CHALLENGING PREVENTIVE CARE, THE ACA'S PHILOSOPHY OF ACCESS, AND DEFERENCE TO SCIENTIFIC EXPERTISE: IMPLICATIONS FOR A HEALTHY AGING POPULATION

Abbe R. Gluck

One of the things that makes the Ann F. Baum Memorial Elder Law Lecture so special is the diverse array of scholars who, over the years, have used the opportunity to explore the intersection of elder justice with many different fields. In so doing, the lecture itself sends a strong message that elder law is part of the broader landscape of public law and policy, rather than being isolated from it. The health law center that I direct at Yale, the Solomon Center for Health Law and Policy, shares the same philosophy, and that makes the opportunity to participate in this volume, in conjunction with the lecture, so meaningful.

This frame of connection with other areas of public law is particularly important for the purpose of this Essay, because my goal is to discuss a subject of great importance to elder health care—preventive

Abbe Gluck is the Alfred M. Rankin Professor of Law and Faculty Director of the Solomon Center for Health Law and Policy, Yale Law School, Professor of Internal Medicine (General Medicine), Yale School of Medicine, and Founding Faculty Director of the Drell/Nitikman Elder Law Project at Yale Law School. Thank you to Dean Jamelle Sharpe and Professor Richard Kaplan, both tremendous scholars, and the Baum family. This Essay is based on remarks given at the Ann F. Baum Memorial Elder Law Lecture on March 6, 2024. Special thanks to Solomon Center Academic Fellow Yaron Covo for spectacular assistance.

care—and situate it within the broader landscape of continuing disputes over the Affordable Care Act (ACA) and the policy reforms it has accomplished. I also will situate current legal challenges that affect access to preventive care in the wider context of the Supreme Court's current focus on transforming and weakening the administrative state.

This Essay focuses on *Braidwood Management Inc. v. Becerra*,[1] a challenge to the ACA's provision that requires some 200 preventive services—vaccines, cancer screenings, hearing tests, heart disease medication, and many more—to be provided to beneficiaries without cost sharing or deductibles. Because the case remains ongoing as of this writing, rather than delving into the details of the legal arguments, my goal is to contextualize the case as part of ongoing debates about healthcare, the Supreme Court, and the administrative state. In doing so, I will explain, of course, how these issues relate to the interests of older Americans.

I. *Braidwood* and the ACA's Preventive Services Mandate: A Brief Overview

A. The Preventive Services Mandate

To introduce the provisions being challenged in *Braidwood*, let me begin by telling a simple story. I have twin boys, who are now seventeen. When they were two years old, after a routine wellness checkup, I received an *enormous* bill, unlike any I had received for their care to date. When I questioned the provider's office, I was told that my insurance did not cover the kids' childhood vaccines. I was certain there had been a mistake, insisted that I have terrific insurance—and I do; it has and had covered all sorts of treatments, including experimental ones. But then I learned what to me at the time was a shocking fact: 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 did

1. The Fifth Circuit issued its decision on appeal in the *Braidwood* case, Braidwood Mgmt., Inc. v. Becerra, 104 F.4th 930 (5th Cir. 2024) (No. 23-10326), and remanded for further proceedings. The government filed a petition for certiorari in September 2024. Petition for Writ of Certiorari, Becerra v. Braidwood Mgmt., Inc., No. 24-316 (Sept. 19, 2024), followed by a conditional cross-petition from the plaintiffs. Conditional Cross-Petition for Writ of Certiorari, Braidwood Mgmt., Inc. v. Becerra, No. 24-475 (Oct. 30, 2024).

not have that enormous bill again. What had changed in the interim? Three words: Affordable Care Act.[2] The ACA was passed in 2010, and the preventive services mandate was one of the provisions that took effect immediately.[3]

Most of us share a similar story.[4] If you think you do not, consider this: How many readers of this Essay have been vaccinated for COVID-19? How many paid a dime out of pocket for it? Would all of the people who received the COVID-19 vaccine have done so if they had to pay fifty, forty, or even twenty dollars? The clear answer is no. There is substantial empirical evidence that goes years back showing that people, especially people of lower means, put off or bypass preventive health care services altogether if there is a price tag, even a relatively small one.[5]

2. *See* 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 [https://perma.cc/UH2Z-G739] ("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.").

3. *See Summary of the Affordable Care Act*, KFF (Apr. 25, 2013), https://www.kff.org/affordable-care-act/fact-sheet/summary-of-the-affordable-care-act/ [https://perma.cc/AV5J-2LVV].

4. *See generally* Karyn Schwartz, Meredith Freed, Juliette Cubanski, Rachel Dolan, Karen Pollitz, Josh Michaud, Jennifer Kates & Tricia Neuman, *Vaccine Coverage, Pricing, and Reimbursement in the U.S.*, KFF (Nov. 18, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/vaccine-coverage-pricing-and-reimbursement-in-the-u-s/ [https://perma.cc/GE97-5SRW] (describing how the COVID-19 vaccine was made free to Americans).

5. *See* Brief of 49 Bipartisan Economic and Other Social Science Scholars in Support of Defendants-Appellants, at 67, Braidwood Mgmt., Inc., 104 F.4th at 930 (No. 23-10326). For a famous study on the effects of expanding access to public insurance coverage on beneficiaries' use of services, *see* Katherine Baicker, Sarah L. Taubman, Heidi L. Allen, Mira Bernstein, Jonathan H. Gruber, Joseph P. Newhouse, Eric C. Schneider, Bill J. Wright, Alan M. Zaslavsky & Amy N. Finkelstein, *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, Roland McDevitt, M. Susan Marquis, Neeraj Sood, & Melinda Beeuwkes Buntin, *Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care*, RAND (June 28, 2012), https://www.rand.org/pubs/research_briefs/RB9672.html [https://perma.cc/55US-M9BC] (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*

So, how exactly were the COVID vaccines made free? The answer is, again, the ACA. The ACA has a provision, the preventive services mandate,[6] which designates a process that relies on the expertise of three bodies that have long been in the business of preventive care evidence-based recommendations—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.[7] 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 the USPSTF;[8] "immunizations" recommended by the ACIP; and "preventive care and screenings" for women, infants, children, and adolescents recommended by the HRSA.[9] The statute requires that all of these preventive services have evidence-based efficacy.[10]

In making recommendations for services, the expert entities described above are supposed to exercise scientific judgment, but, like

---

Zarek C. Brot-Goldberg, Amitabh Chandra, Benjamin R. Handel & Jonathan T. Kolsta, *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 Q. J. ECON. 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 7 (Sept. 29, 2022), https://www.commonwealthfund.org/sites/default/files/2022-09/Collins_state_of_coverage_biennial_survey_2022_db.pdf [https://perma.cc/2SC3-FB73] (finding that 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").

