Healthism:
Health-Status Discrimination & the Law
(Cambridge University Press, forthcoming 2017)

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OVERVIEW

The U.S. Constitution requires that people receive equal protection regardless of their race, ethnicity, national origin, or religion, absent a compelling governmental interest. To a somewhat lesser degree, the government is prohibited from discriminating on the basis of gender, illegitimacy, and, most recently announced in the Supreme Court's landmark *Obergefell v. Rogers* decision, sexual orientation. By statute, Congress has limited certain private actors from discriminating also on the basis of disability, pregnancy, genetic information, immigration status, or military affiliation. Conspicuously absent from this list of protected statuses though, is health. Should the law allow unhealthy individuals to be treated less favorably than healthy ones? Or should we recognize a new type of impermissible discrimination, that is to say, healthism?

"Healthism," like the other "isms" that have preceded it, represents socially undesirable differentiation on the basis of a particular trait, in this case health status. So used, the term carries a pejorative meaning. But not all differentiation on the basis of health necessarily constitutes healthism. In fact, differentiating on the basis of health can be neutral and, in some cases, even desirable. Hence, our project is to distinguish the "good" health-based distinctions from the "bad," or "healthist," ones. This book surveys and evaluates the legal regulation of health in a variety of settings, both historically and especially in the wake of recent comprehensive federal health-care reform. The Affordable Care Act (ACA) embodies law and policy's ambivalent view of health-status discrimination, in some cases prohibiting differential treatment of the unhealthy and in other cases encouraging preferential treatment for the healthy.

Our book catalogs the many ways that government and private entities differentiate people on the basis of their health status and the implications of those policies. It draws examples from a wide range of contexts, including the ACA's triumphant rejection of health-status discrimination in private health insurance sales and pricing; the limits of existing disability discrimination laws to protect unhealthy workers; the potential for personal injury law to disfavor the unhealthy; the expanded possibilities for health-status discrimination through reproductive technologies; and controversial public health strategies to encourage healthy eating and exercise.

We recognize that the law can be a powerful tool to promote wellness and encourage healthy lifestyle choices. But such differentiation can also perpetuate stigma and compound other disadvantages. Accordingly, our thesis is that differentiation on the basis of health status is desirable when it promotes responsible, healthy behaviors, yet undesirable when it perpetuates or exacerbates existing health disparities and social disadvantage. Our approach is distinct from other scholarship in this area, which tends to focus on the potential for health-based distinctions to infringe on personal liberty. Instead, we view the issue through the lenses of social advocacy and health promotion, allowing that even some arguably paternalistic laws, policies, and practices may not be "healthist" inasmuch as they encourage and support healthier lifestyles. We conclude that sometimes the law should permit or even encourage health-based distinctions and sometimes it should prohibit such discrimination. We maintain that this equivocal stance more accurately and honestly captures the wide range of contexts that health touches.

The book concludes by offering a roadmap for navigating the treacherous terrain of health-status discrimination. In some instances, we advocate legal responses to healthist practices and policies, identifying gaps in existing protections for the unhealthy and proposing appropriate reforms. In other instances, we endorse laws that promote healthier behaviors and conduct, with a cautionary eye toward the potential for those laws to perpetuate discrimination and stigmatization of disfavored groups.

CHAPTER SUMMARY

I. Defining Healthism

In the first section of the book, we define key terms for analysis, address some broad objections to the concept of healthism, and introduce the reader to our theoretical framework for assessing whether a particular health-based classification should be considered permissible or discriminatory.

Chapter One: What is Healthism?

The book begins by introducing readers to the concept of healthism, by which we mean discrimination on the basis of health status. According to our definition, an entity discriminates on the basis of health status when it classifies on the basis of health in such a way that produces a normative wrong. Hence, we also unpack essential elements of that definition, including "health," "health status," and "normative wrong." Within health status, we include both static conditions and dynamic behaviors, a decision that complicates our analysis but is necessary to fully explicate the issues raised by health-status discrimination. We also explain what we consider normative wrongs in this context and introduce our key distinction that some instances of health status discrimination are neutral or even desirable. Our definitional discussion is grounded in existing antidiscrimination paradigms and conceptual frameworks, including antisubordination, anticlassification, and immutability.

Chapter Two: Challenging Healthism.

