No. 24-316

IN THE
Supreme Court of the United States

ROBERT F. KENNEDY, JR., SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners,

v.

BRAIDWOOD MANAGEMENT, ET AL.,
Respondents.

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

BRIEF OF 48 BIPARTISAN ECONOMIC AND OTHER SOCIAL SCIENCE SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF *AMICI* AND SUMMARY OF ARGUMENT 1

ARGUMENT 5

I. The Preventive Services Provision Rests on Sound Economic Principles Specific to Preventive Care 5

II. Our Fragmented Health Insurance System Necessitates that All Insurers, Public and Private, Cover Preventive Services Without Cost-Sharing 12

III. The Preventive Services Provision Enhances Workforce Productivity and Supports a Strong Economy 16

CONCLUSION 23

APPENDIX - List of *Amici* 1a

TABLE OF AUTHORITIES

STATUTES

42 U.S.C. § 300gg–13(a) 1, 2

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INTEREST OF *AMICI* AND SUMMARY OF ARGUMENT[1]

The *amici curiae* Economic and Other Social Science Scholars are 48 distinguished professors and internationally recognized scholars of economics and health policy and law who have taught and researched the economic and social forces operating in the health care and health insurance markets. *Amici* have closely followed the development, adoption, and implementation of the Affordable Care Act ("ACA") and are intimately familiar with its provisions, including the Preventive Services Provision ("Provision"), 42 U.S.C. § 300gg–13(a), at issue in this case. The Economic Scholars include economists who have served in high-ranking positions in multiple administrations, as well as in Congress on behalf of both parties; three Nobel Laureates in Economics; two recipients of the Arrow award for best paper in health economics; one recipient of the American Society of Health Economists Medal, which is awarded biennially to the economist aged 40 or under who has made the most significant contributions to the field of health economics; and one recipient of the Victor R. Fuchs Lifetime Achievement Award from the American Society of Health Economists. A complete list of *amici* can be found in the Appendix. *Amici* submit this brief to assist this Court in understanding the

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[1] Pursuant to Rule 37.6, counsel for *amici curiae* state that no counsel for a party authored this brief in whole or in part, and no person or entity other than *amici* or their counsel has made a monetary contribution to the preparation or submission of this brief.

economic theory that underlies the mandatory coverage of high-value preventive services without cost-sharing as well as the economic benefits such coverage provides.

The Fifth Circuit partially affirmed a district court decision enjoining the enforcement of one component of the ACA's Preventive Services Provision ("Provision"), 42 U.S.C. § 300gg–13(a)(1).[2] The Provision requires most private insurers and group health plans (whether offered by insurance companies or self-insured employers) to cover services that have received an "A" or "B" rating from the U.S. Preventive Services Task Force ("USPSTF") without cost-sharing.[3] The Fifth Circuit's decision puts that required coverage at risk, and with it, more than 150 million Americans' access to essential preventive health care.[4]

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[2] Pet. App. 2a-3a; Pet. App. 83a.

[3] 42 U.S.C. § 300gg–13(a) also requires coverage without cost-sharing of immunizations recommended by the Centers for Disease Control's ("CDC") Advisory Committee on Immunization Practices ("ACIP"), 42 U.S.C. § 300gg–13(a)(2), and preventive care and screenings provided for by the Health Resource and Services Administration ("HRSA") for infants, children, adolescents, and women. 42 U.S.C. § 300gg–13(a)(3)-(4). For USPSTF-services, A-grade services are those for which evidence demonstrates a high certainty of substantial net benefit. B-grade services are those for which evidence demonstrates a high certainty of moderate net benefit or a moderate certainty of moderate to substantial net benefit. U.S. Preventive Services Task Force, *A & B Recommendations*, https://bit.ly/3JnxC7m (last visited Feb. 9, 2025).