6. 42 U.S.C. § 300gg-13.

7. Laurie Sobel, Usha Ranji, Kaye Pestaina, Lindsey Dawson & Juliette Cubanski, *Explaining Litigation Challenging the ACA's Preventive Services Requirements: Braidwood Management Inc. v. Becerra*, KFF (May 15, 2023), https://www.kff.org/womens-health-policy/issue-brief/explaining-litigation-challenging-the-acas-preventive-services-requirements-braidwood-management-inc-v-becerra/ [https://perma.cc/Z4YW-AHMR].

8. 42 U.S.C. § 300gg-13(a)(1).

9. *Id.* § 300gg-13(a)(2)-(4).

10. *See Access to Preventative Services without Cost-Sharing: Evidence from the Affordable Care Act*, ASPE OFF. HEALTH POL'Y (Jan. 11, 2022), https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf [https://perma.cc/SXF6-AUAQ].

many entities in the U.S. Department of Health and Human Services (HHS) that do so, they are still under the supervision or direction of HHS in various ways—some are part of HHS; others may be removed by HHS leadership.[11] (Questions about the extent to which they are supervised are at the core of the litigation.) But the key policy point is that one cannot be charged out of pocket for the services recommended by these expert bodies. While these provisions apply only to private insurance plans, Medicaid—the program for low-income individuals—largely tracks those recommendations too, with the same result.[12] That is why COVID-19 vaccines were free for everyone—from the community health center patient to the CEO.[13] And that is also why access to cost-free preventive care is a critical health-equity issue.

B. Preventive Services and Older Adults

What does this have to do with seniors? To begin, almost seventy percent of Americans ages fifty to sixty-four are in the private insurance system,[14] which means that they directly benefit from the ACA's preventive services mandate.[15] As for people age sixty-five and older, those individuals are entitled to preventive services from Medicare via U.S. Centers for Medicare & Medicaid Services (CMS) designation, and that guarantee also relies in part on the recommendations of the USPSTF.[16] While Medicare's preventive service guarantee is not directly implicated by the *Braidwood* challenge, *Braidwood* absolutely has implications for Medicare. It is critical to both the health of the aging population and

11. *See What the Latest Decision in the Braidwood Case Could Mean for Preventive Care*, COMMONWEALTH FUND (July 19, 2024), https://www.commonwealthfund.org/blog/2024/what-latest-decision-braidwood-case-could-mean-preventive-care [https://perma.cc/P2TY-ZTYS]. The specifics of the structure of some of those appointments are relevant to aspects of the challenges in the *Braidwood* case; the Appointments Clause and nondelegation challenges in the case are not the focus of this Essay.

12. 42 U.S.C. § 1396d(a)(13).

13. *See* Schwartz et al., *supra* note 4.

14. Namkee G. Choi, Diana M. DiNitto & Bryan Y. Choi, *Unmet Healthcare Needs and Healthcare Access Gaps Among Uninsured U.S. Adults Aged 50–64*, 17 INT'L J. ENV'T RSCH. & PUB. HEALTH (SPECIAL ISSUE) 1, at 5 (2020).

15. *See id.*; 42 U.S.C. § 300gg-13(a).

16. *See* 42 U.S.C. §§ 1395x, 1395l; *see also* Naomi Seiler, Mary-Beth Malcarney, Katie Horton & Scott Dafflitto, *Coverage of Clinical Preventive Services Under the Affordable Care Act: From Law to Access*, 129 PUB. HEALTH REPS. 526, 528 (2014); *Preventive & Screening Services*, MEDICARE.GOV, https://www.medicare.gov/coverage/preventive-screening-services [https://perma.cc/2YH3-DDLV] (last visited Sept. 24, 2024).

Medicare's financial stability that the system ensures that people age into Medicare as healthy as possible.[17] Preventive care before age sixty-five is essential to that goal.[18]

Among the many services covered under the ACA's preventive services mandate are drugs prescribed to prevent disease and promote health among older adults.[19] As just one example, approximately forty million Americans age sixty and over have at least one form of cardiovascular disease.[20] Over the past decade, the USPSTF has recommended that adults ages forty to seventy-five who are at risk for developing cardiovascular disease use statins to prevent such disease, including heart attack and stroke.[21] The ACA's preventive care mandate covers those costs for free.[22]

As another example, women age fifty and older account for more than eighty percent of the diagnosed cases of invasive breast cancer.[23] Researchers have found that more than ninety percent of breast cancer-related deaths occur among individuals in this age category.[24] Accordingly, the USPSTF recommends "risk-reducing medications" that have proven effective at reducing the prevalence of breast cancer among women at increased risk.[25] The ACA covers those cost-free too.[26]

17. Choi et al., *supra* note 14, at 9.

18. *See id.*

19. This point and some of the examples in the following paragraphs have been discussed in greater detail in the amicus brief submitted by the AARP in the *Braidwood* case. *See* Brief of Amici Curiae AARP and AARP Foundation Supporting Defendants-Appellants/Cross-Appellees and Urging Reversal at 7-11, Braidwood Mgmt., Inc. v. Becerra, 104 F.4th 930 (5th Cir. 2024) (No. 23-10326) [hereinafter AARP Amicus Brief].

20. Ali Yazdanyar & Anne B. Newman, *The Burden of Cardiovascular Disease in the Elderly: Morbidity, Mortality, and Costs*, 25 CLIN. GERIATRIC MED. 563, 564 (2009).

