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PREFACE

Situating *Braidwood* in Broader Conversations About Health Policy and Administrative Law

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This symposium centers on *Braidwood v. Becerra*,[1] a case that challenges the preventive care provisions of the Affordable Care Act (ACA).[2] In a complex year in the courts, it might be easy to think this case is not as important as others or that it is too deep in the weeds. That would be a grave mistake. The issues that *Braidwood* raises are not only central to health policy, but they go to the heart of the philosophy underlying the ACA, as well as to some of the most important current debates in the U.S. Supreme Court about the future of the regulatory state and deference to scientific expertise.

This issue features leading experts whose pieces examine in detail the various legal arguments that *Braidwood* involves. Instead of repeating or preempting those arguments, this introduction aims to do something different by way of setting the stage. My goal is to situate the case in broader debates about health care, the Court, and the administrative state.

I. Braidwood and the Preventive Services Mandate: A Brief Overview

Before turning to these broader concerns, a brief background on the legislative framework and the *Braidwood* case is in order.

A. The Preventive Services Mandate

At its most simplified, *Braidwood* is about the ACA's requirement that people receive preventive care, including vaccines, cancer screening, hearing screening, medication that prevents heart disease or HIV, and more — close to 200 such services — at no cost to the patient beyond their insurance. The plaintiffs wish to wipe off the books this "preventive services mandate," which requires health plans to provide these 200 services to beneficiaries without a co-pay or deductibles.

It may seem obvious that people should have access to preventive services, but it is too easy to forget that, before the ACA, our health system did not widely cover preventive care at no cost. Like so many other provisions of the ACA that have had a tremendous impact, we have come to take the preventive services protections for granted. For that reason, I always begin any discussion of preventive care with a personal anecdote.

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[1]Braidwood Mgmt. v. Becerra, 627 F. Supp. 3d 624 (N.D. Tex. 2022). These remarks were delivered while the case was pending before the Court of Appeals for the Fifth Circuit, which heard oral arguments on March 4, 2024. The Fifth Circuit issued its opinion on June 21, 2024. *See* Braidwood Mgmt. v. Becerra, 104 F.4th 930 (5th Cir. 2024). Final appeals remain pending.

[2]42 U.S.C. § 300gg-13.

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I have twin boys who are now seventeen. When they were two years old, I received an *enormous* bill after a routine wellness checkup — unlike any I had received for their care to date. When I questioned the office, I was told my insurance did not cover the kids' childhood vaccines. I was certain there had been a mistake and insisted that I had terrific insurance — which I did, and I still do; it has covered all sorts of treatments, including experimental ones. But then I learned what was a shocking fact to me at the time: my insurance, like most others, did not cover *basic vaccines*, even for children. Fast forward to 2012, when my daughter was born. Her two-year visit passed uneventfully. It was not until months later that I realized I had not received that bill again. What had changed in the interim? Three words: Affordable Care Act.[3] The ACA was enacted in 2010 and the preventive services mandate was one of the provisions that took effect immediately.

Most of us share a similar story. If you think you do not… How many readers of this symposium issue have been vaccinated for COVID-19? How many paid a dime out of pocket for it? Would all of the people who got vaccinated against COVID-19 have done so if they had to pay fifty, forty, or even twenty dollars for it? The clear answer is no. A mountain of empirical evidence going back years shows that people, especially those of lower means, put off or completely bypass preventive health care services with even a modest price tag.[4] For that reason, we should make clear from the beginning of our discussion in this issue that *Braidwood* is a case that threatens health equity as much as anything else.

So, how exactly were the COVID vaccines made free? The ACA has a provision, the preventive services mandate,[5] which designates a process that relies on the expertise of three bodies that have long been in the business of evidence-based recommendations for preventive care — working in this space long before the ACA was enacted. Those bodies — the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA) — make recommendations for preventive services, ranging from general preventive care, to vaccines, to preventive care specifically targeted toward women and children. Specifically, the ACA requires coverage for "evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations" of USPSTF;[6] "immunizations" recommended by the ACIP; and "preventive care and screenings" for women, infants, children, and adolescents recommended by

[3] Abbe R. Gluck & Erica Turret, *Happy Tenth Birthday, Obamacare: This Crisis Would Be Much Worse Without You*, Health Affs. (Mar. 23, 2020), https://www.healthaffairs.org/content/forefront/happy-tenth-birthday-obamacare-crisis-would-much-worse-without-you ("It is also the ACA that will allow the federal government to mandate that insurers must cover a future COVID-19 vaccine at no out-of-pocket costs to all individuals, as a required preventive service.").