[4] Assistant Sec'y for Plan. and Eval., U.S. Dep't of Health & Human Services, *Access to Preventive Services Without Cost-Sharing:*

The United States petitioned for certiorari on the question of whether the structure of the Task Force violates the Appointments Clause of the U.S. Constitution. This Court granted the government's petition on January 10, 2025.

As economists, *amici* know that invalidating or otherwise calling into question the validity of the Provision will impose significant costs on individuals, the health care system, and the larger economy. In the lower courts, Respondents argued "[t]here is considerable tension between the government's insistence that these preventive-care services are valuable and its simultaneous assumption that people will lose coverage for those services or decline to pay for them if co-pays are added."[5] As we explain, economic principles rebut this assertion — there is no such tension.

Accordingly, *Amici* write to make three points in urging this Court to reverse the Fifth Circuit's decision as to legality of the USPSTF. *First*, the Provision rests on a strong economic foundation. From an economic perspective, optimal insurance design incentivizes high-value care and deters low-value care. As we explain, preventive services are high value, producing significant health and economic benefits. These services are precisely the ones that society should want individuals

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Evidence from the Affordable Care Act (Jan. 11, 2022), https://bit.ly/3Js5bFv.

[5] Response to Motion for a Partial Stay of Final Judgment Pending Appeal at 15, ECF No. 66.

to use because they generate better health outcomes over time at low cost. Those benefits would be lost if insurers and employers were allowed to drop high-value services at their discretion or reimpose cost-sharing, particularly given the substantial research showing that cost-sharing strongly deters individuals from obtaining services regardless of their value.

Second, requiring this coverage solves a market problem. In the U.S. health care system, individuals regularly move in and out of different insurance plans. As a result, no single insurer or group health plan has the full economic incentive to provide coverage for preventive care because the cost-savings generated by that care — for example, the lower cost of treating cancers detected earlier — typically accrue in the future, often to a different insurer or employer-sponsored group health plan. This asymmetry belies Respondents' contentions below that, if these services are in fact valuable, insurers and employers will continue to provide the current level of coverage or that consumers can and will pay for these services in the Provision's absence.[6]

This problem is particularly acute given the large role Medicare plays in our health insurance system. Medicare guarantees coverage for most U.S. individuals when they turn 65. Private insurers know that their customers are likely to switch to Medicare at that age, which makes insurers less likely to take on the immediate costs of preventive care because the savings

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[6] *See id.*

are disproportionately realized as the person ages. That in turn leaves Medicare — and ultimately the taxpayer — to bear the increased costs of an aging population in poorer health and with a pent-up demand for services. Requiring private insurers and employer plans to cover preventive care helps correct the skewed incentives created by a fragmented market.

Third, and finally, the overall economy benefits from investment in prevention. When preventive measures forestall disease or detect it earlier, individuals live longer, more economically productive lives. Longstanding health economics research has quantified the high economic value of many of the preventive services covered through the Provision. Without the Provision, utilization of preventive care will decrease as individuals respond to increased cost-sharing, as they predictably and consistently do, by forgoing care. That decline in the usage of proven high-value care would translate into substantial economic loss in the form of lost lives and lost years of work.

ARGUMENT

I. The Preventive Services Provision Rests on Sound Economic Principles Specific to Preventive Care.

The ACA's Preventive Services Provision reflects decades of health economics research regarding the advantages and drawbacks of cost-sharing. Insurers and employers impose cost-sharing to transfer some of the economic burden posed by the generally high cost of health care services from the insurer or employer to the enrollee. Cost-sharing comes in multiple forms: (1) a co-payment, a set amount charged to the consumer at the

point of service; (2) co-insurance, a percentage of the cost of a service for which the consumer is responsible; or (3) a deductible, an annual dollar amount the consumer must pay for health care services prior to insurance paying out claims. The cost-cutting effect of cost-sharing, from the perspective of the insurer or employer, is not only due to the increased dollar amount the insured now contributes, but also the resulting decrease in health care utilization and the corresponding reduction in total claims the insurer or employer must pay. Cost-sharing has this depressive effect on utilization because it raises the price of insured care for consumers.