21. *Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication*, U.S. PREVENTIVE SERVS. TASK FORCE (Aug. 23, 2022), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/statin-use-in-adults-preventive-medication [https://perma.cc/2QNF-FWQM].

22. *See* 42 U.S.C. § 300gg-13(a)(1).

23. Angela N. Giaquinto, Hyuna Sung, Kimberly D. Miller, Joan L. Kramer, Lisa A. Newman, Adair Minihan, Ahmedin Jemal & Rebecca L. Siegel, *Breast Cancer Statistics*, 72 CA: CANCER J. FOR CLINICIANS 524, 524 (2022).

24. *Id.* at 526.

25. *Breast Cancer: Medication Use to Reduce Risk, Final Recommendation Statement*, U.S. PREVENTIVE SERVS. TASK FORCE (Sept. 3, 2019), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-medications-for-risk-reduction [https://perma.cc/B7ZE-F8BG].

26. *Medication to Lower Cancer Risk for Certain Women*, FORCE, https://www.facingourrisk.org/privacy-policy-legal/laws-protections/ACA/screening-preventive-

Similarly, the USPSTF recommends screenings and certain CT scans for older adults who have a history of smoking with the aim to detect and prevent lung cancer,[27] the second most prevalent cancer in the United States and the most common cause of cancer death in the country.[28] This is particularly important given that (1) age is one of the risk factors for lung cancer,[29] and (2) lung cancer "is usually fatal because most cases are diagnosed at a late stage."[30] Among countless other USPSTF recommendations is osteoporosis screening for women sixty-five and older,[31] a condition affecting approximately ten million adults.[32] Osteoporosis screening is a significant intervention, given that up to thirty percent of people who have a hip fracture die within one year.[33]

C. Braidwood v. Becerra

The plaintiffs in *Braidwood* are four individuals and two companies.[34] One of these companies is Braidwood Management Inc., "a Christian for-profit corporation," whose owner "wishes to provide

services/drugs-lower-cancer-risk [https://perma.cc/Z9FB-6FHS] (last visited Sept. 24, 2024).

27. *Lung Cancer: Screening, Final Recommendation Statement*, U.S. PREVENTIVE SERVS. TASK FORCE (Mar. 9, 2021), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening [https://perma.cc/7K8J-NLR6].

28. *Cancer Facts & Figures 2023*, AM. CANCER SOC'Y 31 (2023), https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2023/2023-cancer-facts-and-figures.pdf [https://perma.cc/XE92-PBZD].

29. *Id.* at 32.

30. *Id.* at 31.

31. *Osteoporosis to Prevent Fractures: Screening, Final Recommendation Statement*, U.S. PREVENTIVE SERVS. TASK FORCE (June 26, 2018), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening [https://perma.cc/YC36-PH54].

32. *Healthy People 2030: Osteoporosis Workgroup*, U.S. DEP'T OF HEALTH & HUM. SERV., https://health.gov/healthypeople/about/workgroups/osteoporosis-workgroup [https://perma.cc/9UWC-6LFQ] (last visited Sept. 24, 2024).

33. Carmen A. Brauer, Marcelo Coca-Perraillon, David M. Cutler & Allison B. Rosen, *Incidence and Mortality of Hip Fractures in the United States*, 302 JAMA 1573, 1574 (2009); AARP Amicus Brief, *supra* note 19, at 17.

34. The lawsuit included a larger number of plaintiffs, identified by the district court as both "religious objector" and "non-religious objector" plaintiffs. Braidwood Mgmt. Inc. 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" have standing. *Id.* at 625. Thus, these plaintiffs are referred to as the "prevailing plaintiffs." Opening Brief for the Federal Defendants at 6, Braidwood Mgmt. Inc. v. Becerra, 666 F. Supp. 3d 613 (N.D. Tex. 2023) (No. 23-10326).

health insurance" for the company's employees "that excludes coverage of preventive care such as contraceptives and PrEP drugs."[35]

The plaintiffs' challenge to the preventive services mandate initially rested on several prongs, and some of those arguments, rejected below, have been revived as the parties seek Supreme Court review. First, the challengers invoked 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.[36] Specifically, the challengers argue that merely noting that the recommendations should be "evidence-based" and designating the kind of care and populations involved is not sufficient to satisfy the nondelegation criteria.[37] Second, the challengers made 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 for appointing such officers.[38] Third, the challengers invoked religious freedom, objecting to the mandatory coverage of pre-exposure prophylaxis (PrEP), a drug aimed at preventing HIV, as a covered preventive service. Citing the Religious Freedom Restoration Act (RFRA), plaintiffs objected to underwriting insurance that facilitates behaviors such as "sexual activity outside marriage between one man and one woman."[39] According to Braidwood's claims, by being forced to cover PrEP in its insurance plan at no cost, it is effectively being forced to endorse such behaviors against its religious beliefs.[40]

35. Braidwood Mgmt. Inc. v. Becerra, 627 F. Supp. 3d 624, 634 (N.D. Tex. 2022).

36. *Id.* at 649. 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." *Id.* 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 at 60, Braidwood Mgmt. Inc. v. Becerra, 666 F. Supp. 3d 613 (N.D. Tex. 2023) (No. 23-10326).

37. *Braidwood Mgmt. Inc.*, 627 F. Supp. 3d at 649.

38. *Id.* at 639.

39. *Id.* at 652.

40. *Id.* at 653.

As of this writing, the case has been decided by two courts, the U.S. District Court of the Northern District of Texas and the Fifth Circuit.[41] The district court held that the USPSTF's structure, and in particular the independence the court concluded was granted to the Task Force's decisions, violated the Appointments Clause.[42] It found no similar violation with respect to ACIP and HRSA, because the HHS Secretary has the authority to ratify their recommendations.[43] The district court rejected the 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."[44] On appeal, the Fifth Circuit upheld the district court's determinations on the Appointments Clause challenges.[45] 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.[46]

The United States filed a petition for certiorari in September 2024.[47] The plaintiffs subsequently filed a conditional cross-petition for a writ of certiorari, reviving their nondelegation challenge to all three expert bodies.[48] As of this writing, the petitions remain pending.