[4] *See* Brief of 49 Bipartisan Economic and Other Social Science Scholars as Amici Curiae Supporting Defendants-Appellants, at 6-7, Braidwood Mgmt. v. Becerra, No. 23-10326 (5th Cir. June 27, 2023). For a famous study on the effects of expanding access to public insurance coverage on beneficiaries' use of services, see Katherine Baicker et al., *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes*, 368 N. Eng. J. Med. 1713, 1718 (2013) (finding, based on interviews and a survey, that "Medicaid coverage resulted in an increase in the number of prescription drugs received and office visits"). For a summary of the "most comprehensive study" on the effects of high-deductible plans on enrollees' use of care, see Amelia Haviland et al., RAND, Skin In the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care (2012) (reporting a decrease in use of preventive care services, including childhood vaccinations, mammography, cervical cancer screening, and colorectal cancer screening among customers of health plans that include high deductibles); *see also* Zarek C. Brot-Goldberg et al., *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 Q.J. Econs. 1261, 1293-96 (2017) (finding, based on a natural experiment, that the transition from an insurance plan that provides free health care to a health plan that includes high deductibles led customers to reduce consumption of preventive care services); Sara R. Collins, Lauren A. Haynes & Relebohile Masitha, *The State of U.S. Health Insurance in 2022*, Commonwealth Fund (Sept. 29, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey (finding, based on a survey of 8,022 adults, that "[s]ixty-one percent of working-age adults who were underinsured and 71 percent of those who lacked continuous coverage said they had avoided getting needed health care because of the cost of that care").

[5] 42 U.S.C. § 300gg-13.

[6] *Id.* § 300gg-13(a)(1).

HRSA.[7] These preventive services have evidence-based efficacy and, as a result, experts have concluded they should be made available cost free.

In making recommendations, the expert entities described above are supposed to exercise independent scientific judgment. Like many entities in the Department of Health & Human Services (HHS) that do so, they still generally operate under the supervision of HHS in various ways — some are part of HHS; others are appointed by HHS leadership. The specifics of those appointments are relevant to some of the challenges in the lawsuit and will be detailed in other contributions to this symposium.[8] For the purpose of this introduction, however, the key point is that one cannot be charged out of pocket for the services recommended by these expert bodies. And while these provisions apply only to private plans, Medicaid — the program for low-income individuals — largely tracks those recommendations with the same result.[9] And that is why COVID-19 vaccines were free for everyone, from the community health center to board CEO.

It is not an insignificant tidbit that one of the components of this preventive services mandate — the sub-provision requiring health plans to provide specific preventive services for women[10] — was added to the ACA on the Senate floor following an intense political debate about the age at which women's mammograms should be covered.[11] By looking to experts — rather than a majority of senators — to define which services should be covered, the ACA salutarily diminishes the role of politics in deciding what specific health care services people should receive. And with the preventive services ultimately covered under the ACA — whether it is colon cancer screening, statins for heart disease, or contraception — all kinds of people, male and female alike, benefit.

And that is what is being challenged in this case. The government estimates that more than 150 million people gained access via the preventive services provisions in the ACA in 2020.[12] We do not yet have data for 2021, but access to COVID-19 vaccines likely boosted some preventive care numbers, even as suspension of other healthcare services during the pandemic likely simultaneously depressed them.[13]

[7] *Id.* § 300gg-13(a)(2)–(4).

[8] Among other things, the Fifth Circuit disagreed that USPSTF was "supervised" by HHS. Braidwood Mgmt. v. Becerra, 104 F.4th 930, 944 (5th Cir. 2024).

[9] 42 U.S.C. § 1396d(a)(13). Preventive services are also covered by Medicare, the program for individuals age 65 and older. *See* 42 U.S.C. § 1395x(s). For more on preventive services covered under Medicare, see *Preventive & Screening Services*, MEDICARE.Gov, https://www.medicare.gov/coverage/preventive-screening-services (last visited May 2, 2024).

[10] 42 U.S.C. § 300gg-13(a)(4) ("[W]ith respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.").

