Professor
James E. Rogers College of Law, University of
Arizona

John A. Robertson, JD
Vinson & Elkins Chair in Law
University of Texas School of Law

Patricia (Winnie) Roche, JD
Associate Professor of Health Law, Bioethics
& Human Rights
Boston University School of Public Health

Marc A. Rodwin, JD, PhD
Professor
Suffolk University Law School

Sara Rosenbaum, JD
Harold and Jane Hirsh Professor, Health Law and Policy
George Washington University School of Public Health Services and School of Law

Rand E. Rosenblatt, JD
Professor of Law
Rutgers University School of Law – Camden

Arnold J. Rosoff, JD
Professor of Legal Studies & Health Care Management
The Wharton School, University of Pennsylvania

Karen H. Rothenberg, JD, MPA
Marjorie Cook Professor of Law
University of Maryland Francis King Carey School of Law

Mark A. Rothstein, JD
Herbert F. Boehl Chair of Law and Medicine
Director, Institute for Bioethics, Health Policy and Law
University of Louisville School of Medicine

William M. Sage, MD, JD
Vice Provost for Health Affairs and James R. Dougherty Chair for Faculty Excellence
University of Texas at Austin

Sallie T. Sanford, JD
Assistant Professor
University of Washington School of Law

Richard S. Saver, JD
Professor of Law and Adjunct Professor of Social Medicine and Public Health
University of North Carolina – Chapel Hill

Nadia N. Sawicki
Assistant Professor of Law
Beazley Institution for Health Law and Policy
Loyola University Chicago School of Law

Winsor C. Schmidt, JD, LLM
Endowed Chair / Distinguished Scholar in Urban Health Policy
University of Louisville School of Medicine and School of Public Health and Information Sciences

Robert Schwartz, JD
Professor of Law
University of New Mexico

Sheila R. Shulman, LLB, MPH
Research Associate Professor, Retired
SUNY Buffalo Law School

Ross D. Silverman, JD, MPH
Professor of Medical Humanities and Medical Jurisprudence
Southern Illinois University Schools of Medicine and Law

Lawrence E. Singer, JD, MHSA
Associate Professor and Director, Beazley Institute
for Health Law and Policy
Loyola University Chicago School of Law

Jason Smith, MTS, JD
Assistant Professor
University of Connecticut School of Medicine

Jennifer Smith, JD
Associate Professor of Law
Florida A&M University College of Law

Roy G. Spece
Professor of Law
University of Arizona James E. Rogers College
of Law

Joel Teitelbaum, JD, LLM
Associate Professor of Health Policy
George Washington University

Evelyn M. Tenenbaum, JD
Professor of Law
Albany Law School
Professor of Medical Education
Albany Medical College

Nicolas P. Terry, LLM
Hall Render Professor of Law and Director,
Hall Center for Law and Health
Indiana University Robert H. McKinney School
of Law

Lance Tibbles, JD
Professor of Law
Capital University Law School

Stacey A. Tovino, JD, PhD
Professor of Law
William S. Boyd School of Law, University of Nevada, Las Vegas

David Trueman, JD, PhD
Lecturer-in-Law
Columbia University School of Law

Jean Wright Veilleux, JD, LLM
Assistant Professor of Law
Charlotte School of Law

Walter J. Wadlington
James Madison Professor Emeritus
University of Virginia School of Law

Joanna K. Weinberg, JD, LLM
Senior Lecturer, Center for State and Local Government Law
UC Hastings College of the Law

Lindsay F. Wiley, JD, MPH
Assistant Professor of Law
American University Washington College of Law

Susan M. Wolf, JD
McKnight Presidential Professor of Law, Medicine & Public Policy
University of Minnesota