41. *Braidwood Mgmt. Inc.*, 666 F. Supp. 3d at 616, *aff'd* in part, *rev'd* in part and *remanded* (district court); Braidwood Mgmt., Inc. v. Becerra, 104 F.4th 930 (5th Cir. 2024).

42. *Braidwood Mgmt. Inc.*, 627 F. Supp. 3d at 646 ("Because PSTF members are principal officers, they must be appointed by the President and confirmed by the Senate. The PSTF members indisputably fail that constitutional requirement.") (internal citations omitted).

43. *Id.* at 641 ("The Secretary effectively ratified the ACIP and HRSA actions that Plaintiffs challenge, so the Court need not address the Appointments Clause issues regarding those two agencies.").

44. *Id.* at 652.

45. *Braidwood Mgmt., Inc.*, 104 F.4th at 936. 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 957 (noting that the district court "had no opportunity to consider the above three contentions that the plaintiffs now advance on appeal" and that "it prudent for the district court to consider these arguments in the first instance").

46. *Id.* at 950–57.

47. Petition for Writ of Certiorari, *supra* note 1.

48. Conditional Cross-Petition for Writ of Certiorari, *supra* note 1.

Given the uncertainty of the outcome, this Essay will not delve deeply into the weeds of the administrative law claims. Rather, the Essay focuses on the case's broader significance for health law, elder law, and administrative law.

II. The Bigger Picture

A. The ACA

First and foremost, this case must be understood as an attack on the ACA, perhaps the most challenged statute in modern American history—and the most resilient.[49] 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 two thousand lawsuits.[50]

It also has been a resounding success. Returning to the COVID-19 pandemic, the ACA is one of the unsung heroes of the national health emergency.[51] 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.[52] And, again, our vaccines were free.[53]

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.[54] 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

49. *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).

50. *Id.*

51. Abbe R. Gluck & Lawrence O. Gostin, *Why the End of the Public Health Emergency Really Matters*, HEALTH AFFS. (May 11, 2023), https://www.healthaffairs.org/content/forefront/why-end-public-health-emergency-really-matters [https://perma.cc/A4WR-9HMF]; Gluck & Turret, *supra* note 2.

52. *See generally* Aviva Aron-Dine, *Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic*, CTR. ON BUDGET & POL'Y PRIORITIES (Sept. 23, 2020), https://www.cbpp.org/research/health/health-care-lifeline-the-affordable-care-act-and-the-covid-19-pandemic [https://perma.cc/C2AA-BD2Y] (describing how millions benefited from the ACA during the COVID-19 pandemic).

53. *See supra* notes 12–13 and accompanying text.

54. 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).

becomes enmeshed in the fabric of our lives in ways that affect the way we think about rights.[55] 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—and whether this challenge is different from the so-called "existential" challenges that in years past threatened to bring the entire statute down?[56] My contention here is that, while *Braidwood* concerns only part of the ACA, and a part that has received less public attention, in many respects, the challenge goes to the heart of what the ACA stands for.[57] It should not be underestimated.

1. A MORAL ATTACK ON DISFAVORED GROUPS AND REINCARNATION OF THE CONCEPT OF THE "DESERVING POOR"

Before the ACA was enacted, women faced higher insurance premiums or had trouble getting insured at all.[58] Some people used to joke, cynically, that being female was treated as a preexisting (and thus often disqualifying) health condition.[59] Women were not the only population that had access-to-insurance challenges before the ACA.[60] While women were often discriminated against by private insurers,[61] 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

55. *See* 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 . . . over time does 'stick' in the public culture such that [t]he 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").

56. Gluck et al., *supra* note 49, at 1477–91 (describing "three significant 'existential' challenges to the ACA").

57. *See* discussion *infra* Sections II.A.1–3.

58. 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 [https://perma.cc/JRE8-F7BZ].

59. *See id.*

60. *See, e.g.*, Lois K. Lee, Alyna Chien, Amanda Steward, Larissa Truschel, Jennifer Hoffmann, Elyse Portillo, Lydia E. Pace, Mark Clapp & Allison A. Galbraith, *Women's Coverage, Utilization, Affordability, And Health After the ACA: A Review of the Literature*, 39 HEALTH AFFS. 387, 387 (2020) (describing how both men and women with preexisting conditions were denied coverage before the ACA).

61. *See* Grady, *supra* note 58.

below the poverty line living in Nebraska had access to 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.[62] Indeed, the ACA worked the transformative shift of eliminating the old notion of the "*deserving poor*"—that is, the notion that only certain populations (e.g., pregnant persons, children, older adults) are deserving of public health insurance if they cannot afford it, and that others, like men of working age, are not.[63] That is a fundamental premise of the ACA—ending discrimination with respect to insurance access that turns on who you are.[64]

Nevertheless, health-care disparities remain a critical problem. With respect to the population over fifty and under sixty-four, it has been documented that already-existing health-care disparities persist and may even increase over time.[65] The ACA's underlying philosophy is in part an upstream one: aim to get everyone insured early in their lifespan, thereby reducing health disparities that are produced earlier in life to have a healthier older population down the line.[66]

Braidwood jeopardizes this focus on healthcare access that the ACA wrought. The case threatens to restore the concept of the worthy

62. *See* Gluck et al., *supra* note 49, at 1510 (noting that, in enacting the ACA, "Congress took a large step toward 'universalizing' Medicaid").

