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ARTICLE

The Potential Effects of *Braidwood Management v. Becerra* and Impact on Community Health Centers

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Abstract

Braidwood Management, Inc. v. Becerra challenges the Affordable Care Act free preventive coverage guarantee. Community health centers serve over 30 million residents of medically underserved urban and rural communities. Their limited federal grant funding makes them reliant on insurance revenue for their operations, Medicaid and subsidized marketplace coverage in particular, both of which are implicated by the case. To understand these implications, we developed an analytic model that crosswalks the preventive services potentially affected by *Braidwood* and the preventive care that all health centers must furnish. Of the 193 preventive services now covered under the guarantee, only forty-eight would survive were the *Braidwood* plaintiffs to prevail. In underserved communities, health centers are a principal source of the nearly 150 affected services, as evidenced by the care they are required to furnish under federal law, the quality metrics they are expected to meet, and the health diagnoses and treatments identified in federal performance reporting requirements. Thus, the impact on access, quality, patient health, and health center finances and care capability will likely be substantial.

Keywords: Medicaid; community health center; preventive care

I. Introduction

Preventive health services consist of services — such as screenings, counseling, and immunizations — that can prevent illness or its severity, including death.[1] Clinical preventive care services, such as immunization, prevent the onset of illnesses.[2] Preventive care also can prevent potentially lethal conditions, such as high blood pressure, from worsening. Extensive research has found that preventive care can decrease the incidence of disease, facilitate earlier detection, improve health outcomes, and avert premature death.[3] The importance of preventive services to support population and community health will increase as the U.S. population continues to grow older and sicker. Indeed, a principal goal

[1] *See, e.g.*, *Preventive Services*, Healthcare.gov, https://www.healthcare.gov/glossary/preventive-services/ [https://perma.cc/7BVV-ZVT8]; *see also* Hugh Rodman Leavell & E. Gurney Clark, Preventive Medicine for the Doctor in his Community 1-13 (McGraw-Hill, 3d ed. 1965); *see also* Ctrs. for Disease Control & Prevention, Picture of America: Prevention 1, https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf [https://perma.cc/72F9-DFFJ] (last updated Apr. 6, 2017).

[2] *See Vaccines and Immunizations*, World Health Org., https://www.who.int/health-topics/vaccines-and-immunization [https://perma.cc/P6VV-TQRA].

[3] *See* Off. of the Assistant Sec'y for Plan. and Evaluation, Access to Preventive Services Without Cost-Sharing: Evidence from the Affordable Care Act *passim* (2022), https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf [https://perma.cc/ME4V-YNMM]; Shirley Musich, et al., *The Impact of Personalized Preventive Care on Health Care Quality, Utilization, and Expenditures*, 19 Population Health Mgmt. 389, *passim* (2016).

of Healthy People 2030, a national health initiative under the Department of Health and Human Services identifying science-based public health objectives, is to improve access to, and use of, preventive care.[4]

Preventive services play a particularly important role in maternal and infant health, a matter of high concern in the United States.[5] Health problems in connection with pregnancy and the postpartum period have emerged as chief problems,[6] and many drivers of maternal mortality are amenable to preventive care, such as early detection and treatment of high blood pressure and gestational diabetes.[7] The value of prevention extends beyond physical health conditions; a Centers for Disease Control and Prevention (CDC) study found that 23% of pregnancy-related deaths were the result of mental health conditions, and early screening and detection before, during, or after pregnancy can help alleviate deadly outcomes.[8] Early intervention not only protects mothers, but can also avert infant mortality and lifelong disabling consequences attributable to serious conditions, such as low birthweight.[9]

Preventive care largely takes place in the context of primary care.[10] However, while primary care is essential to a high-performing health care system, the United States falls well behind other nations on measures of primary care access and quality.[11] In recent years, the Biden Administration has taken steps to increase access to primary care using strategies identified by the National Academies of Science, Engineering, and Medicine.[12]

Chief among those tools are community health centers (CHCs or "health centers"). Established as a small demonstration in 1965, over the course of nearly six decades CHCs have emerged as the chief strategy for anchoring comprehensive primary care in medically underserved rural and urban

[4] *See Preventative Care*, Off. of Disease Prevention & Health Promotion, https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care [https://perma.cc/WZ9Z-E5N8].

[5] *See, e.g.*, K. S. Joseph et al., *Maternal Mortality in the United States: Recent Trends, Current Status, and Future Considerations*, 137 Obstetrics & Gynecology 763, *passim* (2021); *see also* Eugene Declercq & Laurie Zephyrin, Commonwealth Fund, Maternal Mortality in the United States: A Primer *passim* (2020), https://www.commonwealthfund.org/sites/default/files/2020-12/Declercq_maternal_mortality_primer_db.pdf [https://perma.cc/KDG7-K77C].

[6] *See, e.g.*, Donna L. Hoyert, Nat'l Ctr. for Health Stat., Ctrs. for Disease Control & Prevention, Maternal Mortality Rates in the United States, 2021 *passim* (2023), https://stacks.cdc.gov/view/cdc/124678 [https://perma.cc/SGA6-GD3E]; *see also Pregnancy Mortality Surveillance System*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#causes [https://perma.cc/9S69-HNGD] (last updated Mar. 23, 2023).