[11] Press Release, Nat'l Org. for Women, Senator Mikulski's Women's Health Amendment Is an Important Improvement to the Senate Health Care Reform Bill (Dec. 1, 2009), https://now.org/media-center/press-release/senator-mikulskis-womens-health-amendment-is-an-important-improvement-to-the-senate-health-care-reform-bill/ (urging "all senators to support Senator Mikulski's amendment, which will guarantee women in their 40s access to mammograms and other screenings"); David M. Herszenhorn & Robert Peer, *Senate Passes Women's Health Amendment*, N.Y. TIMES (Dec. 3, 2009), https://archive.nytimes.com/prescriptions.blogs.nytimes.com/2009/12/03/senate-passes-womens-health-amendment/ ("The debate over amendments related to women's health care had focused heavily on the question of when it is appropriate to begin annual mammograms to screen for breast cancer.").

[12] *See* Opening Brief for Federal Defendants at 1, Braidwood Mgmt. v. Becerra, No. 23-10326 (June 20, 2023) ("This statutory requirement gives 150 million Americans access (at no extra cost) to more than 50 services—many life-saving"); *see also* OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, U.S. DEP'T OF HEALTH & HUM. SERVS., HP-2022-01, ACCESS TO PREVENTIVE SERVICES WITHOUT COST-SHARING: EVIDENCE FROM THE AFFORDABLE CARE ACT at 3, 4, 6 (2022), https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf (referring to "more than 150 million people with private health coverage" who "benefit[] from the ACA's coverage of preventive services without cost-sharing"). A study based on 2018 data concluded that, that year, 100 million people actually utilized the benefit. *See* Krutika Amin et al., *Preventive Services Use Among People with Private Insurance Coverage*, PETERSON-KFF HEALTH SYS. TRACKER (Mar. 20, 2023), https://www.healthsystemtracker.org/brief/preventive-services-use-among-people-with-private-insurance-coverage/.

[13] *Cf. id.* ("[P]reventive services utilization changed during the pandemic, as many people delayed or went without routine screenings in 2020 and most adults received COVID-19 vaccines in 2021.").

B. The Case

The plaintiffs in *Braidwood* are four individuals and two companies.[14] One of these companies is Braidwood, "a Christian for-profit corporation," whose owner "wishes to provide health insurance" for the company's employees "that excludes coverage of preventive care such as contraceptives and PrEP drugs."[15]

The plaintiffs' challenge to the preventive services mandate rests on several prongs. First, the challengers invoke the nondelegation doctrine, arguing that Congress has not given enough guidance to the three expert agencies for deciding which services and immunizations should be covered.[16] Specifically, the challengers argue that merely noting that the recommendations should be "evidenced-based" and designating the kind of care and populations involved is not sufficient to satisfy the nondelegation criteria. Second, the challengers make a claim regarding the appointments and supervision of the various recommenders, arguing that (1) members of USPSTF, ACIP, and HRSA are in fact "Officers of the United States," and (2) the appointment process for these members did not meet the constitutional requirements. Third, the challengers invoke religious freedom and object to the mandatory coverage of pre-exposure prophylaxis ("PrEP"), a drug aimed at preventing HIV, as a covered (mandated) preventive service. Citing the Religious Freedom Restoration Act (RFRA), plaintiffs object to underwriting insurance that facilitates behaviors such as "sexual activity outside marriage between one man and one woman."[17] According to Braidwood's claims, by covering PrEP in its insurance plan at no cost, it effectively endorses such behaviors against its religious beliefs.

As of this writing, the case has been decided by two courts. The district court held that the USPSTF's structure, and in particular the independence the court concluded was granted to its decisions, violated the Appointments Clause. It found no similar violation with respect to ACIP and HRSA because the HHS Secretary has the authority to ratify their recommendations. The district court rejected plaintiffs' argument that the preventive services mandate violated the nondelegation doctrine, but ruled for the plaintiffs that requiring Braidwood to cover PrEP in its insurance plan "substantially burdens the religious exercise of Braidwood's owners."[18] On appeal, the Court of Appeals for the Fifth Circuit upheld the district court's determinations regarding the Appointments Clause challenges.[19] It disagreed with the district court, however, on the appropriate relief. Specifically, the Fifth Circuit held that the plaintiffs were entitled to only "party-specific injunctive relief," as opposed to vacatur and universal injunction ordered by the district court.[20] Just before this volume went to press, the United States filed its petition for certiorari, seeking review by the U.S. Supreme Court.[21]

Other essays in this issue detail the case's evolution. The remainder of this introduction will focus on the broader significance of *Braidwood* for health law and policy, as well as administrative law.

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[14]The lawsuit included a larger number of plaintiffs, identified by the district court as both "religious objector" and "non-religious objector" plaintiffs. Braidwood Mgmt. v. Becerra, 666 F. Supp. 3d 613, 619 n.6 (N.D. Tex. 2023). In a March 2023 decision, the district court held that only the "religious objector Plaintiffs" had standing. *Id.* at 625. The Fifth Circuit did not disturb that judgment. Braidwood Mgmt. v. Becerra, 104 F.4th 930, 938 n.18 (5th Cir. 2024).