63. *See id.*

64. *See id.*

65. *See* Beth Carter, *Eliminating Access to No-Cost Preventive Health Services Could Affect More Than 12 Million Adults Ages 50 to 64*, AARP PUB. POL'Y INST. (Nov. 8, 2023), https://www.aarp.org/content/dam/aarp/ppi/topics/health/coverage-access/eliminating-access-no-cost-preventive-health-services-could-affect-more-than-12-million-adults-ages-50-64.doi.10.26419-2fppi.00209.001.pdf [https://perma.cc/C5ZL-KDYA]; Choi et al., *supra* note 14, at 9; Judy Ng & Sarah Hudson Scholle, *Disparities in Quality of Care for Midlife Adults (Ages 45–64) Versus Older Adults (Ages >65)*, NAT'L COMM. FOR QUALITY ASSURANCE (May 2010), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//43371/report.pdf [https://perma.cc/MA82-S3DD] (describing disparities in health and quality of health care among people ages forty-five to sixty-four); Beth Carter & Olivia Dean, *Rural-Urban Health Disparities Among US Adults Ages 50 and Older*, AARP PUB. POL'Y INST., 3–6 (Oct. 2021), https://www.aarp.org/content/dam/aarp/ppi/2021/10/rural-urban-health-disparities-among-us-adults-50-older.doi.10.26419-2Fppi.00151.001.pdf [https://perma.cc/Z4L6-7E4E] (describing disparities in health across racial and urban/rural lines). For information about health-care disparities that does not pertain to a particular age group, *see* DAYNA BOWEN MATTHEW, JUST HEALTH: TREATING STRUCTURAL RACISM TO HEAL AMERICA 48 (2022) ("In many key areas, the racial divide in health is tragically widening."); DAVID A. ANSELL, THE DEATH GAP: HOW INEQUALITY KILLS 113–32 (2021) (describing racial disparities in health care with a focus on breast cancer).

66. *See generally* Gluck et al., *supra* note 49, at 1477 (describing the ACA's goal of "[b]ringing as many additional people as possible into the shared risk pool").

health recipient and undo the transformative shift away from the "deserving poor."

The way to understand this case is thus not only as a nondelegation challenge but also a *moral attack* on the population whose medication is being challenged here—gay men who are at risk of contracting HIV—and the other populations that stand to lose healthcare if the challenge is successful. Recall that the case stems from challengers who do not want to pay for insurance that includes the PrEP medication.[67] It is a challenge to the idea that populations at risk for HIV deserve preventive care, even as employers cover preventative care for other populations with different health risks.

But all of those populations, in turn, age into Medicare like everyone else. Access to preventive care before Medicare will help everyone age into better care with better health.[68] The AARP amicus brief in the *Braidwood* case includes some interesting statistics about the number of people age fifty and older who have HIV.[69] According to the AARP's data, this age group constitutes more than half of the people living with HIV in the United States.[70] Moreover, in 2018, seventeen percent of new HIV diagnoses were people from this age group.[71]

Nor are the implications of this case relevant only to gay men. Tomorrow the challenge could be to 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 being 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 hypothetical-but-possible examples are not deserving. Put differently, the message is that participants in and directors of insurance plans can morally judge other potential participants and those potential participants' behavior and translate those judgments into exclusion from insurance.

Preventing that kind of discrimination is at the core of the ACA and is one reason why this lawsuit threatens the soul of the law.

67. *See supra* Section I.C.
68. AARP Amicus Brief, *supra* note 19, at 10.
69. *Id.* at 9–10.
70. *Id.*
71. *Id.*

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, and that is the ACA's effort to move the healthcare system from an individual-focused approach to a community-based approach.[72]

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.[73] The ACA moves the needle more than ever before toward a so-called "solidarity" approach, where 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.[74] That is another extremely significant philosophical shift (it would have been even more effective had the Supreme Court not made the Medicaid expansion optional,[75] because, in drafting the ACA, Congress in fact made the Medicaid expansion mandatory[76]).

It is also important to recognize 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. A prevention approach is also not exactly the same as a population-health or public-health approach, but it shares those approaches' philosophical underpinnings. Indeed, 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 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 system from health care delivery and financing.[77] And it

72. *See* Gluck et al., *supra* note 49, at 1473–77.

73. *See* Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American-Style*, 48 J.L. MED. & ETHICS 2, 2 (2020).

74. *Id.*

75. *See* 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.").

76. Gluck et al., *supra* note 49, at 1510.

77. For the classic treatment, *see* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 180–97 (1982) (detailing 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).

has always been more difficult to get Congress to invest in population-level changes, including prevention.[78] 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.[79] Population-level changes are also harder to justify financially because Congress legislates in a short-term budget window;[80] but the benefits of population health tend to accrue over a much longer term (think, tobacco cessation strategies).

According to some statistics, public health is responsible for seventy percent of a population's health,[81] but receives less than three percent of U.S. health dollars in the United States.[82] Consider just one example in the cancer context, which I have written about elsewhere.[83] The National Cancer Institute's annual budget in 2020 was about $6 billion for research to address cancer after it occurs.[84] By contrast, the Center for Disease Control and Prevention's (CDC) prevention programs—across *all* diseases, plus pandemic preparedness, global health initiatives, state and local grants—were allotted $7.9 billion in funding.[85] The funding for CDC's cancer prevention programs was just $358.79 million.[86] 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.

---

78. *See* Evan M. Melhado, *Health Planning in the United States and the Decline of Public-Interest Policymaking*, 84 MILBANK Q. 359, 402.

79. *See* Hon. Rosa L. DeLauro & Abbe R. Gluck, *Cancer and Congress*, *in* A NEW DEAL FOR CANCER: LESSONS FROM A 50 YEAR WAR (Abbe R. Gluck & Charles S. Fuchs eds., 2021).

80. *See What is the Budget Window?*, PETER G. PETERSON FOUND., https://www.pgpf.org/budget-basics/understanding-complex-budget-terms-and-processes-and-why-they-matter/what-is-the-budget-window [https://perma.cc/AD7A-73QR] (last visited Sept. 24, 2024).

81. *What is Public Health? An Introduction.*, COLUM. MAILMAN SCH. OF PUB. HEALTH, https://www.publichealth.columbia.edu/news/what-public-health-introduction [https://perma.cc/2DXP-GL48] (last visited Sept. 24, 2024).

82. David Batts, Randolph Gordon, Alison Muckle Egizi & Claire Boozer Cruse, *The Future of the Public's Health*, DELOITTE INSIGHTS (Nov. 29, 2021), https://www2.deloitte.com/us/en/insights/industry/health-care/the-future-of-public-health.html [https://perma.cc/GPT3-GTEW].