Next we address potential objections to healthism as a concept. We acknowledge general concerns about the proliferation of protected categories as well as specific critiques that our new concept overlaps existing legal protections for, e.g., disability, age, genetic information, pregnancy. As our precursor scholarship has explained, however, existing laws leave troubling gaps in which individuals remain exposed to normatively wrong health-status discrimination. In many cases, those individuals falling into those gaps are already vulnerable to unequal treatment on grounds that the law has not fully recognized. Given the salience of health in current policymaking, our rubric offers an appealing way to address a number of social wrongs.

We also recognize, and ultimately incorporate into our thesis, the valid critique that some forms of health-related differentiations are rational and generate social welfare. With respect to rationality, we conclude that just because a policy is rational does not mean it is not also discriminatory. For example, it might be economically rational for an employer to avoid hiring women of reproductive age because of the high likelihood of lost productivity due to childbearing and rearing. Nevertheless, the law protects individuals from discrimination based on age, pregnancy, and family leave. More squarely in the health context, it is surely economically rational for an insurer to charge higher premiums or simply refuse to cover unhealthy individuals. Nevertheless, in passing the ACA, Congress, made a policy decision to all but prohibit such discrimination as socially undesirable.

In addition to identifying public policy decisions to override the rational actor model, we note limits of the model itself. First, we draw on behavioral economic theory to note that individuals do not always act rationally but, rather, are influenced by implicit bias and other judgment errors. Second, we recognize societal restrictions on individuals' apparently free choice, which undermine a strict rational

actor analysis. Several factors, such as where a person lives, her available resources, her amount of free time, or her current health status, may impede her ability to make healthier choices. Given those social determinants of health, any initiatives designed to facilitate healthy decision-making will inevitably fail if individuals lack meaningful choices. Accordingly, we advocate some paternalistic interventions designed to improve health. Because of these various complexities, understanding healthism demands a more rigorous theoretical framework.

Chapter Three: Understanding Healthism.

Finally, in defining healthism we make one of the key insights of the book: not all differentiation on the basis of health status is healthist. Not all health-based classifications lead to a normative wrong. In fact, when individuals have the ability to make meaningful decisions, distinguishing on the basis of health can actually produce a positive impact. Namely, health-status differentiation can incentivize individuals to take steps to improve their health and thereby gain the privileges accorded to the healthy, or avoid the disadvantages assigned to the unhealthy. We are sensitive to the limits of free choice identified in the previous chapter and recognize the potential to perpetuate bias and stigma against individuals who apparently make "bad" choices, although those decisions may not actually be entirely voluntary or within the individuals' control.

We seek to navigate the difficult dichotomy that at times would prohibit distinguishing between individuals on the basis of health and at other times would condone such differentiation. We therefore introduce the theoretical framework we will apply in Part III, which holds that the law should permit or seek to encourage health-based classifications that promote wellness, encourage healthy decision-making, and facilitate increased access to health care and should outlaw or otherwise discourage those differentiations that are based in animus, create stigma, intrude on private conduct, limit access to health care or the ability to make healthier choices, generate poorer health outcomes, or exacerbate existing health disparities.

II. Existing Law: The Need for a New Conceptual Framework

In the second section of the book, we discuss the existing federal laws that regulate discrimination related to health. We explain that while these statutes may address some of the undesirable healthism we wish to target, they ultimately fall short of the kind of legal regulation necessary to address a significant portion of socially harmful health-status classifications. Our project first identifies then fills that gap in the law.

Chapter Four: Limits of the ADA and GINA.

Here we explain why the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) fail to adequately address healthist conduct. The ADA is a fairly comprehensive statute, outlawing discrimination on the basis of disability in employment, government services, and public accommodations. The legal definition of disability includes current, past, and perceived impairments. Thus, the ADA prohibits certain healthist conduct, for example if a gym refused to allow people with cerebral palsy to join, or an employer fired an employee for being diagnosed with cancer. For our purposes, however, the ADA's protections ultimately fall short. Even with its broad definition of disability, the ADA only covers certain health statuses. Specifically, it covers health-related traits (current, past, and hypothetical) but it does not cover health-related conduct, such as tobacco use. We will discuss the "lifestyle discrimination" trend among employers, which may include refusing to hire individuals who test positive for nicotine. We consider such policies healthist but find them outside the purview of the ADA. Likewise, the ADA's protection of certain other health-related attributes, such as obesity, remains ambiguous.