[15]Braidwood Mgmt. v. Becerra, 627 F. Supp. 3d 624, 634 (N.D. Tex. 2022).

[16]The district court rejected the plaintiffs' nondelegation claim, holding that "the authority granted to the agencies falls within the constitutional parameters outlined by the Supreme Court and the Fifth Circuit." *Braidwood Mgmt.*, 627 F. Supp. 3d at 652 (relying on a recent Fifth Circuit decision, Big Time Vapes, Inc. v. Food & Drug Admin., 963 F.3d 436 (5th Cir. 2020)). In their brief on appeal, the plaintiffs acknowledged that their nondelegation claim is "foreclosed" by *Big Time Vapes, Inc.*, but they stated that they were "preserving this claim for the Supreme Court." Brief of Appellees/Cross-Appellants Braidwood Management Inc., et al., at 60, Braidwood Mgmt. v. Becerra, No. 23-10326 (Aug. 7, 2023). It therefore remains relevant to our discussion.

[17]*Braidwood Mgmt.*, 627 F. Supp. 3d at 652.

[18]*Id.*

[19]Braidwood Mgmt. v. Becerra, 104 F.4th 930 (5th Cir. 2024).

[20]*Id.* at 950-55. On the Appointments Clause challenge to ACIP and HRSA, the Fifth Circuit remanded the case to the district court for further consideration as to whether the HHS Secretary did in fact effectively ratify their recommendations. *Id.* at 956-57.

[21]Braidwood Mgmt. v. Becerra, 104 F.4th 930 (5th Cir. 2024), *petition for cert.* filed, No. 23-10326 (U.S. Sep. 19, 2024).

II. The Bigger Picture

A. The ACA

First and foremost, this case must be understood as an attack on the ACA, which is perhaps the most challenged statute in modern American history — and the most resilient. The ACA is now almost fourteen years old. It has survived seven trips to the Supreme Court, as well as more than seventy efforts to repeal it, a change of congressional control, three different presidents, and more than 2,000 lawsuits.[22]

The ACA also has been a resounding success. Returning to the COVID-19 pandemic, it is one of the unsung heroes of the national health emergency. Our insurance rolls, both public and private, swelled by tens of millions to meet the needs of a population dealing with an unprecedented health crisis where access to care was critical for many. And, again, our vaccines were free.

In the world of legislation scholarship, which is the other world in which I live, the ACA offers a classic example of public-law entrenchment.[23] It has become what some call a "super statute" — an initially controversial mandate that survives political change (three presidents spanning different political parties) and legal contestation, and then becomes enmeshed in the fabric of our lives in ways that affect the way we think about rights.[24] The Constitution does not provide a right to health care, but the ACA has brought us closer to that ideal than ever before.

And so, the question that arises now is: why are we still fighting over this law? Another question is whether this challenge is different from the so-called "existential" challenges that in years past threatened to bring down the entire statute.[25] My contention here is that, while *Braidwood* challenges only part of the ACA, and a part that has received relatively little attention, in many respects the plaintiffs' claims go to the heart of what the ACA stands for. This case should not be underestimated.

1. A Moral Attack on Disfavored Groups and Reincarnation of the "Deserving Poor"

Before the ACA was enacted, women faced higher insurance premiums or had trouble getting insured at all. Some people used to joke, cynically, that being female was treated as a pre-existing (and thus often disqualifying) health condition.[26] Women were not the only population that had access-to-insurance challenges before the ACA. While women were often discriminated against by private insurers,[27] in the public insurance context, it was *Congress* that did the discriminating — in terms of whom Congress deemed eligible for Medicaid and other public programs.

In the early years of the ACA, I routinely asked lecture audiences if they thought, prior to the statute's enactment, that a childless male below the poverty line living in Nebraska had access to government-provided health insurance. Most people assumed the answer was yes. But of course, the answer was actually no — and the ACA does not get sufficient credit for changing that. Indeed, the ACA made the transformative shift of eliminating the old notion of the "deserving poor" — that is, that only certain populations (e.g., pregnant persons, children, older adults) are deserving of public health insurance if

[22]*See* Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 Geo. L.J. 1471, 1472–73 (2020) (providing data on ACA litigation).

[23]Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 Geo. L.J. 495, 502 (2020) (documenting and analyzing the ways in which the ACA "adapted and endured" various challenges).