Studies consistently demonstrate that individuals seek out fewer health care services, across the spectrum of care, in response to cost-sharing. As the landmark RAND Health Insurance Experiment found in the 1970s, enrollees in health plans with higher levels of cost-sharing spent less on health care because they initiated fewer episodes of care.[7] A recent survey found that 60 percent of adults in employer plans who either had high out-of-pocket costs or deductibles relative to their income reported not obtaining needed health care due to cost.[8] A study of a large self-insured employer's shift from a plan that offered free care to a high

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[7] Amelia Haviland et al., *Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care*, RAND Corporation (2012), https://bit.ly/46e82eZ.

[8] Sara R. Collins & Avni Gupta, *The State of Health Insurance Coverage in the U.S.*, Commonwealth Fund (Nov. 2024), https://bit.ly/42OQ57q.

deductible plan found that enrollees reduced spending for all types of care, including high-value services like preventive care.[9]

Some argue in favor of cost-sharing and its effects on the basis that it deters insured consumers from over-purchasing health care services as a result of insurance covering the cost of the service rather than the consumers themselves.[10] However, regardless of one's view of this argument when applied to health care services in general, it is an ill-fit for the high-value preventive services covered by the Provision. The application of cost-sharing to these types of services leads patients, particularly those with tight budgets, to behave in ways not in the best interest of their health and ability to lead long, economically productive lives.

Tailored cost-sharing that varies based on the type of service provided reflects value-based insurance design ("V-BID"). V-BID constitutes an approach to health insurance that aims to incentivize patients and providers to seek out more valuable services in terms of their cost-effectiveness, i.e., the relationship between the cost of the service and the medical benefit it

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[9] 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. Econ. 1261 (2017).

[10] John A. Nyman, *American Health Policy: Cracks in the Foundation*, 32 J. Health Pol. Pol'y L. 759 (2007), https://bit.ly/3pdaLEX.

provides.[11] Thus, eliminating or reducing cost-sharing for high-value services incentivizes individuals to obtain those services because of the lowered cost of doing so. The strength of this effect varies relative to one's income; the magnitude of the incentive increases as one's income decreases. V-BID has proven effective in shaping consumer behavior. Studies have demonstrated that reducing or eliminating cost-sharing for certain prescription drugs or treatments for specific diseases or chronic conditions is associated with desired changes in targeted utilization.[12]

Preventive care provides the quintessential example of a category of health care services that requires economic incentives to influence optimal consumer behavior. For the reasons set forth in this brief, preventive services provide substantial economic benefits. Consumers may fail to fully take these benefits into account because these benefits largely accrue in the future.[13] As the above studies demonstrate, consumers

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[11] Am. Med. Ass'n, *Value-Based Insurance Design* (2019), https://bit.ly/3CTGyld; Mark V. Pauly & Fredric E. Blavin, *Value Based Cost Sharing Meets the Theory of Moral Hazard: Medical Effectiveness in Insurance Benefits Design* (Nat'l Bureau of Econ. Rsch., Working Paper No. 13044, 2007), https://bit.ly/46aKms5.

[12] Hui Zhang & David W. Cowling, *Association of Participation in a Value-Based Insurance Design Program with Health Care Spending and Utilization*, 6 JAMA Network Open e232666 (2023), https://bit.ly/3qZlgMI.

[13] Jeffrey Liebman & Richard Zeckhauser, *Simple Humans, Complex Insurance, Subtle Subsidies*, 7-8 (Nat'l Bureau of Econ. Rsch., Working Paper No. 14330, 2008), https://bit.ly/3JqagOO ("A

respond to cost-sharing by reducing usage, the opposite of the desired behavior for preventive care. Policymakers thus seek to promote rather than deter utilization.