[7] *See Preventing Pregnancy-Related Deaths*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths.html [https://perma.cc/G9YG-DY3Q] (last updated Apr. 26, 2023); *see also High Blood Pressure During Pregnancy*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/bloodpressure/pregnancy.htm [https://perma.cc/TS9C-V6QD] (last updated June 19, 2023); Nicholas P. Deputy et al., *Prevalence and Changes in Preexisting Diabetes Among Women Who Had a Live Birth – United States, 2012—2016*, 67 Morbidity & Mortality Wkly. Rep. 1201, 1202, 1205 (2018).

[8] *See Four in 5 Pregnancy-Related Deaths in the U.S. Are Preventable*, Ctrs. for Disease Control & Prevention (Sept. 19, 2022), https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html [https://perma.cc/7PCL-FEWF].

[9] *See id.*; *Infant Mortality*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm [https://perma.cc/P92M-MCQ8].

[10] *See generally* Comm. on Future of Primary Care, Inst. of Med., Primary Care: America's Health in a New Era 41 (Molla S. Donaldson et al. eds., 1996) (stating that primary care clinicians manage preventive care); *Primary Care*, U.S. Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/priorities/innovation/key-concepts/primary-care [https://perma.cc/P5PC-MMWW] (defining preventive care as component of primary care); *Primary Care*, HealthCare.gov, https://www.healthcare.gov/glossary/primary-care/ [https://perma.cc/GN3D-M5L8] (including prevention within a definition of primary care); *see also Primary Care*, Am. Acad. of Fam. Physicians, https://www.aafp.org/about/policies/all/primary-care.html [https://perma.cc/V4AG-VA64] (stating that disease prevention is included within primary care).

[11] Leiyu Shi, *The Impact of Primary Care: A Focused Review*, 2012 Scientifica 1, 15 (2012).

[12] *See* Nat'l Acad. of Scis., Eng'g & Med., Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021); U.S. Dep't of Health & Hum. Servs., HHS is Taking Action to Strengthen Primary Care, 2-3 (2023), https://www.hhs.gov/sites/default/files/primary-care-issue-brief.pdf [https://perma.cc/PZ6B-AWMG].

communities.[13] In 2022, CHCs operating across nearly 15,000 sites furnished health care to more than 30 million people, or approximately one in ten Americans.[14] Their patients are disproportionately low income (66% below 100% of the federal poverty level) and people of color (representing 59%of patients).[15] Health centers are known for the quality of their care[16] and their accessibility given their obligation to adjust charges to reflect patient income.[17] The scope of primary health care required of all CHCs under federal law, which authorizes their establishment and operation along with operational funding, is considerable.[18] Required services encompass a full range of preventive health care services like prenatal and perinatal care, cancer screening, cholesterol screening, family planning, preventive dental care, and well-child care, which includes preventive dental and vision care, immunizations, screenings for elevated blood lead levels, and screenings for communicable diseases.

Health centers rely on a combination of grants and patient fees for revenue.[19] Operational grant funding is modest; a temporary surge in COVID-19 funding elevated grant and contract support to about 34% of total operating revenue, but that figure will decline as supplemental COVID-19 funds disappear.[20] Historically, federal operating funds have reflected about 20% of total operations,[21] and when adjusted for inflation, grant funding has actually decreased over time.[22] Funding levels going forward remain unclear: they depend on a combination of discretionary appropriations as well as a Community Health Center Fund established as part of the Affordable Care Act (ACA)[23] that, despite its status as a permanent legal authority, utilizes a funding system that requires extension every few years.[24] Thus, base operational funding for health centers is not only modest, but also in a constant state of uncertainty. In 2022, 513 centers serving 11 million patients were already operating at a deficit.[25]

[13]*Health Centers Then & Now*, CHRONICLES, https://www.chcchronicles.org/histories [https://perma.cc/39P3-F6EZ].

[14]*See* HEALTH CTR. PROGRAM, HEALTH RES. & SERVS. ADMIN., 2022 UNIFORM DATA SYSTEM TRENDS 1 (2023), https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-trends-data-brief.pdf [https://perma.cc/64VN-RV22]; Press Release, U.S. Census Bureau, Growth in U.S. Population Shows Early Indication of Recovery Amid COVID-19 Pandemic (Dec. 22, 2022), https://www.census.gov/newsroom/press-releases/2022/2022-population-estimates.html [https://perma.cc/RL37-42RC].

[15]*See 2022 Health Center Data, Full 2022 National Report*, HEALTH CTR. PROGRAM, HEALTH RES. & SERVS. ADMIN., tbls.3B & 4, [hereinafter *2022 Health Center Data*], https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2022 [https://perma.cc/PW36-AM9W].

[16]*See, e.g.*, Leiyu Shu et al., *Primary Care Quality: Community Health Center and Health Maintenance Organization*, 96 S. MED. J. 787, 787-95 (2003); Julia Paradise et al., *Quality of Care in Community Health Centers and Factors Associated with Performance*, THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAM. FOUND. 1, 1-12 (2013); Elizabeth Jacobs et al., *Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services*, 94 AM. J. PUB. HEALTH 866, 866-69 (2004).