[24]William N. Eskridge, Jr. & John Ferejohn, *Super-Statutes*, 50 Duke L.J. 1215, 1216 (2001) (defining a "super statute" as "a law or series of laws that (1) seeks to establish a new normative or institutional framework for state policy and (2) over time does 'stick' in the public culture such that (3) the super-statute and its institutional or normative principles have a broad effect on the law — including an effect beyond the four corners of the statute").

[25]Gluck et al., *supra* note 17, at 1477–91 (describing "three significant 'existential' challenges to the ACA").

[26]Denise Grady, *Overhaul Will Lower the Costs of Being a Woman*, N.Y. Times (Mar. 30, 2010), https://www.nytimes.com/2010/03/30/health/30women.html?ref=health.

[27]Leslie King & Madonna Harrington Meyer, *The Politics of Reproductive Benefits: U.S. Insurance Coverage of Contraceptive and Infertility Treatments*, 11 Gender & Soc'y 8, 9, 14, 22, 24 (1997).

they cannot afford it.[28] That is a fundamental premise of the ACA: ending discrimination with respect to insurance access that turns on who you are.

Properly understood, *Braidwood* is a direct challenge to that critical transformation the ACA wrought; *Braidwood* threatens to restore the concept of the "deserving" health recipient. Why?

The case is not only about doctrinal issues like violation of the nondelegation doctrine or the Appointments Clause. It is also a moral attack on the population whose medication is being challenged here — gay men who are at risk of contracting HIV. Recall that the case is about someone who does not want to pay for insurance that covers PrEP. It is a challenge to the idea that populations at risk for HIV deserve preventive care.

It is worth dwelling on this issue because it did not figure prominently on appeal. The district judge in Texas, Judge Reed O'Connor, agreed with the challengers that having to pay for cost-free PrEP coverage violated their religious freedom rights. The government chose not to appeal that ruling. There are likely strategic reasons for that choice. For instance, the district court cabined the remedy on the RFRA claim to the six plaintiffs involved, so the effect is narrow; the government may have avoided risking a broader, precedent-setting opinion on appeal.

But tomorrow the challenge could target other populations. For example, employers might argue that they do not want to participate in plans that screen blue-collar workers for, say, lung cancer; other people might oppose to be part of health plans that screen rock musicians for hearing issues; still others might say they do not want to pay to screen obese people for diabetes if they have indulged at McDonald's. The implicit message is that the insurance beneficiaries in such examples are not deserving; put differently, that participants in insurance plans can morally judge people and their behavior and translate this judgment into exclusion from insurance.

Preventing that kind of discrimination is a fundamental achievement of the ACA and *Braidwood* risks undoing that key advance. Before the ACA, this kind of discrimination was rampant in the insurance arena. Consider, for example, the context of HIV. During the AIDS epidemic, insurers used "underwriting guidelines based upon apparent 'gay life-style.'"[29] One insurance company, for instance, "instructed underwriters to segregate the applications of single males" who had jobs "that do not require physical exertion" such as "florists, interior designers, and people in the fashion business."[30] Another insurance company "instructed underwriters to be wary" of insuring "single persons in certain cities who name parents or siblings as beneficiaries or who have been exposed to a person capable of transmitting the HIV virus."[31]

Is that a world we want to return to?

2. A Push to Reverse the ACA's Move Toward a Community-Based Approach

Second, *Braidwood* strikes at another important and related leg of the ACA: the law's effort to move the health care system from an individual-focused approach to a community-based approach.

It is important to understand that the ACA straddles a delicate balance in the long debate about whether our health care system should be focused on the individual or the community. The ACA moves the needle more than ever toward a so-called "solidarity" approach, whereby everyone is closer to being in the same insurance pool so we effectively pay for each other, and the primary goal is to get everyone covered. That was another incredibly important philosophical shift. And it would have been even more

[28] *See* Gluck et al., *supra* note 17, at 1510 (noting that, in enacting the ACA, "Congress took a large step toward 'universalizing' Medicaid").

[29] Mark Scherzer, *Insurance*, *in* AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 185, 197 (Harlon L. Dalton, Scott Burris & the Yale AIDS Law Project eds., 1987).

[30] *Id.*

[31] *Id.*

effective had the Supreme Court not made the Medicaid expansion optional,[32] because in drafting the ACA, Congress in fact made the Medicaid expansion mandatory.[33]

But it is also important to see that Congress's choice to cover preventive care in the ACA is a key part of that same philosophy favoring solidarity in health care access. It is true that the ACA designs the preventive services mandate in a way that is formally about what each *individual* no longer has to pay when they get a screening or a medication. Nonetheless, I would argue that the very idea of focusing on population-wide prevention brings us closer to a population-based public health approach than we have ever been before.