GINA also addresses certain kinds of healthism, albeit in a far more limited fashion. It outlaws discrimination on the basis of genetic information in health insurance and employment. The statute defines genetic information as an individual's genetic test results, the genetic test results of that individual's family members, and manifested health conditions in the individual's family members (i.e., family medical history). Importantly, GINA's focus is on asymptomatic genetic risk: It does not cover an individual's manifested health conditions, even if they are genetic in nature. Hence, GINA protects against discrimination on the basis of very specific health statuses, mainly genetic test results and family medical history, in very specific circumstances, health insurance and employment. Both the ADA and GINA leave unregulated a significant amount of socially undesirable healthism.

In sum, existing laws do not reach all of the forms of health status discrimination, or the cross-cutting contexts in which we find unacceptable healthism at work. Accordingly, we advocate a new protected category for the "unhealthy," as defined in the earlier chapters, and broader legal protection thereof.

Chapter Five: Limits of the ACA and HIPAA.

Both the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act (HIPAA) attempt to limit discrimination on the basis of health status in health insurance. Congress passed HIPAA in 1996. Among other reforms, HIPAA also regulated primarily the large group health insurance market and, to a lesser extent, the small group and individual markets. In particular, the law limited (but did not outright ban) preexisting condition exclusions to specified waiting periods and prohibited insurers from discriminating against individuals within the group on the basis of health status. Although shielding some individuals

from some forms of health-status discrimination in the insurance market, HIPAA left significant gaps in the law.

The ACA, enacted in 2010, was widely trumpeted as combatting healthism in health insurance, the law still does not reach all of the healthist practices in insurance or other contexts that we identify. First, the ACA extended HIPAA's limit on preexisting condition exclusions to a complete ban, and the health-related underwriting and ratemaking prohibitions to the small group and individual markets. The ACA, however, includes certain exceptions, which we conclude leave gaping holes in the law's antidiscriminatory promise. Namely, insurers still vary premiums based on geographic location, age, tobacco use, and wellness program participation. At least two of the permissible rating criteria for the individual and small group markets—age and tobacco use—strongly correlate with health status, and a third—location—loosely correlates with health status. Thus, instead of eliminating health status-based rating in those markets, the ACA simply introduced proxies. Secondly, some of the ACA's other provisions, like those governing attainment-based wellness programs, could perpetuate and perhaps even encourage health-status discrimination by placing the "blame" for poor health on individual behaviors, which may be the product of societal factors or other limits on voluntary choice.

Although federal law has made considerable strides in addressing healthism in health insurance, we provide closer examination of the assumptions underlying those laws with respect to the health promotion versus health discrimination divide. Ultimately, we conclude that broader legal protection for the "unhealthy" is warranted.

Chapter Six: Limits of Contract and Tort Law.

The above statutes—ADA, GINA, HIPAA, and ACA—all effectively restrict private law models of contract rooted in neoclassical notions of economics. Each of these laws restrict employers' and insurers' freedom to refuse to enter certain contracts with certain unhealthy individuals. As explained, we would place further public policy limits on freedom of contract in the employment and health insurance contracts. In this chapter, we consider the need for legal intervention to address healthism in other contractual contexts, particular, health care delivery, the retail marketplace, and housing. Since Reconstruction, federal law has prohibited racism in contract formation and enforcement, and other civil rights laws prohibit discrimination in places of public accommodation and housing. Ample scholarship has considered racism in retail and other contract settings, and advocates the need for wider protections. By analogy, we identify a host of under-examined possible instances of healthism in private contracting, including smoking restrictions; airlines' requiring obese passengers to purchase two seats; and physicians refusing to treat "noncompliant," "uncooperative," or other high-utilization patients. A

number of local jurisdictions have enacted laws restricting certain contracts in the name of health, such as New York City's "Big Gulp Ban" or laws regulating the amount of fat and salt in restaurant foods. Consistent with our dichotomous thesis, we sort the various examples into desirable forms of classification that promote better health and undesirable healthist practices or policies that unfairly discriminate or perpetuate existing stigma or health disparities.

Another area of private law, tort, also has the potential to perpetuate healthism. As with contracts, prior scholarship has considered other forms of discrimination, on the basis of race, gender, age, and other protected categories. We extend that analysis to consider health-status based differential treatment in personal injury law. For example, certain defenses to negligence and products liability—contributory negligence and assumption of risk—may disallow or reduce plaintiffs' recovery based on health status or health-related conduct. On the other hand, the eggshell-skull rule ensures that individuals receive full compensatory damages even if their fragile health status means they are injured more severely than a healthy person would have been. The doctrine of mitigation of damages also has the potential to inject healthist considerations by penalizing patients for failing to take steps, post-injury, to reduce the severity of injuries. To the extent tort law effectively incentivizes individuals to alter their behavior (and we recognize a considerable body of scholarship concluding that it does not), some of those rules may fall on the acceptable health discrimination side of our divide. In any case, tort law examples are especially revealing of difficult questions running throughout our analysis regarding voluntariness and causation.