83. *See generally* DeLauro & Gluck, *supra* note 79.

84. *Id*. at 351.

85. *Id*.

86. *Id*.

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.[87] 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."[88] Rather than establishing a unified health insurance system, the ACA leaves the old system largely in place.[89] Americans still receive services under different programs: Medicaid, private health, or Medicare, and most individuals move from one to another across the arc of life.[90] What this means is that we cannot silo off prevention. As noted above, 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 sixty-five—with an unhealthy older population and the increased costs associated with later-than-ideal prevention measures.

Indeed, we are entering a generation of enormous growth in our aging population.[91] 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.[92] One of the core concerns of experts in this area of aging is this very idea of a healthier older generation, a healthier—not just longer—lifespan.[93] The briefs in the *Braidwood* case are full of evidence of how early prevention is essential to that goal.[94] It is also essential to keeping Medicare sound and not putting the price of lack of prevention on Medicare just as the older population explodes. Consistent with this logic, the U.S. National Academy

87. *Brief of 49 Bipartisan Economic and Other Social Science Scholars in Support of Defendants-Appellants*, *supra* note 5, at 13–16.

88. Gluck et al., *supra* note 49, at 1474.

89. *See id.*

90. *Brief of 49 Bipartisan Economic and Other Social Science Scholars in Support of Defendants-Appellants*, *supra* note 5, at 13–16.

91. *See* Anne Alstott, *Law and the Hundred-Year Life*, 26 ELDER L.J. 131, 131 (2018).

92. *See id.*

93. Yaron Covo, Abbe Gluck & Linda Fried, *The 100 Year-Old-American and Our Health System*, LAW AND THE 100-YEAR-OLD AMERICAN (Anne Alstott, Abbe Gluck & Eugene Rusyn eds.) (forthcoming 2025).

94. *See* discussion *supra* Section I.B; Brief for Appellees, Braidwood Mgmt., v. Becerra, 104 F.4th 930 (2024) (No. 23-10326); Brief for Appellants, Braidwood Mgmt., 104 F.4th at 930 (No. 23-10326).

of Medicine's recently released *Global Roadmap for Healthy Longevity* went out of its way to advocate for significantly increased investment in public health system-led prevention.[95]

In addition to aging trends, another important and related trend that we are seeing recently, and one equally at odds with the challenge in this case, is the welcome increased focus on social determinants of health—a broader and more holistic approach to how we think about health care.[96] That approach understands "health" broadly, to include components like access to nutritious food and housing.[97] The Medical-Legal Partnership (MLP) movement, which I am proud that Yale Law School's Solomon Center for Health Law and Policy has helped to develop, is at the forefront of this interdisciplinary and holistic approach, by recognizing the role that civil legal services play in ensuring access to legal protections and benefits.[98] Another example can be found in new waiver flexibilities that allow Medicaid to help fund access to items like healthy food and even air conditioning.[99]

This more holistic approach to health is particularly important when it comes to older adults, as detailed in the National Academy of Medicine's report mentioned above.[100] I have previously argued, with Yaron Covo and Dean Linda Fried, that promoting older adults' health requires the adoption of a "life-course" perspective, whereby the health system takes preventive measures during the decades that precede old age.[101] In so arguing, we rely on growing evidence showing that the emergence of chronic conditions in older age is not inevitable; rather, it may depend on an array of social and environmental factors, and reducing such exposures is effective prevention.[102] Against this backdrop, we have proposed specific preventive interventions that focus on

95. NAT'L ACAD. OF MED., GLOBAL ROADMAP FOR HEALTHY LONGEVITY 14–15 (2022).

96. *See id.* at 179.

97. *See id.* at 235.

98. *Medical Legal Partnership*s, YALE L. SCH: THE SOLOMON CTR., https://law.yale.edu/solomon-center/medical-legal-partnerships/about-our-medical-legal-partnerships [https://perma.cc/ES59-3NXZ] (last visited Sept. 24, 2024).

99. *See, e.g.*, *CMS Approves New York's Groundbreaking Section 1115 Demonstration Amendment to Improve Primary Care, Behavioral Health, and Health Equity*, CMS: PRESS RELEASES (Jan. 9, 2024), https://www.cms.gov/newsroom/press-releases/cms-approves-new-yorks-groundbreaking-section-1115-demonstration-amendment-improve-primary-care [https://perma.cc/BZ69-V3M2].

100. *See* NAT'L ACAD. OF MED., *supra* note 95.

101. Covo et al., *supra* note 93.

102. *Id.*

physical activity, healthy food, smoking prevention, and increased social connection.[103]

To say that our healthcare system is thus productively expanding the lens of what a healthy life requires, while at the same time facing a challenge that would exclude preventive care from it, is baffling. We cannot have a system trying to move toward a holistically healthier population and a more equity-focused approach to health care with 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, if the PrEP mandate is to be eliminated, there would be "more than 2,000 entirely preventable primary HIV infections" among men who have sex with men (MSM) in the year following the mandate elimination.[104] Another study found that more than 40,000 early deaths are prevented thanks to routine childhood vaccination of *one* birth cohort.[105] And such disease prevention has significant economic consequences: As a result of routine childhood immunization, the U.S. saves more than $13 billion in direct costs and more than $65 billion in indirect costs.[106] In fact, experts estimate that childhood immunization generates a $10.90 return on one dollar invested.[107]

Similar findings have been reported with respect to preventive measures for older people. One study, for example, has estimated that ex ante interventions aimed at preventing obesity, diabetes, and

103. *Id.*

104. A. DAVID PALTIEL, ALI R. AHMED, ELENA Y. JIN, MEREDITHE MCNAMARA, KENNETH A. FREEDBERG, ANNE M. NEILAN, & GREGG S. GONSALVES, OPEN F. INFECTIOUS DISEASES, INCREASED HIV TRANSMISSIONS WITH REDUCED INSURANCE COVERAGE FOR HIV PREEXPOSURE PROPHYLAXIS: POTENTIAL CONSEQUENCES OF BRAIDWOOD MANAGEMENT V. BECERRA 3.