Apart from the problem of the "deserving poor," one of the oldest stories in health policy is the siloing off of the public-health and population-health systems from health care delivery and financing.[34] And it has always been more difficult to get Congress to invest in population-level changes, including prevention. Congress is weak on prevention and public health because the results take a longer time to materialize than the political cycle allows and are often less immediately tangible. Population-level changes are also harder to justify financially because Congress legislates in a short-term budget window, but the benefits of population health tend to accrue over a much longer term (think, tobacco cessation strategies).

As just one example that I have written about elsewhere: the National Cancer Institute's annual budget in 2020 was about $6 billion for research to address cancer after it occurs. By contrast, the budget of the CDC, which focuses on prevention, was $7.9 billion for the *entire* agency — not one disease — and those responsibilities included pandemic preparedness, grants to state and local health departments, global health initiatives, as well as cancer prevention programs, among others.[35] CDC's cancer prevention programs were allotted just $358.79 million in funding.[36]

Budgets reveal priorities and the numbers tell a simple story. Congress has not done enough to fund prevention. The ACA's preventive care provisions push the needle in the right direction. A prevention approach is not exactly the same as a population-health or public-health approach, to be sure, but it shares those approaches' philosophical underpinnings.

As Lindsay Wiley writes, now, under the banner of individual rights… the courts are eroding the legal foundations for privately financed public health."[37] In my view, cases like this reintroduce the idea that our health care system is a zero-sum game — exactly the opposite of a community-based approach.

3. Preventive Care Today Protects Medicare Tomorrow in Our Fragmented Health Care System

It is also worth recognizing, as one of the amicus briefs in the *Braidwood* case points out, that the fragmented nature of our health care system makes the ACA's preventive care provisions all the more important to ensure the stability of our public health programs.[38] To the dismay of some reformists, the ACA did not fix the fact that we have a "mixed system of federal, state, and private healthcare."[39] Rather than establishing a unified health insurance system, the ACA leaves the old system largely in place.

[32]Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588 (2012) ("As for the Medicaid expansion, that portion of the Affordable Care Act violates the Constitution by threatening existing Medicaid funding.").

[33]Gluck et al., *supra* note 17, at 1510.

[34]For the classic treatment, see Paul Starr, The Social Transformation of American Medicine 180–97 (1982), which details how the public health system was siloed from medicine from the beginning, largely due to turf-protective doctors who wanted to keep a government-based approach out.

[35]Hon. Rosa L. DeLauro & Abbe R. Gluck, *Cancer and Congress*, *in* A New Deal for Cancer: Lessons from A 50 Year War, 336, 351 (Abbe R. Gluck & Charles S. Fuchs eds., 2021).

[36]*Id.*

[37]Lindsay F. Wiley, *Extreme Religious Liberty Is Undermining Public Health*, N.Y. Times (Sept. 15, 2022),h ttps://www.nytimes.com/2022/09/15/opinion/religious-liberty-public-health.html. See also *Elizabeth* Sepper & Lindsay F. Wiley, *Religious Resistance and the Public's Health*, 50 Am. J.L. & Med. (forthcoming 2024);(2024).https://www.nytimes.com/2022/09/15/opinion/religious-liberty-public-health.html.

[38]Brief of 49 Bipartisan Economic and Other Social Science Scholars, *supra* note 4, at 13–17.

[39]Gluck et al., *supra* note 17, at 1473–74.

Americans still receive services under different programs — Medicaid, private health insurance, or Medicare — and most individuals move from one to another across the arc of life. What this means is that we cannot silo off prevention. If we do not incorporate prevention into the private insurance framework that most Americans use before retirement age, we effectively saddle Medicare — which most Americans utilize after age 65 — with an unhealthy older population and with the increased costs associated with later-than-ideal prevention measures.

Indeed, we are entering a generation of enormous growth in our aging population. Based on the increase in life expectancy before the COVID-19 pandemic, some demographers believe that a 100-year life will soon become common for Americans.[40] One of the core concerns of experts in this area of aging is this very idea of a healthier older generation and a healthier — not just longer — lifespan.[41] The briefs in this case are full of evidence of how early prevention is essential to that goal. It is also essential to keeping Medicare fiscally sound and not putting the price of lack of prevention on Medicare just as the older population explodes.

