No. 11-400

IN THE

Supreme Court of the United States

STATE OF FLORIDA, *ET AL.*,

Petitioners,

—v.—

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

Respondents.

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

BRIEF OF *AMICI CURIAE*
THE LEADERSHIP CONFERENCE ON CIVIL AND HUMAN RIGHTS, ASIAN AMERICAN LEGAL DEFENSE AND EDUCATION FUND, NATIONAL AIDS HOUSING COALITION, NATIONAL ECONOMIC AND SOCIAL RIGHTS INITIATIVE, NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL, NATIONAL LAW CENTER ON HOMELESSNESS & POVERTY, POVERTY & RACE RESEARCH ACTION COUNCIL, URBAN JUSTICE CENTER AND WILD FOR HUMAN RIGHTS IN SUPPORT OF RESPONDENTS REGARDING MEDICAID EXPANSION

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INTEREST OF AMICI CURIAE

Amici Curiae file this brief in support of Respondents. The statements of interest of *Amici Curiae* are set forth in the Appendix. [1]

SUMMARY OF ARGUMENT

The Medicaid Expansion Provision reflects an effort on the part of Congress to make health care coverage available to millions of low-income individuals, and thereby mitigate racial disparities in access to health care within the United States. As such, the Medicaid Expansion Provision squarely addresses concerns raised on repeated occasions by international human rights bodies, United Nations experts and the wider international community and represents an important step towards bringing the United States into compliance with its international treaty obligations to end racial discrimination in healthcare access, including commitments made in ratifying the International Convention on the Elimination of All Forms of Racial Discrimination and the International Covenant on Civil and Political Rights. Indeed, in both international and domestic settings, the United States government has pointed

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[1] Pursuant to Rule 37.3, letters of consent to the filing of this brief have been submitted to the Clerk of the Court. Pursuant to Rule 37.6, counsel for *amici* states that no counsel for a party authored this brief in whole or in part and none of the parties or their counsel, nor any other person or entity other than *amici*, their members or counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

to the Medicaid Expansion Provision as evidence of its commitment to address racial disparities in access to health care, abide by its international human rights commitments, and advance the nation's global credibility on nondiscrimination in health care. This international context should inform the Court's consideration of the Medicaid Expansion Provision's constitutionality.

ARGUMENT

I. The International Context of the ACA is Relevant to This Court's Consideration of the Constitutionality of the Medicaid Expansion Provision

Beginning in 2014, eligibility for Medicaid shall extend to certain individuals with incomes up to 133 percent of the federal poverty level. 42 U.S.C. 1396a(a)(1)(A)(i)(VIII) (Supp. IV 2010) [hereinafter the Medicaid Expansion Provision of The Patient Protection and Affordable Care Act, Pub. 1, No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. 1 No. 111-152, 124 Stat. 1029 [hereinafter the Affordable Care Act]].

While the Medicaid Expansion Provision is most certainly a domestic U.S. law, its enactment and subsequent judicial consideration take place in an international context, including relevant international law to which the U.S. is a party, and considerable interest from the international community. Consideration of this international context of the Medicaid Expansion Provision would continue a "longstanding practice" of this Court to look beyond our nation's borders for support for its conclusions. *Graham v. Florida*, 130 S. Ct. 2011, 2033 (2010); *see also* Sarah H. Cleveland, *Our International Constitution*, 31 Yale J. Int'l L. 1, 88 (2006) (describing this Court's cases as demonstrating "a longstanding tradition of relying on international law to inform constitutional meaning").

This Court has referred to international authority as "instructive for its interpretation" of federal law. *Roper v. Simmons*, 543 U.S. 551, 575 (2005); *see Abbott v. Abbott*, 130 S. Ct. 1983, 1993-94 (2010) (drawing on the views of sister signatories to a treaty, international case law, and international consensus to inform the Court's conclusion); *see also Grutter v. Bollinger*, 539 U.S. 306, 344 (2003) (Ginsburg, J., concurring) (describing the International Convention on the Elimination of All Forms of Racial Discrimination as instructive on the scope of affirmative government actions with respect to racial equality). Further, consistency between the Court's interpretation and international agreements "demonstrates that the Court's rationale has respected reasoning to support it." *Graham*, 130 S. Ct. at 2034.