[17]42 U.S.C. § 254b(k)(3)(G)(iii) (2018).

[18]42 U.S.C. § 254b(b)(1)(A)(i)(III) (2018).

[19]U.S. GOV'T ACCOUNTABILITY OFF., GAO- -23-106664, HEALTH CENTERS: TRENDS IN REVENUE AND GRANTS SUPPORTED BY THE COMMUNITY HEALTH CENTER FUND (2023), https://www.gao.gov/products/gao-23-106664 [https://perma.cc/C5CZ-467X].

[20]*2022 Health Center Data*, *supra* note 21, at tbls.9D & 9E.

[21]Sara Rosenbaum et al., *Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained*, HENRY J. KAISER FAM. FOUND. (2019), https://www.kff.org/report-section/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained-issue-brief/ [https://perma.cc/UK4M-RMEM].

[22]Celli Horstman et al., *Community Health Centers Need Increased and Sustained Federal Funding*, COMMONWEALTH FUND (2023), https://www.commonwealthfund.org/blog/2023/community-health-centers-need-increased-and-sustained-federal-funding [https://perma.cc/BD32-3HTV].

[23]42 U.S.C. § 254b–2(b) (2018).

[24]Peter Shin et al., *Community Health Center Funding Needed to Preserve and Sustain Critical Access to Nearly 31 Million Patients*, GEIGER GIBSON PROGRAM IN CMTY. HEALTH, MILKEN INST. SCH. OF PUB. HEALTH (Nov. 9, 2023), https://geigergibson.publichealth.gwu.edu/community-health-center-funding-needed-preserve-and-sustain-critical-access-nearly-31-million [https://perma.cc/J3ZC-CGWA].

[25]Peter Shin, et al., *Community Health Centers in Financial Jeopardy Without Sufficient Federal Funding*, GEIGER GIBSON PROGRAM IN CMTY. HEALTH, MILKEN INST. SCH. OF PUB. HEALTH (Jan. 17, 2024), https://geigergibson.publichealth.gwu.edu/community-health-centers-financial-jeopardy-without-sufficient-federal-funding [https://perma.cc/SDA3-9RCK].

For this reason, insurance revenue plays a major role in CHC financial viability. Insurance is vital to health centers and patients, not only from a financial standpoint for the operational income it produces, but also from a clinical standpoint because it enables access to specialized treatment for physical and mental health conditions when they are identified. Given the extreme poverty in which health center patients live, Medicaid is by far the most important source of third-party revenue; in 2022, Medicaid payments represented 42% percent of all operational financing.[26] But as a result of the ACA, private insurance has taken on growing significance: subsidized private insurance has become available to patients with incomes in excess of 138% of the federal poverty level, and 100% of the poverty level in non-ACA-expansion states.[27] Between 2010 and 2022, the percentage of health center patients reporting private insurance coverage rose from 14% to 20%.[28] Since employer coverage rates remained both low and effectively unchanged over this period — especially for low-wage earners — it is reasonable to attribute the sizable growth in coverage to the establishment of a heavily subsidized private insurance marketplace.[29]

For low-income insured people, the scope of insurance coverage and point-of-care cost-sharing also take on added importance because they lack discretionary income needed to overcome insurance coverage limits. A half-century of data underscores that preventive care ranks among the most price-sensitive care[30] both because the need is invisible and the absence of a health problem gives people a false sense of security regarding the consequences of forgoing care. For this reason, the ACA preventive benefits provision is highly important for poorer people generally and health center patients in particular. While health centers are obligated to adjust their charges, patients nonetheless can face modest (but for them insurmountable) charges that cause them to avoid seeking care.[31]

By guaranteeing comprehensive preventive coverage without cost-sharing for virtually all privately insured patients, and those insured through Medicaid expansion,[32] the ACA has made comprehensive preventive care accessible and affordable. For health center patients, the ACA coverage is essential because it offers complete protection against cost-sharing. Coverage provides health centers a much-needed source of revenue, thereby enabling them to allocate their modest levels of grant funding to uninsured patients and services. Despite the ACA, CHCs continue to see large numbers of uninsured patients (19%in 2022[33] with research consistently showing significantly higher rates of uninsurance in non-expansion states)[34] and many key services remain outside the scope of insurance coverage requirements, even for patients with health insurance (e.g., adult dental and vision care).[35]

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[26]Health Res. & Servs. Admin., *supra* note 20.

[27]*Medicaid & CHIP: Medicaid Expansion & What it Means for You*, Healthcare.gov, https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/ [https://perma.cc/LK4A-VTLQ].

[28]Sara Rosenbaum et al, *Community Health Centers: Recent Growth and the Role of the ACA*, Henry J. Kaiser Fam. Found. (2017), https://files.kff.org/attachment/Issue-Brief-Community-Health-Centers-Recent-Growth-and-the-Role-of-the-ACA [https://perma.cc/BE7T-LXZL]; *2022 Health Center Data*, *supra* note 21, at tbl.4.

[29]*Health Insurance Coverage of the Total Population*, KFF, https://www.kff.org/other/state-indicator/total-population [https://perma.cc/4M9R-BYBJ].