Individuals from lower income households may be particularly likely to forgo preventive services, as compared to services that address acute health care needs in the present, because they have limited resources to spend on health care. Data from the Federal Reserve shows that in 2023, nearly four in ten adults with less than $25,000 in family income had one or more bills that they could not pay in full that month, or were one $400 financial setback away from being unable to pay their bills.[14] Numerous studies have shown that "even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services."[15] One study found that

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central finding of behavioral economics is that people tend to underinvest in these sorts of activity, placing excessive weight on current-period costs and underweighting next-period benefits."). A poll conducted after the district court's decision found that "[a]t least 2 in 5 U.S. adults said they are not willing to pay for 11 of the 12 preventive services currently covered by the [ACA]" on their own. Ricky Zipp, *Many Americans Are Likely to Skip Preventive Care if ACA Coverage Falls Through*, Morning Consult (Mar. 8, 2023, 5:00 AM EDT), https://bit.ly/44cMuOc.

[14] *See* Bd. of Governors of the Federal Reserve System, *Economic Well-Being of U.S. Households in 2023* (May 2024), https://bit.ly/3WU2mUz.

[15] Samantha Artiga, Petry Ubri, & Julia Zur, *The Effects of Premiums and Cost Sharing on Low-Income Populations:*

increases in copayment rates that apply across the board would most harm lower-income individuals, "not only because they will feel the greatest economic burden but also because worsening adherence may lead to relatively larger adverse clinical effects."[16] Research conducted prior to the ACA found that workers with lower wages were significantly less likely to receive preventive services than their higher-income counterparts.[17] Pre-ACA implementation, 20% of all women, 13% of insured women, and 35% of women living in a household earning less than 200% of the federal poverty line (including both insured and uninsured individuals) delayed or did not

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Updated Review of Research Findings, Kaiser Family Found. (June 1, 2017), https://bit.ly/3JNtSfZ. *See also* G. Solanki & H.H. Schauffler, *Cost-Sharing and the Utilization of Clinical Preventive Services*, 17 Am. J. Prev. Med. 127 (1999), https://bit.ly/3NDRLsz; Nicole Lurie et al., *Preventive Care: Do We Practice What We Preach?*, 77 Am. J. Pub. Health 801 (1987), https://bit.ly/3p8dQWV (finding that women are significantly less likely to receive preventive services such as mammograms and pap smears when subject to cost-sharing).

[16] Michael Chernew et al., *Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care*, 23 J. Gen. Internal Med. 1131, 1136 (2008), https://bit.ly/3qWT64Z.

[17] Sara R. Collins et al., *Wages, Health Benefits, and Workers' Health*, Commonwealth Fund, 4 (Oct. 2004), https://bit.ly/3CGPQx5 ("Job compensation [was] associated with workers receiving preventive care screens at recommended time intervals, including blood pressure and cholesterol tests, dental exams, pap tests, and mammograms.").

receive preventive services, during the prior year, due to cost.[18]

These dynamics motivated Congress to pursue a V-BID approach in the ACA to ensure all Americans received greater access to high-value health care services. The ACA's Preventive Services Provision utilizes a V-BID model that 1) relies on established bodies of health care experts, such as the USPSTF, to identify high-value preventive services and 2) guarantees coverage without cost-sharing to encourage consumers to obtain those identified services.

The Provision has worked as intended. Since its implementation, the Provision has increased cancer screenings, blood pressure and cholesterol tests, and led to earlier diagnoses of chronic health conditions across the U.S.[19] By expanding coverage options and

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[18] Kaiser Family Found., Fact Sheet: *Preventive Services Covered by Private Health Plans Under the ACA* (Aug. 2015), https://bit.ly/3r2blWk.