II. The Medicaid Expansion Provision Furthers U.S. Compliance with its International Human Rights Treaty Obligations to Ensure Equality in Access to Adequate Health Care Regardless of Race

A. International Bodies and Experts Have Noted Concern Over Racial Disparities in Access to Health Care in the U.S.

In 1994, the U.S. ratified the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), agreeing to "undertake to guarantee the right of everyone, without distinction

as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of… [t]he right to public health [and] medical care." Convention on the Elimination of All Forms of Racial Discrimination art. 5(e)(iv), *opened for signature* Dec. 21, 1965, S. Exec. Doc. C, 95-2 (1978), 660 U.N.T.S. 195.[2] *See also* CERD General Recommendation No. 34 on Racial Discrimination Against People of African Descent, CERD/C/GC/34 (Oct. 3, 2010), ¶¶ 50, 55 (recommending that State parties remove obstacles to enjoyment of right to health as well as ensure equal access to health care for people of African descent).

With ratification of the treaty, the U.S. agreed to submit periodic reports to the CERD Committee, the United Nations body charged with monitoring state compliance with the Convention.[3] CERD, art.

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[2] In ratifying CERD the United States attached an understanding setting forth a division of labor between federal, state and local government for domestic implementation. 140 Cong. Rec. 14326 (daily ed. June 24, 1994) (U.S. Reservations, Declarations, and Understandings, International Convention on the Elimination of All Forms of Racial Discrimination). The record notes that the United States would implement the Convention "to the extent that it exercises jurisdiction over the matters covered therein, otherwise by the state and local governments. To the extent that state and local governments exercise jurisdiction over such matters, the Federal Government, shall, as necessary, take appropriate measures to ensure the fulfillment of this Convention." *Id.* § III. *See also* 138 Cong. Rec. S4781 (daily ed. Apr. 2, 1982) (same understanding regarding International Covenant on Civil and Political Rights).

[3] An obligation that a country accepts when it ratifies a human rights treaty is periodic review by the international committee

9.1. On each occasion that the CERD Committee has conducted such a review, it has held the U.S. to its international obligations and has communicated to the U.S. its concern about the high levels of racial inequality in access to health care in the U.S.

In 2001, commenting on the U.S.'s first set of submissions concerning its compliance with CERD, the CERD Committee specifically noted its concern "about persistent disparities in the enjoyment of, in particular, . . . access to public and private health care." U.N. Comm. on the Elimination of Racial Discrimination, Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America, ¶ 19, U.N. Doc. CERD/C/59/Misc.17/Rev.3 (Aug. 13, 2001).

Reviewing the U.S.'s next submission, in 2008, the CERD Committee again noted its concern, this time in greater detail. Observing "that a large number of persons belonging to racial, ethnic and

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of independent experts charged with monitoring treaty compliance ("the treaty body"). As part of the review, the country must submit a comprehensive report on progress that it has made towards implementing its treaty commitments. *See* Compilation of Guidelines on the Form and Content of Reports to be Submitted by States Parties to the International Human Rights Treaties, U.N. Doc. HRI/GEN/2/Rev.6 (June 3, 2009). At the conclusion of the treaty review, the treaty body issues a set of concluding recommendations highlighting specific areas of concern. Office of the U.N. High Commissioner for Human Rights, The United Nations Human Rights Treaty System: An Introduction to the Core Human Rights Treaties and the Treaty Bodies, Fact Sheet No. 30, (June 2005), pp. 21-23.

national minorities still remain without health insurance and face numerous obstacles to access to adequate health care and services," the Committee specifically recommended that the U.S. take steps to eliminate "the obstacles that currently prevent or limit [racial, ethnic and national minorities'] access to adequate health care, such as lack of health insurance, unequal distribution of health care resources, persistent racial discrimination in the provision of health care and poor quality of health care services." U.N. Comm. on the Elimination of Racial Discrimination, Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America, ¶ 32, U.N. Doc. CERD/C/USA/CO/6 (May 8, 2008).