[30]*See, e.g.*, Jeanne S. Ringel et al., The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System 29-31 (Monograph Reports, 2002); *The Impact of Price on Take-Up and Use of Preventive Health Products*, Abdul Latif Jameel Poverty Action Lab https://www.povertyactionlab.org/policy-insight/impact-price-take-and-use-preventive-health-products [https://perma.cc/2S3X-LXPV].

[31]Rosenbaum et al., *supra* note 34.

[32]Coverage of most forms of preventive care for traditional Medicaid adults is discretionary other than, for example, immunizations, and family planning. Alexandra Gates et al., *Coverage of Preventive Services for Adults in Medicaid*, Henry J. Kaiser Fam. Found. (Nov. 13, 2014), https://www.kff.org/medicaid/issue-brief/coverage-of-preventive-services-for-adults-in-medicaid [https://perma.cc/F9S8-7FXW].

[33]*2022 Health Center Data*, *supra* note 21, at tbl.4.

[34]Rosenbaum et al., *supra* note 34.

[35]*See* Hannah Katch & Paul Van De Water, *Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits*, Ctr. on Budget & Pol'y Priorities (Dec. 8, 2020), https://www.cbpp.org/sites/default/files/atoms/files/12-8-20health.pdf [https://perma.cc/L65A-B2GW]; *see also* 42 U.S.C. § 18022 (2022).

It is against this backdrop that *Braidwood Management, Inc. v. Becerra* has unfolded.[36] *Braidwood* involves wide-ranging constitutional challenges to the legality of the ACA guarantee of free coverage for a broad array of evidence-based preventive health care. The plaintiffs argue that Congress unconstitutionally delegated the power to establish detailed insurance coverage requirements, and that in the context of insurance mandates, the key expert bodies whose recommendations form the basis for the insurance mandates violate the Constitution's Appointments and Vesting Clauses.[37] Separately, plaintiffs argue that the free coverage mandate related to preexposure prophylaxis (PrEP) violates their rights under the Religious Freedom Restoration Act.[38] Thus, the full range of ACA preventive benefits – child health services recommended by the Health Resources and Services Administration (HRSA) Bright Futures program ("Bright Futures"), immunizations recommended by the CDC Advisory Committee on Immunization Practice (ACIP), women's health services recommended by HRSA's Women's Preventive Services Initiative (WPSI), and services recommended by the United States Preventive Services Task Force (USPSTF) – are on the line in *Braidwood*.[39]

Should the challengers ultimately prevail on their claims now before the Fifth Circuit, it is possible that the free preventive benefit guarantee would disappear and, along with it, coverage for some or all of the preventive benefits added since the ACA's enactment.[40] It is also possible that insurers would continue to cover some affected benefits while reinstating cost-sharing including deductibles, coinsurance, and copayments. The extent of benefits loss would be tied to the scope of plaintiffs' victory because different legal claims affect each of the four preventive service bundles in different ways. A total victory on all claims could result in a total loss of all the benefits secured by the free preventive benefit guarantee.[41]

With the loss of the coverage guarantee, some insurers might drop benefits altogether, while others might retain coverage but reimpose cost-sharing. Regardless of whether coverage is nominally retained, reimposition of cost-sharing likely would reinstate the very barriers that historically deterred use of preventive care and the preventable health consequences that would follow.

An analysis by KFF found that about 5% of privately insured people in the United States used a relevant preventive service or drug in 2019,[42] making the access effects of *Braidwood* potentially considerable. In our earlier research focusing on *Braidwood*'s implications for women's health, we found that if post-2010 preventive benefits were to fall away, coverage for 122 preventive services and ninety preventive services relevant to maternal and infant health would be lost in their entirety.[43] Other

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

[37]Cong. Rsch. Serv., LSB11040, Preventive Services Access on the Docket in *Braidwood v. Becerra* (2023).

[38]*Three Reactions to Braidwood v. Becerra*, Harv. L. Sch. Petrie-Flom Ctr. (Apr. 3, 2023), https://blog.petrieflom.law.harvard.edu/2023/04/03/three-reactions-to-braidwood-v-becerra/ [https://perma.cc/CQ6F-CWPV].

[39]*See A & B Recommendations*, U.S. Preventive Servs. Task Force (Sept. 2023), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations [https://perma.cc/HHJ7-A5BD]; *Women's Preventive Services Guidelines*, Health Res. & Servs. Admin., https://www.hrsa.gov/womens-guidelines [https://perma.cc/27MP-RX7A] (last reviewed Dec. 2022); *Bright Futures*, Health Res. & Servs. Admin., https://mchb.hrsa.gov/programs-impact/bright-futures [https://perma.cc/QW4N-LCX2] (last reviewed Nov. 2023); *Vaccine-Specific Recommendations*, Advisory Comm. on Immunization Practs., https://www.cdc.gov/vaccines/hcp/acip-recs/recs-by-date.html [https://perma.cc/PD94-S3YX] (last reviewed Jan. 12, 2024).

[40]Cong. Rsch. Serv., *supra* note 43.