This chapter concludes that tort and contract leave considerable spaces within which socially undesirable differentiation based on health status can flourish. Legislative and common law reforms have not effectively addressed the problem; therefore, we propose certain doctrinal adjustments. At the same time, we recognize the possibilities for legal restrictions on freedom of contract and availability of tort law damages to have salutary effects on health promotion.

III. Navigating the Divide

Having identified the limits of existing laws and need for additional legal regulation of healthism in the United States, we now apply our framework to specific contexts and explore where the law should and should not intervene.

Chapter Seven: The Good: Health-Promoting Classifications.

Throughout the book, we pay careful attention to the contexts in which differentiating on the basis of health can produce favorable public policy outcomes. Consequently, we conclude that health-status differentiation is desirable when it:

- Promotes healthy decision-making
- Facilitates individual choices regarding health
- Lowers health risks
- Lowers health-care costs
- Facilitates better health care and better health-care access

According to those factors, as long as individuals have meaningful choices, it is not healthist to encourage them to make good decisions about their health. In the book, we will explore myriad examples of "good" and "bad" health classification. For purposes of this proposal, we will provide one exemplar of each, applying the identified factors.

For example, a participation-based, employer-provided wellness program could include smoking cessation as a goal. Such a program would target smokers, technically making it differentiation on the basis of health status. But as long as all employees can participate fully—i.e., there are no structural barriers to participation, such as requiring individuals to attend meetings across town that would require having a car or access to child care—the intervention would not be healthist. Such an initiative, if effective, could also lower people's health risks and, by consequence, their potential health-care costs. While potentially creating stigma by singling out smokers, these policies could produce far more good than bad. In such contexts, the law should not only permit health-status classifications but also encourage them.

Chapter Eight: The Bad: Healthist Classifications.

Despite the ability of health-based differentiation to generate positive results, there are times when differentiation on the basis of health status can do more harm than good, rising to the level of socially undesirable discrimination. We conclude that healthism occurs when it:

- Is driven by animus
- Stigmatizes individuals unfairly
- Punishes people for their private conduct
- Impedes access to health care
- Cuts off resources or otherwise limits the ability to adopt healthy life choices
- Produces worse health outcomes
- Maintains or increases existing health disparities

Bans on hiring nicotine users are paradigmatic healthist conduct. As a threshold matter, people generally hold very negative perceptions of smokers, thereby indicating that such policies could be driven, at least in part, by animus. They also stigmatize nicotine users by reducing them to a single characteristic—

nicotine use—without regard for their other attributes that could make them good employees. While outlawing using tobacco products at work might be sound employment policy, testing prospective employees for nicotine infringes on their personal lives as it penalizes them for private conduct outside the workplace.

Moreover, these hiring bans can actually have unintended effects on health-care access. Health care is very expensive in the United States, making most people dependent on health insurance for obtaining needed medical treatment. A majority of non-elderly Americans rely on their employers for health insurance. Hence, denying an individual a job because she tests positive for nicotine also denies her access to the predominant source of health insurance and perhaps also access to health care as a result. Likewise, it denies her wages to pay for health care out-of-pocket, as well as the benefits of employer-provided wellness programs, which frequently include tobacco cessation initiatives. Nicotine bans therefore cut off resources and limit a person's ability to adopt healthier life choices. Shutting nicotine users out of employment may paradoxically produce a healthier workforce but a less healthy overall population. In addition, because people of color, people with disabilities, and lower income individuals are more likely to use nicotine, nicotine bans disproportionately affect these groups, holding the ability to perpetuate existing health disparities. For all these reasons, those bans are healthist, yet they are also outside the scope of the existing laws described in Chapters Four and Five. As a result, we propose a federal employment discrimination to regulate this socially harmful conduct.

IV. Conclusion

The book closes by returning to the conceptual foundations of healthism, offering a roadmap through the various laws and regulations—good and bad—targeting health status.

Chapter Nine: Conclusion.

Our central distinction holds that differentiation on the basis of health status is desirable when it successfully promotes responsible, healthy behaviors, yet undesirable when it perpetuates or exacerbates existing health disparities and social disadvantage. By applying this rubric, we assist the reader in making sense of the seemingly incoherent legal regime that at times protects health status from discriminatory treatment and at times fails to consider or even affirmatively authorizes distinctions based on health as sound public policy.