United Nations independent experts have expressed concerns similar to those raised by the CERD Committee. The Independent Expert on Human Rights and Extreme Poverty made an official visit to the U.S. in 2005, invited by the U.S. government.[4] In his report, submitted to the U.N. Economic and Social Council, the Independent Expert noted the "significant disparity in uninsured rates between non-Hispanic Whites (11.3 per cent), African Americans (19.7 per cent) and Hispanics (32.7 per cent)," and the "deep inequalities linked to

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[4] Independent Experts under the purview of the U.N. make official country visits only upon an invitation from the government. *See* Office of the U.N. High Commissioner for Human Rights, *Special Procedures of the Human Rights Council*, http://www2.ohchr.org/english/bodies/chr/special/index.htm (last visited Feb. 9, 2012).

income, health insurance coverage, race, ethnicity, geography and critically-[needed] access to care." U.N. Independent Expert on Human Rights and Extreme Poverty, Report on Mission to the United States, ¶¶ 32-33, U.N. Doc. E/CN.4/2006/43/Add.1 (March 27, 2006). The Independent Expert concluded that in the U.S., "[i]nequality in the health outcomes are staggering" and urged expansion of the social safety net as one approach to reducing these impacts. *Id*. at ¶¶ 33, 81.

Similar concerns were raised in 2010, during a visit to the United States by the U.N. Working Group of Experts on People of African Descent, a group established in 2002 by the predecessor to the U.N. Human Rights Council. *See* Office of the U.N. High Commissioner for Human Rights, *Working Group of Experts on People of African Descent*, http://www2.ohchr.org/english/issues/racism/groups/african/4african.htm (last visited Feb. 9, 2012). The Working Group found that access to health care is an issue of great importance to people of African descent in the United States, and based on a detailed review of relevant data, that "health disparities between people of African descent and the white population continue to be of concern." U.N. Human Rights Council, Working Group of Experts on People of African Descent, Report on Visit to the United States of America from 25 to 29 January 2010, ¶ 38, U.N. Doc. A/HRC/15/18 (Aug. 6, 2010). The Working Group identified several health issues that are problematic from a racial standpoint, including the

fact that "minorities in the U.S. are less likely than whites to receive needed care." *Id*. at ¶ 79.

B. Responding to International Concern, the United States Has Repeatedly Cited the ACA to Demonstrate U.S. Progress Toward Meeting Its International Obligations and Ensuring Equal Access to Health Care Regardless of Race

Since the ACA's enactment on March 23, 2010, the U.S. has repeatedly cited this legislation – of which the Medicaid Expansion Provision is a key component -- as a response to these international concerns and as evidence of U.S. progress toward meeting its international human rights treaty obligations to achieve racial equality in the enjoyment of public health and medical care. These Executive branch statements concerning the nature of U.S. treaty obligations and the ways in which they are served by the ACA are entitled to "great weight." *Abbott*, 130 S. Ct. at 1993 (citation omitted) (noting that the Court's conclusion was "supported and informed by the State Department's view on the issue"); *see Sumitomo Shoji America, Inc. v. Avagliano*, 457 U.S. 176, 184 n.10 (1982) (deferring to the Executive branch's interpretation of a treaty as memorialized in a brief before the Court).

For example, the United States' report to the U.N. Human Rights Council in conjunction with the Universal Periodic Review, submitted on August 23, 2010 ("the UPR Report"), cites the ACA as evidence of the nation's commitment to reduce discrimination

in access to health care and health insurance in accordance with its international obligations.[5] *See* National Report Submitted in Accordance with Paragraph 15(a) of the Annex to the Human Rights Council Resolution 5/1, United States of America, ¶¶ 70-73, U.N. Doc A/HRC/WG.6/9/USA/1 (Aug. 23, 2010). Acknowledging the alarming disparities in health between minorities and the white population, the U.S. government's UPR Report specifically notes that the ACA will "help our nation reduce disparities and discrimination in access to care that have contributed to poor health."[6] *Id*. at ¶ 71.