[19] *See, e.g.*, Assistant Sec'y for Plan. and Eval., *supra* note 4; Xuesong Han et al., *Has Recommended Preventive Service Use Increased After Elimination of Cost-Sharing as Part of the Affordable Care Act in the United States?*, 78 Preventive Med. 85 (2015), https://bit.ly/43Rx0iM (noting that receipt of many preventive services "significantly increased" after the ACA eliminated cost-sharing for preventive services); Josephine S. Lau et al., *Improvement in Preventive Care of Young Adults After the Affordable Care Act: The Affordable Care Act is Helping*, 168 JAMA Pediatr. 1101 (2014), https://bit.ly/42OPdfr (comparing pre-ACA and post-ACA rates of young adults receiving preventive care

decreasing the likelihood of high out-of-pocket costs, the ACA reduced financial barriers that previously prevented many Americans from obtaining timely health care.[20] If consumers no longer have access to preventive services without cost-sharing, they will predictably use fewer of those services, not only damaging their own health, personal finances, and long-term productivity but also increasing the costs imposed on our system of public health care financing, which substantially relies on government payers.

II. Our Fragmented Health Insurance System Necessitates that All Insurers, Public and Private, Cover Preventive Services Without Cost-Sharing.

The label "preventive" reveals the core purpose of this type of care: to protect against the emergence or belated discovery of significant health problems later in life which both result in worse health outcomes and become more expensive to treat than if addressed earlier. Due to this forward-looking role, preventive care requires a national strategy that incentivizes uptake across insurance plans, in order to spread risk across public and private insurers. The cost-effectiveness of preventive services must be understood across the health care system, not by looking at the

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and finding "significantly higher rates of receiving" several preventive services).

[20] Sherry A. Glied, Sara R. Collins, & Saunders Lin, *Did The ACA Lower Americans' Financial Barriers To Health Care?*, 39 Health Affairs 379 (2020), https://bit.ly/3XlLPYz.

circumstances of individual patients, insurers, or employers in isolation.

This provision counteracts insurers' and employers' incentive to push costs to future insurers. Virtually all Americans change health coverage over the course of their lives, often several times. A change in insurance coverage is a routine occurrence — a new job comes with a different employer-sponsored insurance plan, starting one's own business may mean purchasing coverage on the individual market, and fluctuations in income lead individuals to churn between Medicaid, the public health insurance program for low-income individuals, and private insurance. One study examining the experience of low-income adults in certain southern states found "nearly one-quarter of Respondents in each state reported one or more changes in health insurance status during the previous twelve months."[21] Of course, one of the most common changes in health insurance comes when individuals turn 65, the age at which most Americans become eligible for Medicare, the public health insurance program for seniors and certain individuals with disabilities.

This fragmented system that relies on a combination of public and private insurance, with eligibility rules that make individuals gain and lose eligibility for different

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[21] Benjamin D. Sommers et al., *Insurance Churning Rates For Low-Income Adults under Health Reform: Lower Than Expected But Still Harmful For Many*, 35 Health Affairs 1816, 1818 (2016), https://bit.ly/3PqpcjI.

programs at different times, means that insurers and employers rarely cover the same individual across the lifespan. Accordingly, insurers and employers lack the incentive to spend money on preventive care when the benefits of that investment will likely accrue to a different insurer or employer later in the person's life.[22] In fact, insurers and employers have an economic incentive to avoid screenings and early treatments, because they may no longer cover the individual by the time the health condition worsens. If a screening detects a disease in the present, the insurer and employer must expend resources to treat it — pushing off costs to a future payer may work to their economic self-interest. This disincentive to pay for preventive care exists even if the service is cost-effective for the individual and would reduce the total resources expended on that individual by various payers over a lifetime.