The conclusion examines the extent to which those variable approaches align with our instincts about conditions that are amenable to individual control versus conditions that are perceived as largely immutable. Health offers a particularly rich example for considering that tension because almost all health conditions may

be attributable to individual behavior and choices, factors beyond individuals' physical or social control, or a complex combination of the factors. Our conclusion considers whether the law's current approaches to healthism are justified, or in need of rational reform. We evaluate laws and practices expressly designed to encourage healthier conduct as well as laws and practices that perpetuate unfair differentiation on the basis of health status to offer the outlines of a cross-cutting approach to reducing undesirable healthism in the law.

CONTRIBUTION TO THE EXISTING LITERATURE

Our book has no direct market competitors at present. There is no authoritative text on the subject of health-status discrimination. Texts are available focusing narrowly on specific areas of health-related discrimination, such as on the basis of genetic information, HIV/AIDS, or mental illness. Moreover, no currently offered book considers healthism across a range of contexts, including private insurance, employment, health care delivery, the judicial system, and the marketplace. We write against a backdrop of extensive, systemic health reform at the federal and state level and find health-status differentiation a potentially valuable element of a larger strategy to promote health and wellness while reducing health care costs.

Christina Fisanick's book DISCRIMINATION (Greenhaven 2011) includes a chapter called "Health Discrimination," comprised of articles related to age discrimination, HIV/AIDS discrimination, mental illness discrimination, obesity discrimination, genetic discrimination, and discrimination against people with leprosy. Those articles, however, have a distinctly international focus, discussing discriminatory practices in the United Kingdom, Senegal, the United States, Australia, and India. Additionally, the book is designed for high school education. Thus, while the book identifies similar subject matter, it differs from our book in its format, scope of coverage, and intended audience.

A number of acclaimed scholars have written shorter works on themes that we seek to encompass within our larger conceptual framework. Moreover, even the foundational pieces predate developments in antidiscrimination law and health care reform. Our book will provide a modern, updated discussion. For example, in the early 1980s, Gerald Dworkin provided important foundational work on voluntary health risks, defining three categories of potential relevance to policymaking: role responsibility, casual responsibility, and liability responsibility. Robert Schwartz later built on Dworkin's categories to largely reject any law that would punish individuals if they make "costly, immoral or *unhealthy* life style choices" (emphasis added) because, in Schwartz's view, health care policymaking should focus on more fundamental, systemic flaws rather than individual behaviors. Robert Veatch's 1980 *Journal of the American Medical Association* article took a different stance, urging increased focus on individual responsibility for health, perhaps more

vehemently than most contemporary authors or conservative policymakers. John Knowles 1977 *Daedalus* essay, *The Responsibility of the Individual*, struck a similar tone. We appreciate these classic arguments but recognize the more nuanced health policy landscape that has emerged in recent years. Although some recent scholarship has returned to the issue of individual choice and health status, none has done so comprehensively, in book-length form.

Various acclaimed scholars have addressed discrete topics that we incorporate as examples of healthist or, alternatively, health-promoting laws. But no prior work has attempted to comprehensively map the terrain across a range of contexts. With respect to individual topics included within our discussion, we acknowledge, for example, Deborah Stone's classic article, *The Struggle for the Soul of Health Insurance*, identifying competing models of actuarial fairness and the solidarity principle in health insurance. Ani Satz, Elizabeth Pendo, and Mary Crossley have written extensively and insightfully on disability discrimination in the workplace and in health care delivery. Ronald Bayer, Scott Burris, Lindsey Wiley, and others have examined a number of public health strategies aimed a reducing smoking, obesity, and other health-injurious behaviors. Finally, scholars such as Judith Daar, Jaime King, and Karen Rothenberg have considered the potential for health-status selection via reproductive technologies. Our project draws from these and various other examples to provide a comprehensive portrait of how Americans may experience disadvantage on the basis of health status and to prescribe targeted legal interventions to protect unhealthy individuals.

AUDIENCE

Our intended audience includes students and academics interested in health law, health policy, public health, and related areas. We envision the title as a course book and/or recommended reading for upper-level students. Our book will appeal to lawyers, health insurers, regulators, and medical professionals. Given the prominence of these themes in the popular press and public policy, the book should also have strong appeal to lay people. The book will serve as both a useful compendium of the existing laws and policies regulating health care and a cutting-edge prescription for future reforms.