105. Fangjun Zhou, Abigail Shefer, Jay Wenger, Mark Messonnier, Li Yan Wang, Adriana Lopez, Matthew Moore, Trudy V. Murphy, Margaret Cortese & Lance Rodewald, *Economic Evaluation of the Routine Childhood Immunization Program in the United States, 2009*, 133 PEDIATRICS 577, 577–78 (2014).

106. *Id.*

107. 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 [https://perma.cc/X2H6-YN3S].

hypertension would accrue considerable health-related benefits at reduced costs compared to the costs associated with ex post clinical treatment.[108] In fact, the decrease in cardiovascular disease and other causes of ill health reduces health care costs, with a fourteen fold return on investment.[109] Invalidating the mandate that requires health plans to provide statins at no cost would result in harms and costs that could have been otherwise prevented.

B. The Link Between Preventive Care and Geriatric Care

As the preceding discussion hopefully demonstrates, the implications of the *Braidwood* case are enormous. The outcome threatens many disfavored groups, including older adults, and while the Fifth Circuit's opinion attempts to limit the remedy to the plaintiffs, what happens in the Supreme Court remains to be seen.[110] Without effective preventive care measures in place, Americans will continue experiencing poor health outcomes when they age into their senior years.

The problem is exacerbated by the fact that the U.S. health system is inadequate when it comes to ensuring the health of older adults. Indeed, geriatric care in the United States has significant deficiencies, both in terms of workforce size and quality of care.[111] According to one estimation, there are only 7,500 certified geriatricians in the United States—less than fifth of practicing OB-GYNs (50,000).[112]

By way of comparison, consider the way in which the demand for pediatric services created by the mid-twentieth century "baby boom" transformed pediatric care. Between 1938 and 1955, the number of

108. *See* Dana P. Goldman, Yuhui Zheng, Federico Girosi, Pierre-Carl Michaud, S. Jay Olshansky, David Cutler, & John W. Rowe, *The Benefits of Risk Factor Prevention in Americans Aged 51 Years and Older*, 99 RSCH. & PRAC. 2096 (2009).

109. MATT MCKILLOP & DARA ALPERT LIEBERMAN, TR. FOR AM.'S HEALTH, THE IMPACT OF CHRONIC UNDERFUNDING ON AMERICA'S PUBLIC HEALTH SYSTEM: TRENDS, RISKS, AND RECOMMENDATIONS, 8 (2021).

110. *See* Braidwood Mgmt., v. Becerra, 104 F.4th 930, 953–55 (5th Cir. 2024).

111. John W. Rowe, *The US Eldercare Workforce is Falling Further Behind*, NATURE AGING (Apr. 12, 2021), https://www.nature.com/articles/s43587-021-00057-z [https://perma.cc/P64P-XT84].

112. *Projections of Supply and Demand for Women's Health Service Providers: 2018-2030*, U.S. DEP'T OF HEALTH & HUM. SERVS., at 10 (Mar. 2021); U.S. National Library of Medicine, National Institutes of Health, *The Professional Health Care Workforce*, NAT'L CTR. FOR BIOTECHNOLOGY INFO. (July 7, 2022), https://www.ncbi.nlm.nih.gov/books/NBK595186/ [https://perma.cc/UK9V-E7HS].

pediatricians in the United States tripled,[113] and by the end of the 1960s, the American Association of Pediatricians had almost quadrupled in size compared to 1950.[114] One would expect the U.S. health system to similarly evolve to meet the needs of the growing population of older adults, but this has not been the case: The current number of certified geriatricians reflects only a minuscule increase in comparison to the already small number of certified geriatricians almost two decades ago.[115]

In the book chapter about healthy longevity mentioned above, my coauthors and I point to the connection between the lack of investment in the geriatric workforce and the lack of investment in preventive care.[116] We argue that, when thinking about working toward a healthier aging population, public health and geriatric workforce go hand in hand.[117] Experts are needed to ensure healthy longevity with care tailored to the needs and conditions of the aging population. Both concern investment (or lack thereof) in the future of our aging population. Thus, while the geriatric workforce is not directly implicated by the *Braidwood* case, it—like prevention—is relevant to any discussion of the core features of a health-care system that has as a goal a heathy older generation.

C. The Administrative State and The Supreme Court

Finally, the Supreme Court Term that just concluded in June 2024 was the biggest Term in modern history for the future of the administrative state. Most significantly, the Court decided to overrule the *Chevron* doctrine, its most significant precedent concerning judicial deference to administrative expertise.[118] Another case the Court decided involved medication abortion, in which the question was whether the Court should defer to the U.S. Food and Drug Administration's (FDA) expert judgment in deciding that the medicine, Mifepristone, is safe.[119]

113. DOROTHY PAWLUCH, THE NEW PEDIATRICS: A PROFESSION IN TRANSITION 31 (1996).
114. *See* Alyson Sulaski Wyckoff, AM. ACAD. OF PEDIATRICS: 90 YEARS OF CARING FOR CHILDREN, 1930-2020, at 10–12 (2020).
115. INST. OF MED., RETOOLING FOR AN AGING AMERICA: BUILDING THE HEALTH CARE WORKFORCE 125 (2008).
116. Covo et al., *supra* note 93.
117. *Id.*
118. Loper Bright Enterprises v. Raimondo, 144 S. Ct. 2244, 2264 (2024).
119. *See* Food & Drug Admin. v. All. for Hippocratic Med., 602 U.S. 367, 369, 375, 391 (2024).

The Court rejected the challenge based on standing, and so left the question about deference to the FDA's scientific judgment for another day.[120] And while medication abortion may not be terribly relevant to the older population, it is a significant case even from the perspective of elder care because it threatened a trend of judges substituting their own judgment for that of the FDA or other scientific experts when it comes to the provision of health care services.