[41]Second Memorandum Opinion & Order on Remedies in Relation to Plaintiffs' Motion for Summary Judgment, Braidwood Mgmt. v. Becerra, 666 F. Supp. 3d 613 (2023) (No. 4:20-cv-00283-O).

[42]Kruitka Amin et al., *Use of ACA Preventive Services Potentially Affected by Braidwood v. Becerra*, KFF (May 25, 2023), https://www.kff.org/health-reform/issue-brief/use-of-aca-preventive-services-potentially-affected-by-braidwood-v-becerra/ [https://perma.cc/R4G7-693K].

[43]Caitlin Murphy et al., *Braidwood Mgmt. v. Becerra Could Eliminate Three Quarters of the Affordable Care Act's Preventive Benefits for Women, Infants, and Children*, Geiger Gibson Program in Cmty. Health, Milken Inst. Sch. of Pub. Health (June 8, 2023), https://geigergibson.publichealth.gwu.edu/71-braidwood-management-v-becerra-could-eliminate-three-quarters-affordable-care-acts-preventive [https://perma.cc/FE2C-4QNM].

research has shown that 4.6 million women could lose access to the free contraceptive services they used in 2022 and over 12,000 infants could lose access to the free newborn screening panel.[44]

How might these losses affect CHCs and their patients? The federal requirement that CHCs serve all, irrespective of ability to pay, and provide these services for free when patients cannot otherwise afford them, suggests that CHCs may face additional financial pressure and operating difficulties if the plaintiffs' arguments prevail.[45] The higher the share of services furnished by CHCs that fall into one or more of the preventive services categories, the greater the access and financial risks raised by *Braidwood*, with spillover effects on overall CHC operating revenues and patient care capacity. The implications might be greater for CHCs that have expanded preventive care staffing and service sites to accommodate increased demand, particularly from older working-age patients with rising health needs, children, and women of childbearing age for whom health centers are a major source of both pregnancy-related and preventive reproductive health care.[46]

II. Methods

This paper focuses on the free ACA preventive services that health centers provide, with particular emphasis on women, infants, and children, whose use of preventive care is a major priority both for coverage reforms and CHCs. Together, children under the age of eighteen and women aged eighteen to forty-four represent 51%of all health center patients.[47] This analysis utilizes the publicly available preventive services recommendations from the USPSTF, ACIP, WPSI, and Bright Futures, as well as data from the annual Uniform Data System (UDS) to which all CHCs report annually.

We first compiled all the recommendations subject to the ACA free preventive service requirement through the end of 2023, cataloguing any changes that occurred to each recommendation after the enactment of the ACA, comparing recommendations that overlapped between recommending bodies, and flagging recommendations specific to maternal, infant, or child health. Because the challengers are pursuing the overturn of coverage for all preventive service bundles in the ACA, we examined all bundles but tracked the recommending body source, which allows for more flexible analysis if only a subset of the recommending bodies' recommendations are found to be unconstitutional. To verify our analysis, we ensured at least two team members examined each recommendation. We released these findings on our website in 2023.[48] We then mapped the most recent 2022 UDS measures to these recommendations to quantify the number of patients using relevant services and the potential number of CHC patients who could be impacted under a *Braidwood* ruling for the plaintiffs. Utilizing the UDS, we matched the preventive procedures found in the previous analysis with quality measures when available, given that these measures tended to be more directly comparable to the procedures. In the absence of relevant quality measures, we looked at other

[44]Sara Rosenbaum & Caitlin Murphy, *Insurance Claims Data Show that Millions of Americans Rely on the Affordable Care Act's Free Preventive Coverage Guarantee for Critical Maternal, Infant, and Child Health Care*, Geiger Gibson Program in Cmty. Health, Milken Inst. Sch. of Pub. Health (Sept. 27, 2023), https://geigergibson.publichealth.gwu.edu/insurance-claims-data-show-millions-americans-rely-affordable-care-acts-free-preventive-coverage [https://perma.cc/V3T9-6G87].

[45]*Federally Qualified Health Center (FQHC)*, Healthcare.gov, https://www.healthcare.gov/glossary/federally-qualified-health-center-fqhc/ [https://perma.cc/57MB-PY5L]; *What is a Health Center?*, Health Res. & Servs. Admin., https://bphc.hrsa.gov/about-health-centers/what-health-center [https://perma.cc/WT46-VHEP] (last reviewed May 2023); 42 U.S.C. § 254b (2003).

[46]Sara Rosenbaum et al., *Family Planning and Medicaid Managed Care Integration, Phase Two Report: Insights from the Field*, Geiger Gibson Program in Cmty. Health, Milken Inst. Sch. of Pub. Health (Mar. 1, 2022), https://geigergibson.publichealth.gwu.edu/69-family-planning-and-medicaid-managed-care-integration-phase-two-report-insights-field [https://perma.cc/V9BF-6NSV].

[47]*2022 Health Center Data*, *supra* note 21, at tbl.4.

[48]Murphy et al., *supra* note 49.

recorded services. In the absence of service information, we looked for relevant diagnoses that mapped to screenings for those conditions.