In addition to aging trends, another important and related trend that we are seeing today —one equally at odds with the challenge in this case — is the welcome increased recent focus on social determinants of health, a broader and more holistic approach to how we think about health care. That approach understands "health" broadly to include matters like access to nutritious food and housing. The Medical-Legal Partnership (MLP) movement, which I am proud to say Yale Law School has helped to develop, is at the forefront of this approach.

To say now that we are thus expanding the lens of what a healthy life requires and yet excluding preventive care from it is quite frankly nonsense. We cannot realistically try to move our system toward a holistically healthier population and a more equity-focused approach to health care on one hand, and then cut the legs out from under it by gutting prevention with the other.

The scientific evidence is clear about the potential consequences of invalidating the preventive services mandate. One study, which was conducted in response to the district court's decision in *Braidwood* and cited in a number of amicus briefs, estimates that elimination of the PrEP mandate would result in "more than 2000 entirely preventable primary HIV infections" among men who have sex with men (MSM) within one year.[42] Another study found that routine childhood vaccination of *one* birth cohort prevents more than 40,000 early deaths.[43] And such disease prevention has significant economic consequences: as a result of routine childhood immunization, the United States saves more than $13 billion in direct costs and more than $65 billion in indirect costs. In fact, experts estimate that childhood immunization generates a $10.90 return on every one dollar invested.[44]

B. Religious Freedom, the Administrative State, and the Supreme Court

Now I want to turn to my final point, which is the link between this case and broader debates happening in the Supreme Court. Specifically, I am going to discuss religious freedom and then scientific and technical expertise, and the ongoing attack on the administrative state.

First, religious freedom. I have already pointed out that part of this challenge was a moral and religious attack on targeted groups and that challenges in this vein do not have a logical stopping point. Single pregnant women could be next, or persons with substance use disorders. Of course, these concerns

[40]*See* Anne Alstott, *Law and the Hundred-Year Life*, 26 Elder L.J. 131, 131 (2018).

[41]Yaron Covo, Abbe Gluck & Linda Fried, *The 100 Year-Old-American and Our Health System*, *in* Law and the 100-Year-Old American (Anne Alstott, Abbe Gluck & Eugene Rusyn eds., forthcoming 2024).

[42]A. David Paltiel et al., *Increased HIV Transmissions with Reduced Insurance Coverage for HIV Preexposure Prophylaxis: Potential Consequences of* Braidwood Management v. Becerra, Open F. Infectious Diseases, Mar. 16, 2023, at 3.

[43]Fangjun Zhou et al., *Economic Evaluation of the Routine Childhood Immunization Program in the United States, 2009*, 133 Pediatrics 577, 577 (2014).

[44]J. Nadine Gracia & Amy Pisani, *Vaccine Infrastructure and Education Is the Best Medical Investment Our Country Can Make*, Health Affs. (Jan. 21, 2020), https://www.healthaffairs.org/content/forefront/vaccine-infrastructure-and-education-best-medical-investment-our-country-can-make.

are relevant to the broader Supreme Court landscape today because of how the current Court has elevated the principle of religious freedom over many other rights. This is a phenomenon that took hold during the COVID-19 pandemic and its presence, I think, is not mistakable.[45]

Second, administrative expertise. The 2023 Term was a shattering one for the administrative state, with the groundwork having been laid over the past several terms. The Court has spent the last few years making it much more difficult for Congress to delegate to subject matter experts, with decisions involving both the structure of how appointments are made and the structure of supervision of administrative bodies, both of which are implicated in *Braidwood.* The Supreme Court also has issued important and disruptive decisions holding that Congress must legislate on important matters with specificity, rather than delegating broadly to agencies — the so-called "major questions doctrine."[46]

This past Term saw two major health-care-deference cases at the Court. In the first, *Food & Drug Administration v. Alliance for Hippocratic Medicine*, the Court rejected plaintiffs' challenge to the scientific judgment of the FDA that the drug mifepristone, used in medication abortions, is safe.[47] But the decision was based on standing — the Court held that the plaintiffs did not suffer a concrete injury that entitled them to sue — and so left the future of FDA deference to another day. The second case, *Loper Bright Enterprises v. Raimondo*,[48] was far more momentous. The Court overruled the most important administrative deference doctrine, the *Chevron* doctrine,[49] in a decision in which the Court announced *itself* as the best interpreter of statutes, even where statutory interpretation questions involve highly complex, scientific, or otherwise technical questions outside of judicial expertise and close to the realm of policy.[50]

Loper Bright is a seismic shift, and thousands of law review pages will be devoted to it in the coming months. For our purposes here, let me just connect it to *Braidwood.* What we are seeing is an attack on expertise; the promotion of the idea that politicization of scientific knowledge and other complex questions is a better answer than delegation to those who have views informed by evidence. Scientific expertise is particularly at risk. The consequence of the new anti-deference regime is that the key decisionmaker, instead of agencies, is Congress — which, as we have seen, cannot resist politicizing debates about specific medical treatments.