Our insurance infrastructure, in which the government provides health coverage for seniors through Medicare, exacerbates these incentives. In the absence of the Provision, undiscovered health conditions will worsen, only to be identified once the person has aged into Medicare. This increases costs for the Medicare program, which are borne by taxpayers. Research shows significant increases in Medicare expenditures among previously uninsured populations who lacked access to appropriate care prior to becoming

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[22] Bradley Herring, *Suboptimal Provision of Preventive Healthcare Due to Expected Enrollee Turnover Among Private Insurers*, 19 Health Econ. 438 (2010), https://bit.ly/42TTpuy.

eligible for the program.[23] This is particularly true for services that are addressed through preventive screenings, such as cardiovascular disease and diabetes. The same logic applies to insured individuals who would go without preventive care in the absence of no cost-sharing coverage. Reintroduced cost-sharing or the elimination of coverage for these services could reduce utilization of preventive care prior to age 65 with a resulting increase in Medicare expenditures for those who did not receive these services.

A similar feedback loop also affects Medicaid. Low-income individuals frequently churn between Medicaid and private insurance (or no insurance at all) as changes in their income affect their eligibility for the program.[24] If individuals forgo preventive services due to cost when not on Medicaid, conditions may worsen by the time they regain eligibility, posing increased costs. In this way, diminished uptake of high-value preventive services for low-income individuals would have significant implications for federal and state budgets as both levels

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[23] *See* J. Michael McWilliams et al., *Medicare Spending for Previously Uninsured Adults*, Annals Internal Med. (Dec. 1, 2009), https://bit.ly/430qZ28; J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 357 New Engl. J. Med. 357 (2007), https://bit.ly/3qT1T7Y.

[24] Sarah Sugar et al., *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic*, ASPE (Apr. 12, 2021), https://bit.ly/3JrWHye.

of government share responsibility for Medicaid expenditures.

III. The Preventive Services Provision Enhances Workforce Productivity and Supports a Strong Economy.

Coverage of preventive services, by promoting population health, produces population-level benefits. Preventive services often prevent or mitigate costs for third parties who are not direct consumers or payers for the services. The uptake of preventive care generates substantial cost savings in terms of direct costs to Medicare and societal savings.

First, access to preventive care supports economic security.[25] Productivity losses stemming from the illnesses of workers and their families cost the economy as much as $150 billion per year.[26] For school-age

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[25] Jeffrey Levi, Laura M. Segal, & Chrissie Juliano, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, Trust for America's Health (July 2008), https://bit.ly/3NFYcLH; *see also* Krutika Amin et al., *Preventive Services Use Among People with Private Insurance Coverage*, Kaiser Fam. Found. (Mar. 20, 2023), https://bit.ly/4gVKbVD ("Missed or delayed screenings [due to higher out-of-pocket costs without cost sharing] could lead to later diagnoses of health conditions that might have been more treatable or less costly if caught earlier)."

[26] Dan Witters & Sangeeta Agrawal, *Unhealthy U.S. Workers' Absenteeism Costs $153 Billion*, Gallup (Oct. 17, 2011), https://bit.ly/43PRZ5C; Michelle M. Doty et al., *Health and Productivity Among U.S. Workers*, Commonwealth Fund (Aug. 2005), https://bit.ly/3Xg1SXL.

children, student health and well-being affects attendance, grades, test scores, and graduation rates.[27] Preventive services play an important economic role because they "potentially reduce the time that family members spend caring for relatives who are sick."[28] In addition, preventive services can reduce the likelihood of early death or disability, and therefore improve worker, and thus economic, productivity.[29]

Second, as explained in Section II.A, because individuals change insurers and employers often, it is typically not in the interest of any particular insurer or employer to bear the cost of preventive services. Just as a present insurer is not likely to reap the benefits of reduced health care costs in the future, a present employer will not likely bear the costs of future losses to workforce productivity when a particular employee's disease is detected at a later stage. The future cost of a preventable early death or disability is a societal cost that a current employer or insurer can easily ignore. Similarly, no private insurer or employer has an economic incentive to invest in preventive services for children. The economic costs of poor health's negative impact on academic performance and future income will

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[27] Brigitte Vaughn et al., In Brief: *Schools and The Affordable Care Act*, Safe Supportive Learning (June 2013), https://bit.ly/46iHbyg.