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[5] The Universal Periodic Review (UPR) is a mechanism, created by the U.N. General Assembly in 2006 along with the U.N. Human Rights Council, by which the Human Rights Council facilitates an intergovernmental review of the human rights record of each U.N. member state. U.N. General Assembly, Resolution, 60/251, Human Rights Council, U.N. Doc. A/RES/60/251 (Apr. 3, 2006); U.N. Human Rights Council, Institution-Building of the United Nations Human Rights Council (June 18, 2007). The United States' first UPR occurred in 2010.

[6] For example, the report notes that African Americans are 29 percent more likely to die from heart disease than non-Hispanic whites. Asian American men suffer from stomach cancer 114 percent more often than non-Hispanic white men. Hispanic women are 2.2 times more likely to be diagnosed with cervical cancer than non-Hispanic white women. American Indians and Alaska Natives are 2.2 times as likely to have diabetes as non-Hispanic whites. Additionally, these racial and ethnic groups accounted for almost 70 percent of the newly diagnosed cases of HIV and AIDS in 2003. UPR Report at ¶ 71, *citing* U.S. Dep't of Health and Human Services, Office of Minority Health, *Protecting the Health of Minority Communities* (2006), *available at* http:// www.hhs.gov/news/factsheet/minorityhealth.html.

The U.S. State Department's Legal Adviser, Harold Koh, underscored this assertion in remarks formally responding to the recommendations of the U.N. Human Rights Council that resulted from the UPR. In particular, the Legal Adviser cited the "recent landmark healthcare reform" as the latest example of a U.S. federal program established to "empower our citizens to live what FDR called a 'healthy peacetime life.'" Harold Hongju Koh, *Response of the United States of America to Recommendations of the United Nations Human Rights Council*, U.S. Dep't of State (Nov. 9, 2010), http://www.state.gov/s/l/releases/remarks/150677.html.

In December 2011, the U.S. government cited the ACA in its periodic report to the U.N. Human Rights Committee concerning U.S. compliance with its commitments under provisions of the International Covenant on Civil and Political Rights ("ICCPR"). *See* Fourth Periodic Report of the United States of America to the United Nations Human Rights Committee Concerning the International Covenant on Civil and Political Rights, ¶¶ 27, 44, 88, 90, 434, 498, U.N. Doc. CCPR/C/USA/4 (Dec. 30, 2011) [hereinafter ICCPR Report]. Like CERD, the ICCPR has been ratified by the U.S.; Article 2 of the ICCPR obligates each state party to adhere to principles of nondiscrimination on the basis of race as well as other grounds. *See* International Covenant on Civil and Political Rights art. 2, *opened for signature* Dec. 16, 1966, S. Exec. Doc. E, 95-2 (1978), 999 U.N.T.S. 171. The U.S. government's ICCPR Report notes that the ACA addresses

"concerns regarding racial and ethnic disparities in healthcare access" and intimates that the Medicaid Expansion Provision specifically furthers U.S. efforts to provide all children adequate health care. *See* ICCPR Report at ¶¶ 90, 434-35.

Finally, speaking in a domestic forum and training his remarks toward an international audience, in March 2011, Assistant Secretary of State for Democracy, Human Rights, and Labor Michael Posner articulated the U.S. government's perspective that the ACA plays an important role in establishing the nation's international leadership on access to health care, asserting that

> Our government's commitment to provide for the basic social and economic needs of our people is clear, and it reflects the will of the American people. The people ask us to care for the sick … and we do. In 2009, our nation spent nearly $900 billion on Medicare and Medicaid. And as you know, last year the administration passed and signed the Affordable Care Act to expand access to health care in America.

Michael Posner, Assistant Secretary of State for Human Rights, Democracy and Labor, *The Four Freedoms Turn 70: Ensuring Economic, Political, and National Security in the 21st Century,* Annual Meeting of the American Society of International

Law, Washington, D.C., March 24, 2011, *available at* http://www.state.gov/j/drl/rls/rm/2011/159195.htm.

C. Congress Intended the Medicaid Expansion Provision to Help Alleviate Racial Disparities in Health Care Access

The ameliorative impact of the Medicaid Expansion Provision is not simply a byproduct of other choices made in the legislative process, but was an important consideration in Congressional enactment of the measure as part of the Affordable Care Act.