Yet even when Congress does try to act, the Court is no longer allowing Congress to say, "we want to do something in a specific area but we have limitations — whether political or competence limitations — and we want to delegate broadly rather than legislate with rigid specificity." Instead, the Court is mandating legislative specificity—it tells Congress it can delegate, but that it needs to be hyper-specific about the questions it wants answered. But that simply does not work for crafting enduring statutory regimes — especially ones that turn on evolving scientific knowledge. Congress cannot go back and

[45]*See* Abbe R. Gluck & Jacob Hutt, *Epilogue: COVID-19 in the Courts*, *in* COVID-19 and the Law: Disruption, Impact, and Legacy 391, 397 (I. Glenn Cohen, Abbe R. Gluck, Katherine L. Kraschel & Carmel Shachar eds., 2023) ("[T]he most successful refutations of *Jacobson* came from those raising free exercise of religion claims in the face of generally applicable pandemic mitigation efforts."); *see also* Stephen I. Vladeck, *The Most-Favored Right: Covid, the Supreme Court, and the (New) Free Exercise Clause*, 15 N.Y.U. J.L. & Liberty 699, 746 (2022) (noting that the Supreme Court showed "favoritism for the Free Exercise Clause, at the expense of every other constitutional right, in the specific and unique context of COVID-related emergency orders"); Lee Epstein & Eric A. Posner, *The Roberts Court and the Transformation of Constitutional Protections for Religion: A Statistical Portrait*, Sup. Ct. Rev. 315, 338 (2021) ("In practice, the Court's rulings have mostly but not exclusively protected the conservative values of mainstream Christian organizations against secular laws, including public health orders to counter the Covid-19 pandemic ….").

[46]Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., Occupational Safety & Health Admin., 595 U.S. 109, 122 (2022) (Gorsuch, J., concurring); West Virginia v. Env't Prot. Agency, 597 U.S. 697, 723–32 (2022); *see also* Gluck & Hutt, *supra* note 40, at 393 ("The ascendance of the major questions doctrine may be one of COVID-19's most important legal legacies and the one with the biggest implications for the future of the modern administrative state.").

[47]FDA v. All. for Hippocratic Med., 602 U.S. 367 (2024).

[48]*See* Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244 (2024).

[49]*See generally* Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837 (1984).

[50]*Loper Bright*, 144 S. Ct. at 2263-73.

amend a statute every time evidence evolves. In fact, Congress often fails to issue technical amendments to correct even obvious statutory errors. It is just too hard to pass legislation.

When the decisionmaker is not Congress — and an agency is not permitted to exercise the discretion Congress tried to delegate to it — the decisionmaker becomes perhaps the worst option of all: the courts. Indeed, when a court refuses to defer to agency expertise it, in effect, substitutes the agency's view with the court's *own* judgement.

In her dissenting opinion in *Loper Bright Enterprises v. Raimondo*,[51] the case that overruled *Chevron*, Justice Kagan wrote that the majority opinion:

"gives courts the power to make all manner of scientific and technical judgments. It gives courts the power to make all manner of policy calls, including about how to weigh competing goods and values …. It puts courts at the apex of the administrative process as to every conceivable subject—because there are always gaps and ambiguities in regulatory statutes, and often of great import. What actions can be taken to address climate change or other environmental challenges? What will the Nation's health-care system look like in the coming decades? Or the financial or transportation systems? What rules are going to constrain the development of A.I.? In every sphere of current or future federal regulation, expect courts from now on to play a commanding role …. It is a role this Court has now claimed for itself, as well as for other judges."[52]

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I do not think anyone believes the courts should be deciders of whether adults over 50 should be able to access heart medication, cancer screening, or any of the other 200 services cost free. I think most people would hope their employer does not hold that power over them either. But hopefully, this introduction has made the case that access to these services is central to the key philosophical progress that the ACA has made. The importance of these services lies not only in their scientifically proven ability to protect the health of the population, but also in ensuring that access to health care does not depend on who you are.

[51] 144 S. Ct. 2244 (2024).
[52] *Id.* at 2311.

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