[28] Congressional Budget Office, *How CBO Analyzes Approaches to Improve Health Through Disease Prevention* (June 2020), https://bit.ly/44fbLHx.

[29] Steven H. Woolf, *A Closer Look at the Economic Argument for Disease Prevention*, 301 JAMA 536 (2009).

not fully emerge until later in the child's life. Accordingly, economics counsels in favor of health insurance design that counteracts what would result from insurers and employers acting in their own self-interest. The Provision performs precisely this role.

The below examples illustrate the broad and long-lasting economic benefits of the preventive services for which the ACA guarantees coverage without cost-sharing.[30]

Cancer Screenings. Experts assess the economic benefits of cancer screenings not only in terms of the cost of future services[31] but also in the number of productive life years gained.[32] Studies have found that national cost savings associated with early cancer diagnosis is

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[30] These are merely intended as examples and by no means constitute an exclusive list of preventive services that have widespread economic benefits.

[31] *See, e.g.*, Centers for Disease Control, *Health and Economic Benefits of Breast Cancer Interventions* (July 11, 2024), https://bit.ly/4hs9H5O (noting that early detection of breast cancer can reduce health care costs); Centers for Disease Control, *Health and Economic Benefits of Colorectal Cancer Interventions* (Oct. 16, 2024), https://bit.ly/4hTAHev (noting that increasing screening could reduce Medicare spending by $14 billion by 2050).

[32] Woolf, *supra* note 29; Am. Lung Ass'n, *Lung Cancer Key Findings*, https://bit.ly/43haToe (last updated Nov. 13, 2024) ("Lung cancer screening has saved 80,000 additional years of life leading to $40 million in savings, which would increase to 500,000 additional years of life and $500 million if all those eligible had been screened.").

estimated at $26 billion per year.[33] For example, lung cancer is the third most common cancer and the leading cause of cancer mortality in the United States[34] and is significantly more treatable when detected early.[35] Earlier diagnosis and treatment can lead to shortened treatment courses, ultimately reducing the financial impact on patients and families and enabling patients to continue participation in the workforce for longer.[36]

PrEP. Utilization of HIV preexposure prophylaxis (PrEP) not only protects the individual using PrEP from contracting HIV, but results in community-wide reductions in HIV prevalence. One study found that if the number of individuals using PrEP increased by only 25%, a 54% decrease in new HIV cases would result.[37] The potential economic impacts are staggering, as one study found that avoiding just one additional HIV

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[33] Zura Kakushadze, Rakesh Raghubanshi, & Willie Yu, *Estimating Cost Savings from Early Cancer Diagnosis*, 2 Data 13 (2017), https://bit.ly/46surWa.

[34] Centers for Disease Control and Prevention, *Lung Cancer Statistics* (June 13, 2024), http://bit.ly/4gFMxYu.

[35] Joel V. Brill, *Screening for Cancer: The Economic, Medical, and Psychosocial Issues*, Am. J. Managed Care Supplement (Nov. 16, 2020), https://bit.ly/44dPJ7O.

[36] *Id.*

[37] Ruchita Balasubramanian et al., *Projected Impact of Expanded Long-Acting Injectable PrEP Use Among Men Who Have Sex With Men on Local HIV Epidemics*, 91 J. Acquired Immune Deficiency Syndrome 144 (2022), https://bit.ly/42QAf8L.

infection saves nearly $230,000 in medical costs.[38] Researchers have projected that an elimination of coverage for PrEP without cost sharing would result in a minimum of 2,000 entirely preventable HIV infections in year one alone.[39]

Prenatal Screenings and Services. Prenatal screenings and services promote healthy babies and eventually, productive adults. USPSTF-recommended prenatal care includes services related to preeclampsia, gestational diabetes, and healthy weight, as well as screening for domestic violence,[40] and USPSTF-recommended post-natal care includes breast feeding services and supports and services related to

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[38] Bruce R. Schackman et al., *The Lifetime Medical Cost Savings from Preventing HIV in the United States*, 53 Med Care 293 (2015), https://bit.ly/43Pwf9V.