As an initial matter, it is well documented that the number of people of color who live at the poverty level and qualify for Medicaid is disproportionate to their representation in the general population. *See*, *e.g.*, U.S. Dep't of Health and Human Services, Office of Minority Health, African American Profile, *available at* http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=51 ("In 2010, the U.S. Census Bureau reported that 27.4 percent of African-Americans in comparison to 9.9 percent of non-Hispanic Whites were living at the poverty level… [and] 28 percent of African-Americans in comparison to 11 percent of non-Hispanic Whites relied on Medicaid, public health insurance."); U.S. Dep't of Health and Human Services, Office of Minority Health, American Indian/Alaska Native Profile, *available at* http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=52 (28 percent of American Indians and Alaska Natives live at the poverty level and 30

percent of American Indians and Alaska Natives relied on Medicaid coverage); U.S. Dep't of Health and Human Services, Office of Minority Health, Hispanic/Latino Profile, *available at* http://minorityhealth.hhs.gov/templates/browse.aspx ?lvl=2&lvlID=54 (26.6 percent of Hispanics living at the poverty level and 30.3 percent of Mexicans, 39.8 percent of Puerto Ricans, 31.6 percent of Cubans, and 26.8 percent of other Latino groups relied on public health coverage).

Racial and ethnic minorities also disproportionately lack health insurance. The Centers for Disease Control (CDC) estimates that "[a]pproximately two of every five persons of Hispanic ethnicity and one of five non-Hispanic blacks were classified as uninsured during both 2004 and 2008." Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, CDC Health Disparities and Inequalities Report – United States, 2011, Supp./Vol. 60, (Jan. 14, 2011), at 35, *available at* http://www.cdc.gov/mmwr/pdf/ other/su6001.pdf. According to the CDC, "[b]oth these groups had significantly higher uninsured rates… compared with… non-Hispanic whites." *Id*. Because ethnic and racial minorities tend to have lower incomes, the Medicaid Expansion Provision will have an "enormous impact on helping them afford coverage." American Diabetes Ass'n et al., *Medicaid: A Lifeline for Blacks and Latinos With Serious Health Care Needs*, Oct. 2011, at 19-20.

Congress was well-aware of this anticipated impact of the Medicaid Expansion Provision as it considered the measure. Concerned organizations made certain that this information was part of the Congressional record. For example, Families, USA, a non-profit organization promoting high quality affordable health care for all Americans, in a hearing before the House Ways and Means Committee, stated that

> Hispanics/Latinos, African Americans, and people of other racial or ethnic minorities were much more likely to be uninsured than whites: 55.1 percent of Hispanics/Latinos, 40.3 percent of African Americans, and 34.0 percent of other racial and ethnic minorities went without health insurance in 2007-08, compared to 25.1 percent of whites.

Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs: *Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 154 (2009) (statement of Families, USA).

Further, the statements of Members of Congress during the congressional debates of the ACA and its predecessor bills show that Congressional representatives were fully aware that the Medicaid Expansion Provision would be an important mechanism for increasing the access to medical care of people of color. Some members of Congress opposed the expansion arguing, as did Congressman Bill Cassidy, that Medicaid should not

be made available to "more and more people." 156 Cong. Rec. H1461 (daily ed. March 16, 2010). The majority of Congress, however, ultimately supported the expansion and, for many members, the fact that it would remedy racial disparities was key.

For example, in an early debate, Representative Marcia Fudge observed that "nearly half -- or 48 percent -- of black adults suffer from some form of chronic condition compared to 39 percent of all adults," yet "one in every five black Americans lack health insurance compared to one in every eight whites." 155 Cong. Rec. H8397 (daily ed. July 20, 2009) (statement of Rep. Fudge). Representative Fudge continued, "Considering the statistics that I mentioned, I'm glad to report that affordability and access to quality health care are two problems that are addressed" by the Medicaid Expansion Provision of the then-pending health care reform bill. *Id.*