While only a subset of CHC patients are covered under insurance that could be subject to change under a ruling in favor of plaintiffs, this analysis provides an important first upper bound so that researchers, health centers, government officials, patients, and advocates can begin to understand the practical implications of such a decision. Furthermore, because marketplace coverage plays an outsize role in non-expansion states (owing to the lower subsidy eligibility threshold), losses could be especially significant for CHCs already facing greater revenue challenges because so many of their patients fall into the Medicaid coverage gap, leaving them with higher uninsured rates.[49] health centers in non-expansion states experience uninsured rates between seventeen percentage points higher than those located in states adopting the ACA expansion.[50]

Preparing these estimates is challenging given the uncertainty in the publicly funded insurance markets. This is particularly true over the 2023–2024 period because of the process of "unwinding" Medicaid's continuous coverage guarantee, which spanned the COVID-19 public health emergency pandemic period and is projected to result in considerable losses in coverage, including ACA expansion coverage.[51] An unknown number of those undergoing unwinding may move to marketplace coverage, and early enrollment estimates suggest that to some degree, this lateral movement may be happening for people whose ACA coverage losses are attributable to slightly higher income. How well this large-scale cross-market transition will occur is unclear. Regardless, this coverage disruption underscores the difficulties confronting CHCs as their grant funding declines and the proportion of insured patients also declines. Further revenue losses from *Braidwood* would only add to the problem.

Other challenges that arise in conducting a *Braidwood* impact estimate for CHC practice have to do with limits of the UDS. As valuable as the reporting system is, it does not distinguish between types of Medicaid coverage (e.g., expansion versus traditional eligibility categories). It is not possible to know, furthermore, what percentage of the Medicaid health center patient population losing coverage might eventually and successfully make their way to subsidized marketplace coverage. Additionally, the UDS does not provide detailed information as to the insurance status of patients for each relevant service or diagnosis. Thus, we cannot assume that the percentage of patients with a specific insurance type is consistent across each service or diagnosis, particularly for pregnant people, which is a Medicaid eligibility population category.[52]

III. Results

As shown in Table 1 in Supplementary material, we identified 193 unique procedures at stake in *Braidwood*.[53] Two-thirds (125) of these procedures pertain to maternal and infant health, while nearly 30% (fifty-five) pertain to children and adolescents. If the Supreme Court ultimately overturned the

[49]Evan V. Goldstein, *Community Health Centers Maintained Initial Increases in Medicaid Covered Adult Patients at 5-Years Post-Medicaid-Expansion*, 58 Inquiry 1, 2 (2021).

[50]Author calculations derived from Rosenbaum, *supra* note 27.

[51]*Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches*, U.S. Dep't of Health & Hum. Servs. (Aug. 19, 2022), https://aspe.hhs.gov/sites/default/files/documents/dc73e82abf7fc26b6a8e5cc52ae42d48/aspe-end-mcaid-continuous-coverage.pdf [https://perma.cc/2HXH-3LZ4]; Peter Shin et al., *Updated Estimates Show That Medicaid Unwinding Threatens Health Center Capacity to Serve Vulnerable Patients*, Geiger Gibson Program in Cmty. Health, Milken Inst. Sch. of Pub. Health (Nov. 9, 2023), https://geigergibson.publichealth.gwu.edu/updated-estimates-show-medicaid-unwinding-threatens-health-center-capacity-serve-vulnerable [https://perma.cc/3R28-YWCM].

[52]*Medicaid Eligibility*, Medicaid.gov, https://www.medicaid.gov/medicaid/eligibility/index.html [https://perma.cc/9Q7D-PPG6].

[53]*See infra* Table 1 Supplementary material: ACA Preventive Services Protected or Eliminated Under *Braidwood*.

preventive benefit guarantee across all four preventive service bundles (i.e., children's health, women's health, immunizations, and USPSTF recommendations), then only 25% (forty-eight) of procedures would remain fully covered without cost-sharing. Since ACA enactment, 122 entirely new recommendations have come online, including lung cancer screening, statin use for prevention of cardiovascular disease, and type 2 diabetes screening. Another thirteen procedures would remain intact but only for certain populations. For example, adolescents would no longer qualify for free alcohol use screening. Finally, ten procedures would lose changes designed to improve effectiveness as science has advanced; it is not clear that expert advisory committees would continue to recommend them under those circumstances.

Of the 125 procedures that pertain to maternal and infant health, ninety would be completely removed, including the Recommended Uniform Screening Panel for newborns and screenings for gestational diabetes, depression, and intimate partner violence for mothers. Another five procedures would only remain in place for a subset of currently recommended populations and one procedure would lose a substantial change. Of the fifty-five procedures that pertain only to child and adolescent health, twenty-four would be entirely removed, including screenings for anxiety and hepatitis C as well as provision of fluoride varnish. Another five procedures impacting children and adolescents would only remain in place for a subset of currently recommended populations and two would lose a substantial change. Among these losses, adolescents would no longer qualify for a free meningococcal vaccine.