[39] A. David Paltiel et al., *Increased HIV Transmissions With Reduced Insurance Coverage for HIV Preexposure Prophylaxis: Potential Consequences of* Braidwood Management v. Becerra, 10 Open Forum Infectious Diseases 139 (2023); *see also* Lorraine T. Dean et al., *Estimating the Impact of Out-Of-Pocket Cost Changes on Abandonment of HIV Pre-Exposure Prophylaxis*, 43 Health Affairs 36, 43 (2024) (estimating that up to 42% of patients currently receiving PrEP at no cost may not maintain their prescriptions if out-of-pocket costs increase); *see also* Rahel Dawit et al., *Identifying HIV PrEP Attributes to Increase PrEP Use Among Different Groups of Gay, Bisexual, and Other Men Who Have Sex with Men: A Latent Class Analysis of a Discrete Choice Experiment*, 28 AIDS & Behav. 125 (2024) (finding that lowering cost is a key factor to increasing PrEP use).

[40] U.S. Preventive Services Task Force, *supra* note 3.

postpartum depression.[41] These services benefit not only the pregnant individuals who receive them, but also their children and society at large, by reducing maternal mortality.[42] Pregnant people who do not receive prenatal care are substantially more likely to have babies born with a low birth weight and experience higher rates of infant mortality.[43] Thus, a reduction in coverage for these services will lead to more immediate and devastating economic consequences in addition to those that accrue further in the future.[44] But the future economic impact is stark. Studies demonstrate that "children with low birth weight are less likely to pass English and math exams at age 16 and less likely to be employed in their 20s and 30s."[45] Care that "increas[es] a child's birth weight reduces risks of mortality in the

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[41] *Id.* Other women's and children's services must be covered under other subsections of the Preventive Services Provision. *See* 42 U.S.C. § 300gg-13(a)(3)-(4).

[42] Urban Institute, *Maternal Prenatal and Postnatal Care* (Dec. 28, 2021), https://urbn.is/46dIAq2.

[43] Office on Women's Health, U.S. Dep't of Health and Human Services, *Prenatal Care*, https://bit.ly/44cqlQ0 (last updated Feb. 22, 2021).

[44] George Washington University, *Report:* Braidwood Management v Becerra *Could Eliminate 75% of the ACA's Preventive Benefits for Women, Infants, and Children* (June 13, 2023) https://bit.ly/3Xz78Gd.

[45] Urban Institute, *Maternal Prenatal*, *supra* note 42.

first year of life, increases the likelihood of high school completion, and increases adult full-time earnings."[46]

The Provision, by mandating coverage of the above services without cost-sharing, promotes all the described economic gains and more. Long-standing economic research demonstrates that if consumers must pay more for preventive care, their usage of these high-value services will decline, placing the above economic benefits at risk.

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[46] *Id.*; *see also* Sandra E. Black, Paul J. Devereux, & Kjell Salvanes, *From the Cradle to the Labor Market? Effect of Birth Weight on Adult Outcomes*, 122 J. Q. Econ. 409 (2007), https://bit.ly/439XQ8d.

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Court reverse the decisions below.

February 25, 2025

Respectfully submitted,

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APPENDIX

INDEX

APPENDIX - List of *Amici* 1a

APPENDIX

List of *Amici*

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Jessica Banthin, Ph.D., Senior Fellow, Urban Institute; Deputy Assistant Director, Congressional Budget Office (2013-19);

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Leonard Burman, Ph.D., Professor Emeritus, Maxwell School of Citizenship & Public Affairs, Syracuse University; Institute Fellow, Urban Institute;

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