Last Term's focus on the administrative state and deference to agencies' expertise did not occur in a vacuum. Over the last few years, the Court has made it much more difficult for Congress to delegate to subject-matter experts, with decisions involving the structure of how appointments are made and the structure of supervision of administrative bodies, both of which are implicated in *Braidwood*.[121]

The Supreme Court also has issued important and disruptive decisions holding that Congress has to legislate on important matters with exacting specificity, rather than delegating to agencies.[122] This emerging, so-called "major questions doctrine,"[123] is arguably the most important recent doctrinal development for public law apart from the death of *Chevron*. By requiring Congress to legislate with specificity for regulatory schemes designed to last decades into the future, the Court ties Congress in knots: The Court expects Congress to do something that is both not feasible and undesirable when it comes to an ever-evolving field such as health care. Under the guise of a doctrine that aims to safeguard Congress's powers, the Court has hamstrung Congress and put itself in the driver's seat.

One more set of cases worth highlighting involves the challenges to new statutory provisions that, after twenty years of a carveout that protected the drug industry, now allow Medicare to negotiate with

120. *See id.* at 373, 378–86.

121. *See* Braidwood Mgmt., Inc. v. Becerra, 104 F.4th 930, 950–57 (5th Cir. 2024).

122. *See* Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 845, 865 (1984).

123. Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., Occupational Safety & Health Admin., 595 U.S. 109, 122, 142 (2022) (Gorsuch J., concurring); W. Virginia v. Env't Prot. Agency, 597 U.S. 697, 723–32 (2022); *see also* Abbe R. Gluck & Jacob Hutt, *Epilogue: COVID-19 in the Courts*, *in* COVID-19 AND THE LAW: DISRUPTION, IMPACT, AND LEGACY 391, 392–93 (I. Glenn Cohen, Abbe R. Gluck, Katherine L. Kraschel & Carmel Shachar eds., 2023) ("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.").

pharmaceutical companies over drug prices.[124] The challenged provisions have obvious relevance to the older population, because they help protect Medicare's financial stability. High drug prices also further adversely impact the health of the older population because millions of older people do not consistently adhere to prescription drug treatment due to rising costs that make such treatments unaffordable to many.[125] Specifically, nonadherence to prescribed medication—including because of unaffordability—leads to worse health conditions, causes 125,000 deaths per year, and results in additional spending of three hundred billion dollars annually.[126] That, in turn, increases the strain on Medicare's finances.[127] Thus far, most of these challenges have been rejected,[128] but cases remain pending.[129]

What does all this have to do with *Braidwood* and prevention under the ACA? In the context of Medicare drug pricing, although not the same kind of assault on the administrative state as the other challenges before the Court, the challenges share the feature of aiming to limit the reach of the federal government in health care and cripple the ability of government-established programs to best serve their beneficiaries. In the context of the administrative law cases, what we are seeing across the board is an attack on expertise and the furtherance 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 one key decisionmaker, instead

124. *See Inflation Reduction Act*, O'NEILL INST.: HEALTH CARE LITIG. TRACKER, https://litigationtracker.law.georgetown.edu/issues/inflation-reduction-act/ [https://perma.cc/6UJS-BF64] (last visited Sept. 23, 2024).

125. *See Medication Adherence: Taking Your Meds as Directed*, AM. HEALTH ASS'N, https://www.heart.org/en/health-topics/consumer-healthcare/medication-information/medication-adherence-taking-your-meds-as-directed [https://perma.cc/48WQ-PY7L] (last visited Sept. 20, 2024).

126. *Id.*

127. *See id.*

128. *See, e.g.*, Boehringer Ingelheim Pharmaceuticals, Inc. v. U.S. Dep't of Health & Human Services, No. 3:23-CV-01103 (MPS), 2024 WL 3292657 (D. Conn. July 3, 2024) (granting the government's motion for summary judgment and denying plaintiff's motion for summary judgment); Bristol Myers Squibb Co. v. Becerra, No. CV 23-3335 (ZNQ) (JBD), 2024 WL 1855054 (D.N.J. Apr. 29, 2024).

129. *See Merck et al. v. Becerra et al.*, O'NEILL INST.: HEALTH CARE LITIG. TRACKER (July 17, 2024), https://litigationtracker.law.georgetown.edu/litigation/merck-v-becerra-et-al/ [https://perma.cc/9TAW-PUCW]. *E.g.*, Merck & Co., Inc. v. Becerra, 1:23CV01615 (D.C.) (pending); Dayton Area Chamber of Com. v. Becerra, 3:23-CV-156 (S.D. Ohio) (same).

of agencies, becomes Congress, which cannot resist politicizing debates about specific medical treatments. Indeed, part of the preventive services mandate in the ACA was added to that law following a fight on the Senate floor about at what age women should receive insurance coverage for mammograms.[130] The idea in the ACA was to get that question *out* of Congress and to the experts.

Braidwood, alongside all these other attacks on the administrative state, would reverse course. Instead of delegating scientific decisions to experts, such decisions will be made by politicians, judges, and sometimes even employers. The populations most likely to be affected by these threats are those—like the older population—for whom health care is a primary concern. Congress simply cannot legislate with the kind of specificity the court is demanding. For some justices, of course, that is exactly the point—the idea is to reign in the size of the public regulatory state. But when Congress does not decide and the agencies are not allowed to decide, who decides legal questions? The courts.

In her dissenting opinion in *Loper Bright Enterprises v. Raimondo*,[131] 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

130. *See* Press Release, Barbara Mikulski, United States Senator, *Senator Mikulski's Women's Health Amendment Is an Important Improvement to the Senate Health Care Reform Bill*, NAT'L ORG. FOR WOMEN (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/ [https://perma.cc/98QH-RY8A] (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/ [https://perma.cc/U9VD-5A55] ("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.").

131. *Id.* at 2294–2311.

> 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.[132]

***

I do not think anyone believes the courts should be deciders of whether adults over fifty should be able to access heart medication, cancer screening, or any of the other two hundred services cost-free. I think most people would hope their employer does not hold that power over them either. Hopefully, this Essay 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 aging population, but also in ensuring that Medicare remains fiscally sound and, most critically, that access to health care does not depend on who you are.

132. *Id.* at 2311.