Public debates that culminated in the historical enactment of the ACA, focused considerable public attention to the practical effects of full implementation of new law in a range of contexts, including public and private health insurance, access to care, and health promotion. Those conversations have sparked philosophical debates about the role of "nanny state," "big government," and "big business" in individuals' lives. High-profile Supreme Court litigation over the ACA's health insurance mandate and federal subsidies for private insurance evidences the country's deep divide over the proper realm of health: whether it is

more appropriately viewed as a matter of personal responsibility or the government's responsibility to regulate and, perhaps, even to provide.

The book will also offer a provocative classroom text, highlighting fundamental debates about health regulation and health-care delivery, in the particular context of an historic federal health reform effort. It could be assigned to professional, graduate, and undergraduate level courses in health law, health policy, insurance law, employment discrimination, bioethics, and public health. It will also appeal to a broad range of nonacademic audiences, given the range of settings in which the role of healthism is explored. The topics covered engage some of the most hotly debated public policy and bioethical issues of our day.

MANUSCRIPT DETAILS AND TIMING

We anticipate a manuscript of approximately 200 pages but are open to suggestions for shortening or lengthening the project. We are on-schedule to have a completed manuscript by late summer/early fall 2016.

Some portions of the manuscript will draw on our previously published scholarship on healthism, including Jessica Roberts's *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 University of Illinois Law Review 1159, *Healthism and the Law of Employment Discrimination*, 99 Iowa Law Review 571 (2014), and our co-authored work-in-progress, *What Is (and Isn't) Healthism?* (in progress). These portions will be revised and incorporated within the manuscript as examples and explication of our key concepts and thesis. Most of the manuscript will be newly drafted discussion and examples.

AUTHORS' BIOGRAPHIES

Both authors are nationally recognized experts in the areas of health law, health care financing and regulation, health care reform, public health law, and bioethics.

Jessica L. Roberts is Interim Director of the Health Law and Policy Institute and Associate Professor of Law at the University of Houston Law Center. Her teaching interests include Health Law Survey, Disabilities & the Law, and Genetics & the Law. She was recently awarded a competitive, national, three-year research grant, the Greenwall Faculty Scholar in Bioethics Grant, and was also recognized by her home institution with the Teaching Excellence Award and Provost's Certificate of Excellence. Professor Roberts is a pioneer in the area of discrimination on the basis of health-related information. Her work has appeared or is forthcoming in the Iowa Law Review, the Minnesota Law Review, the Vanderbilt Law Review, the Notre Dame Law Review, the University of Illinois Law

Review, and the University of Colorado Law Review. She is a graduate of the University of Southern California and the Yale Law School. Before entering academia, Professor Roberts clerked for Judge Roger L. Gregory, U.S. Court of Appeals for the Fourth Circuit, and Justice Dale Wainwright, Supreme Court of Texas. She also completed the Associate in Law program at Columbia University.

Elizabeth Weeks Leonard is a Professor of Law at the University of Georgia where she teaches Health Care Financing & Regulation, Health Care Fraud & Abuse, Health Law Survey, and Torts. She has chaired the Association of American Law Schools Section on Law, Medicine & Health Care and co-edits the Health Law Section of Jotwell, an online journal highlighting top legal academic scholarship. Professor Leonard has written extensively on federal and state health reform, health care federalism, employer-based health insurance, public health, and health care and individual rights. She is currently co-authoring Law of American Health Care, a new health law casebook for Aspen/Wolters Kluwer. Her scholarship has been published or is forthcoming in the Cambridge University Press, Carolina Academic Press, Boston University Law Review, Wake Forest Law Review, Washington University Law Review, University of Pennsylvania Journal of Constitutional Law, and the Journal of Corporation Law. She is a graduate of Columbia University and the University of Georgia School of Law. Before entering academia, Professor Leonard clerked for Judge Jacques L. Wiener, Jr., U.S. Court of Appeals for the Fifth Circuit, and Chief Justice Thomas R. Phillips, Supreme Court of Texas. She then practiced with the Health Industry Group of Vinson & Elkins, LLP in Houston and Washington.

CONTACT INFORMATION

Thank you for reviewing this manuscript proposal. We would be delighted to answer any questions you may have and look forward to responding to any editorial or peer review suggestions for improving our proposal. Please feel free to contact either of us at jrobert6@central.uh.edu, (713) 743-2101, or weeksleo@uga.edu, (706) 542-4309.