When the ACA reached the House floor, Congresswoman Nydia Velazquez noted that "Latinos have been left behind, suffering the highest uninsured rate of any other community," and asserted that "[f]or the Latino community, [the ACA] delivers coverage to 8.8 million people." 156 Cong. Rec. H1909 (daily ed. Mar. 21, 2010) (statement of Rep. Velazquez). Similarly, Congresswoman Donna Christensen observed that "[t]his year and every year past, over 80,000 African Americans died, whose deaths were preventable, because they were unable to get healthcare," and unequivocally stated that "this bill is for all people of color… and [will] finally

begin to eliminate health disparities." 155 Cong. Rec. H12843 (daily ed. Nov. 7, 2009) (statements of Rep. Christensen). *See also* 156 Cong. Rec. H4407 (daily ed. June 14, 2010) (statement of Rep. Jackson Lee, comparing Congressional debate concerning the Medicaid Expansion Provision to earlier debates over the 1964 Civil Rights Act and the 1965 Voting Rights Act).

This understanding that the Medicaid Expansion Provision will ameliorate racial disparities has also been articulated by the Executive Branch as it prepares to implement the relevant provisions of the ACA. For example, the U.S. Department of Health and Human Services has created an action plan to reduce racial and ethnic health disparities. *See* U.S. Dep't of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, April 2011, *available at* http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. In support of its strategy to "reduce disparities in health insurance coverage and access to care," the action plan states that the Medicaid Expansion, among other ACA measures, "will have a focus on reducing disparities in coverage for racial and ethnic minorities." *Id*. at 15.

In sum, the enactment of the Medicaid Expansion Provision was an important and deliberate advance toward decreasing racial discrimination in access to health care. This action is entirely consistent with, and indeed furthers, the

nation's international human rights treaty obligations to end racial discrimination in the enjoyment of equal access to public health care and medical care.

CONCLUSION

For the foregoing reasons, this Court should affirm the opinion of the Eleventh Circuit Court of Appeals upholding the Medicaid Expansion Provision of the ACA.

Respectfully submitted,

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APPENDIX

STATEMENTS OF INTEREST OF AMICI CURIAE

The **Leadership Conference on Civil and Human Rights** is the nation's oldest and largest civil and human rights coalition, consisting of more than 210 national organizations charged with promoting and protecting the rights of all persons in the United States. The Leadership Conference was founded in 1950 by A. Philip Randolph, head of the Brotherhood of Sleeping Car Porters; Roy Wilkins of the NAACP; and Arnold Aronson, a leader of the National Jewish Community Relations Advisory Council. The Leadership Conference works to build an America that is as good as its ideals. We use international human rights norms and standards to promote the elimination of racial disparities and advance equality and non-discrimination in the areas of health care, education, employment and criminal justice. We support the authority of Congress to enact legislation, such as the Patient Protection and Affordable Care Act, which increases Americans' access to quality health care. Through our shadow reports to the U.N. Committee on the Elimination of Racial Discrimination and participation in the Universal Periodic Review process, The Leadership Conference has advocated for U.S. accountability for its human rights obligations, specifically to provide access to and eliminate inequities in our health care system. The Medicaid Expansion Provision Affordable Care Act will lead to broader access to quality health care by the most vulnerable segments

of society, including children, people of color, women, seniors, and people with disabilities. By addressing the huge disparities in both access to and quality of coverage and care, the Medicaid Expansion Provision takes a momentous step toward respecting, protecting and fulfilling the right of all Americans to secure affordable, high quality health care.

The **Asian American Legal Defense and Education Fund** (AALDEF), founded in 1974, is a national organization that protects and promotes the civil rights of Asian Americans. By combining litigation, advocacy, education, and organizing, AALDEF works with Asian American communities across the country to secure human rights for all. The Medicaid Expansion Provision of the Affordable Care Act is an important step in furtherance of the federal government's obligations under international human rights law and should be upheld.