When comparing the UDS to the 193 unique preventive procedures, we found nine quality measures collected annually that map to the recommendations, including a significant overlap in ages of populations examined; six other services that aligned with the unique preventive procedures; and seven diagnoses that aligned with a condition for which a screening is within the 193 procedures.[54] The quality measures captured were: (1) tobacco cessation intervention for adults; (2) depression screening for people aged twelve and over; (3) BMI screening with a follow-up plan as appropriate for people aged eighteen and over; (4) HIV screening for people aged fifteen to sixty-five; (5) cervical cancer screening for women aged twenty-three to sixty-four (twenty-one to sixty-five in the USPSTF recommendation); (6) statin use for patients at high risk of cardiovascular events (ages forty to seventy-five in the USPSTF recommendation); (7) colorectal cancer screening for people aged fifty to seventy-four (fifty to seventy-five in the USPSTF recommendation); (8) breast cancer screening for women aged fifty-one to seventy-three (fifty to seventy-four in the USPSTF recommendation); and (9) children aged two who received age-appropriate vaccines by their second birthday. Quality measures are of particular importance because they are a means of accountability to ensure that providers are performing services as they should.[55] These current values are important for two reasons: (1) we need to know current values to understand the volume of patients using these services who may experience changes to their coverage; and (2) CHCs may be unable to perform as well on these measures due to changes stemming from the *Braidwood* case outside of their control. Six of these quality measures are associated with recommendations specific to women, infants, and children, though tobacco cessation interventions, depression screenings, and HIV screenings also apply to recommendations specifying more general populations.

Use of services recommended for women, infants, and children was common. Nationally, we found that slightly over 11 million health center patients were screened for tobacco use and received counseling if appropriate — about 36% of all health center patients nationally. Tobacco cessation counseling is a USPSTF-recommended service explicitly for both pregnant and non-pregnant adults. Nearly 11 million people were screened for depression as well, a service recommended under USPSTF and Bright Futures for adults, including pregnant and postpartum women, as well as children and adolescents. Roughly 7 million patients received an HIV screening (approximately 23% of all health center patients nationally),

[54] *See infra* Table 2 Supplementary material: Community Health Center Provision of ACA-Protected Preventive Services.

[55] *Uses of Quality Measurement*, Agency for Healthcare Quality & Rsch., https://www.ahrq.gov/patient-safety/quality-resources/tools/chtoolbx/uses/index.html [https://perma.cc/DMT3-GY4J] (last reviewed June 2020).

a recommended service under USPSTF and WPSI. About 4 million women received cervical cancer screenings, and nearly 1.7 million received breast cancer screenings, services recommended under USPSTF and WPSI. Roughly 1.6 million women received contraception management, a recommended service in the WPSI service bundle, and 1.1 million patients received a hepatitis B test, a service recommended under USPSTF and Bright Futures for multiple populations including pregnant women. Approximately 126,000 patients aged two received age-appropriate vaccines by their second birthday, or approximately 33% of all patients turning two, and roughly 540,000 children aged nine to seventy-two months received a lead test screening.

We found substantial variation by state for the preventive procedure recommendations contained in the UDS.[56] The occurrence of tobacco screening ranged from 20% of CHC patients in Wisconsin to 51% of patients in New Hampshire. Similarly, depression screening ranged from 15% in Wisconsin to 52% in Nevada. The range for HIV screenings is particularly stark: 7% in Wyoming and 42% in the District of Columbia.

IV. Discussion

This analysis documents the considerable exposure faced by CHCs and their patients should the *Braidwood* plaintiffs succeed. Female patients subject to the ACA preventive service provision constitute a population particularly vulnerable to the withdrawal of preventive coverage, as suggested by the finding that cervical cancer screenings, breast cancer screenings, and contraception management are three common services that centers provide. Indeed, American women generally appear to use these preventive services frequently. In 2022, 72% of all women aged forty and up had received a mammogram in the past two years, and 73% of women aged eighteen to sixty-four had received a pap smear in the past three years.[57] In 2020, about three-quarters of all women reported receiving a well-woman visit or general check-up in the past two years; these frequently include mammograms, pap smears, and contraceptive counseling.[58] Women living in a household earning below 200% of the federal poverty level, which is the majority of female CHC patients, are particularly likely to postpone preventive services because of cost.[59]

The evidence shows that a significant portion of health center patients receive thee preventive services (or should receive them based on diagnoses) at stake in the *Braidwood* case. Health center data limitations do not allow us to determine the percentage of patients who receive *any* of the 193 procedures at stake or understand how many may experience some change to their ability to pay for the services they need. However, a recent KFF analysis suggests that 60% of individuals who are privately insured receive at least one preventive service annually, and it seems likely that owing to the preventive orientation of health centers, their patients receive preventive service at a rate meeting or exceeding this value.[60]

[56] *See infra* Table 3 Supplementary material: Community Health Center Patients Receiving Preventive Care Services Covered by the ACA Preventive Service Benefit and Identified as a Community Health Center Care Measure, by State.

[57] *State Profiles for Women's Health: U.S. Women's Healthcare Access & Utilization Data*, KFF, https://www.kff.org/interactive/womens-health-profiles/united-states/healthcare-access-usage/ [https://perma.cc/KV37-79JA].