The **National AIDS Housing Coalition** (NAHC) is an eighteen year old national membership nonprofit housing policy and advocacy organization. NAHC works to end the HIV/AIDS epidemic by ensuring that people with HIV/AIDS have quality, affordable and appropriate housing. NAHC compiles, synthesizes and disseminates research on the role of housing as the baseline for access to HIV health care and for effective HIV prevention interventions. Access to healthcare is of course essential for people with HIV/AIDS, and in the U.S. health insurance is central to the ability of people with HIV/AIDS to access and manage their illness. NAHC works with partners to advance the human rights frame for

addressing HIV prevention and healthcare by fully globalizing research and policy discussions on the role of housing interventions as a response to the HIV/AIDS pandemic.

The **National Economic and Social Rights Initiative** (NESRI) advocates for U.S. accountability to international human rights norms, particularly with regard to health, education, housing and work with dignity. During the public debates leading to enactment of the Affordable Care Act, NESRI provided education and analysis for the public focusing on areas where ACA falls short of international norms by failing to make health care a public good available to all on equal terms, as well as where ACA brought the U.S. into greater compliance with those norms.

The **National Health Care for the Homeless Council** (NHCHC) is a non-profit membership organization representing Health Care for the Homeless (HCH) projects funded by the Health Resources and Services Administration, their staff, and the patients they serve. HCH projects provide primary medical care, behavioral health services, and other support services to individuals and families experiencing homelessness, 65% of whom are uninsured. Extending comprehensive health insurance to homeless persons is seen by NHCHC as a necessary (though insufficient) step toward realization of their human right to health care. For over 25 years, HCH projects have worked to remedy the poor access to health care services, disparities in health outcomes, and extraordinarily poor quality of

life experienced by homeless persons. The Affordable Care Act will remedy some of these inequities by expanding health insurance coverage for poor people, and it is in the vital interests of homeless people and their health care providers that the statute be upheld.

The **National Law Center on Homelessness & Poverty** (NLCHP) is a nonprofit organization based in Washington, D.C. It was founded in 1989 with the mission to prevent and end homelessness by serving as the legal arm of the nationwide movement to end and prevent homelessness. To achieve its mission, NLCHP seeks to address the causes of homelessness, including the shortage of affordable housing, insufficient income, and inadequate social services, such as health care. NLCHP pursues three main strategies: impact litigation, policy advocacy, and public education. Health care and human rights are both central to NLCHP's mission and work. NLCHP views human rights as part of and integral to U.S. law, and incorporates it in all of its strategies. NLCHP participates actively in relevant international processes, and was active in the review of the United States through the CERD and UPR processes.

The **Poverty & Race Research Action Council** (PRRAC) is a civil rights policy organization based in Washington, D.C., committed to bringing the insights of social science research to the fields of civil rights and poverty law. PRRAC's research and advocacy work focuses on the racial impact of government policies in the areas of housing,

education, and health. PRRAC is committed to the full domestic implementation of the Convention on All Forms of Racial Discrimination (CERD) and was instrumental in presenting a coalition report, *Unequal Health Outcomes in the United States: A Report to the U.N. Committee on the Elimination of Racial Discrimination* (January 2008) to the U.N. CERD Committee during its most recent periodic review of U.S. compliance with the treaty.

The **Urban Justice Center** (UJC) is a non-profit organization that serves poor New Yorkers through a combination of direct legal service, systemic advocacy, community education and political organizing. Our work defends the human rights of people who are often overlooked or turned away by other organizations, including the homeless; the mentally ill; domestic violence survivors; lesbian, gay, bisexual, and transgender youth; and people suffering human rights abuses caused by U.S. social welfare policies. UJC has worked to bring the United States into compliance with its human rights obligations in addressing race disparities including in access to healthcare.

WILD for Human Rights (WILD) is an initiative of the Miller Institute for Global Challenges and the Law at the UC Berkeley School of Law. Its mission is to promote human rights through the conscious leadership and action of women and girls, especially young women of color. With a vision of social and political change, it strives to improve the conditions of women and girls and their communities. WILD provides human rights education and training,

engages in research and public advocacy, and collaborates on the adoption and implementation of international human rights standards in the United States and globally. This Court's consideration of how the principles of human rights would support the Medicaid Expansion Provision of the ACA and respond to racial disparities in access to medical care is therefore of significant interest to WILD.