[58] *See* Michelle Long et al., *Women's Health Care Utilization and Costs: Findings from the 2020 KFF Women's Health Survey*, KFF (Apr. 21, 2021), https://www.kff.org/womens-health-policy/issue-brief/womens-health-care-utilization-and-costs-findings-from-the-2020-kff-womens-health-survey [https://perma.cc/33KH-DDZR]; *see also Preventive Care: A National Profile on Use, Disparities, and Health Benefits*, P'ship for Prevention, (2007), https://search.issuelab.org/resource/preventive-care-a-national-profile-on-use-disparities-and-health-benefits.html [https://perma.cc/HR2L-6CW4].

[59] Geetest Solanki & Helen Halpin Shauffler, *Cost-Sharing and the Utilization of Clinical Preventive Services*, 17 Am. J. Preventive Med. 2, 127-33 (1999).

[60] *See* Kruitka Amin et al., *Preventive Services Use Among People with Private Insurance Coverage*, KFF (Mar. 20, 2023), https://www.kff.org/private-insurance/issue-brief/preventive-services-use-among-people-with-private-insurance-coverage/ [https://perma.cc/BW4Y-4BLB] (finding that 60% of privately insured individuals in 2018 reported receiving "some ACA preventive care" that year).

It is important to note that some health centers and their patients are more likely to be disproportionately affected by the effects of the *Braidwood* case. The state-level analyses provide some insight into these differences. For example, if the ruling regarding PrEP is upheld, health centers in Washington, DC would likely experience greater impact than centers in North Dakota because a higher percentage of DC patients receive PrEP management. When focusing on depression screenings, it appears that Wisconsin would likely experience less impact than New Hampshire.

An additional complication in understanding the magnitude of effects is that the percentage of patients who have insurance subject to the ACA preventive service provision differs by state. For example, while California has a relatively low percentage of health center patients who have private insurance (9%), and are therefore likely subject to the ACA provision, it has a relatively high percentage of health center patients who have Medicaid (67%).[61] We do not know what percentage of these Medicaid patients are in the expansion population, nor do we know if California would continue to offer full preventive coverage under its Medicaid plan, although continued coverage is likely. Other states, however, might not make the same choice. In contrast, 38% of Wyoming's health center patients rely on private insurance and only 21% use Medicaid.[62] Because Wyoming has not expanded Medicaid, the state's entire Medicaid enrollee population is not subject to the *Braidwood* ruling, making determining the potential effects of the *Braidwood* case somewhat more straightforward. Nonetheless, across all states, an analysis of which states and health centers tend to see more patients utilizing preventive services provides suggestive evidence as to where there may be issues.

We also lack information as to the cost of the preventive services at stake and health centers' current reimbursement rates. However, this figure could be determined in future research. While we can find the base payment rate that Medicare must pay CHCs ($180.16 in 2022),[63] we cannot estimate the shortfall that would occur if coverage were eliminated without more detailed information. With the shortfall figure, we could begin to quantify the trade-offs that health centers may need to make. When faced with budget deficits in the past, health centers have contemplated cutting hours or services, closing sites, and layoffs.[64] For patients, these decisions mean less access to care that spills over to all patients, not just those with insurance subject to ACA preventive service provisions. Less access to care can translate to poorer health as conditions go untreated or undetected. Additionally, as patients face confusion as to whether they must pay for services, they may be less likely to seek care, particularly preventive care that does not treat an immediate acute condition.

V. Conclusion

Preventive services are a core part of CHC services by mission, legal mandate, and practice. A *Braidwood* ruling that eliminates coverage and changes the availability of free preventive services would have substantial effects on centers and their patients, upending care in many communities. At a time when CHCs are already experiencing a shift in patient coverage due to the Medicaid unwinding,[65] grant funding is uncertain and stagnant,[66] CHCs are in involved in the delivery of one in six low-income births,[67] and there is increased concern about pregnancy complications in a world in which the Supreme

[61] *2022 Health Center Data*, *supra* note 21, at tbl.4 row 8.

[62] *Id.*

[63] U.S. Ctrs. for Medicare & Medicaid Servs., R11057CP, Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2022 (Oct. 22, 2021).

[64] Sara Boden, *Federal Shutdown Could Disrupt Patient Care at Safety-Net Clinics Across U.S.*, NPR (Sept. 29, 2023, 6:53 AM), https://www.npr.org/sections/health-shots/2023/09/29/1201738506/federal-shutdown-could-disrupt-patient-care-at-safety-net-clinics-across-u-s [https://perma.cc/DZC7-5ENG].

[65] Peter Shin et al., *supra* note 57.

[66] *Id.*

[67] *Community Health Centers in the Wake of Dobbs*, Geiger Gibson Program in Cmty. Health, Milken Inst. Sch. of Pub. Health (July 22, 2022), https://geigergibson.publichealth.gwu.edu/community-health-centers-wake-dobbs [https://perma.cc/LAS2-YKRP].

Court overturned constitutional protection for abortion,[68] the ability for health centers to provide relevant preventive screening services and receive payment for such services is essential.

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[68]Sara Rosenbaum, *EMTALA Pregnancy Protections Versus State Abortion Bans: The Supreme Court Will Decide*, Health Affs. Forefront (Jan. 9, 2024), https://www.healthaffairs.org/content/forefront/emtala-pregnancy-protections-versus-state-abortion-bans-supreme-court-decide.

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