

**United States of Care & Community Catalyst**  
**Webinar Transcript**

State Webinar on *Braidwood v. Becerra*

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**Lisa Hunter**

Hi, everyone. Thank you so much for joining us for today's webinar. I am Lisa Hunter, the Senior Director for Policy and External Affairs here at United States of Care. Today's webinar provides a very timely update on the *Braidwood v. Becerra* case. We're going to be sharing some helpful tools and resources to help support you all in state advocacy efforts and hopefully insulate from an adverse ruling. I want to say a special thank you to Community Catalyst for co-hosting today's webinar and for their partnership and their leadership on this issue. I also want to recognize some really terrific panelists who are so generous to provide some of their time and expertise today. I appreciate how the content that they're bringing into today's webinar is really in service to this community of advocates. You all are pursuing consumer protections at this very precarious moment. We're lucky to have these panelists here today and we're also lucky to have all of you tuning in. With that, let's go ahead and move on to the next slide and I will run through the agenda here. I'm going to start off in just a moment to give a brief background history on preventive services. I'm going to quickly toss it over to Tim Jost, who will be providing a legal overview of the case. Hopefully, everyone will be able to catch up and learn about how the lawsuit's really evolved through the courts and what we should be watching for next. After Tim, Dr. Mark Fendrick from the University of Michigan Center on Value-Based Insurance Design is going to underscore what's at stake in this case from a clinical and health equity perspective. Then, my colleague Kelsey Wulfsuhle is going to give us a snapshot of what's happening across the country in terms of states taking action. Ashley Blackburn from Massachusetts Health Care For All is going to share the experience that her organization is having, championing a legislative pathway to protect preventive services in Massachusetts. Colin Reush will then round us out from Community Catalyst with ways that advocates can engage and organize in their own communities on this issue. Then, we'll cap it off with a Q&A at the end with some helpful resources and tools to leverage in your own advocacy.

First, a couple of housekeeping notes. Today's webinar is going to be recorded so you can refer back to this webinar later. The primary audience for today is really the advocacy community, specifically those of you who are working in states, and it is not for press purposes. Following today's webinar, all of the registrants are going to receive resources from today, including a few sign on forms, should you be interested, so keep an eye out for that. Lastly, if you'd like to ask any questions of the panelists, you can use the Q&A function in Zoom to submit those throughout the presentation. We're going to be collecting them and then we'll address any questions at the end of the webinar. Next slide, please. Here's a list of our esteemed panelists who I've just introduced. I think we can go on to the next slide. Excellent.

Okay, onto the program. So at the center of this case is the Affordable Care Act preventive services provision. As a reminder, back in 2010 when the ACA was passed, what we saw was really history getting made and a lot of great ways. The preventive services provision within the

ACA was signed into law. That is a key federal reform that for the first time ever required most private health plans to cover preventive services with no cost-sharing, meaning that people could seek out preventive care without having to pay a copay coinsurance or reach a deductible. That was a real game changer, for not only enrollees going into ACA marketplaces but also for the 150 million people who are under employer-sponsored insurance. So, how did Congress set up preventive services? They left it to the experts, by allowing three different bodies who are grounded in clinical evidence to make recommendations on specific preventive services subject to this requirement. These bodies are ACIP, which makes recommendations on vaccines and immunizations; USPSTF, an acronym that I think we all can rattle off of our tongue pretty easily now; and then HRSA, which makes recommendations on services for women and children. USPSTF is the focus of the *Braidwood v. Becerra* case. Next slide, please. I'm going to set the table for Tim Jost, who's going to take the next section, but just to give folks a little bit of wayfinding here, the plaintiffs in this case are a handful of people and employers that primarily argued that the preventive services requirements violates their religious freedom because it involves coverage of an HIV treatment, PrEP. There's more behind this, obviously, which I'm going to leave to Tim to explain. You have the federal government represented in this case, by the Secretary of HHS, Xavier Becerra, who is the defendant. The court took this up in the US District Court for the Northern District of Texas under Judge Reed O'Connor. If that name sounds familiar, it's because we've heard it before; we've heard it in the context of ACA litigation before as well. An initial ruling came out from Judge O'Connor in September of 2022, which sided with the plaintiffs. But the ruling didn't include, or was silent on, a scope or remedy – exactly how far would this ruling go? Then, in March of 2023, just a few months ago, Judge O'Connor clarified that the ruling applied nationwide and was effective immediately. This is the point where I'm gonna go ahead and pass the mic over to Tim, who is actually a legal scholar and not just playing one on TV. Tim, why don't you go ahead and take it away.

### **Tim Jost**

Thank you, Lisa. The plaintiffs in *Braidwood* assert that the ACA's preventive services requirements are unconstitutional in several respects. First, they claim that the members of the USPSTF, who recommends coverage for general preventive services; ACIP, which recommends vaccine and immunization coverage; and HRSA, which recommends Women's and Children's Services are "officers of the United States," because they have continuing positions and significant authority under US law. The Constitution requires officers of the United States to be appointed by the President, a court, or a department head. Members of the USPSTF are appointed by the Agency for Healthcare Research and Quality, rather than the President or the Secretary. In September of last year, O'Connor held that this violates the Appointments Clause requirement. He said, however, that because the recommendations of ACIP and HRSA are subject to the approval of the HHS Secretary, who is properly appointed, that ACIP and HRSA recommendations do not violate the Appointments Clause. He also rejected the plaintiffs' claim that the USPSTF violates the vesting clause, and I won't get into that. Next, the plaintiffs argued that all three entities violate the Constitution's Non-Delegation Doctrine, which prohibits Congress from delegating responsibilities to administrative agencies without giving them enough direction as to what to do. He held that under previous decisions of the Fifth Circuit Court of Appeals, which governs Texas, the ACA's requirements do not violate the Non-Delegation Doctrine. He urged the Fifth Circuit and the Supreme Court to reconsider their

law and delegation and possibly to hold all three entities unconstitutional. Finally, Judge O'Connor held that the requirement that self-funded plans and insurers cover PrEP and HIV preventive services violates Braidwood's rights under the Religious Freedom Restoration Act, which requires that the government use the least restrictive means of promoting a compelling governmental interest when it burdens religious freedom. He agreed with the plaintiffs' argument that having to pay for coverage would cause them to support immoral conduct, and thus, violate their religious freedom. Next slide.

In March, Judge O'Connor decided several additional issues that remained outstanding in the case. Most importantly, he held that all federal agency actions taken to implement and enforce the preventive care requirements in response to an A or B recommendation of the USPSTF on or after March 23 2010, the date that the ACA was adopted, that all of those recommendations are illegal, requiring insurers to comply with them. He therefore vacated the rule imposing these requirements. He further enjoined the federal government from enforcing their requirements and from enforcing the PrEP coverage requirement against religious objectors. Next slide.

The federal government has appealed this decision to the Fifth Circuit Court of Appeals. The plaintiffs have cross-appealed, which is to say they are arguing with the parts of Judge O'Connor's judgment that held part of 2713 to be legal. We don't know exactly what they will argue, but it is likely they will argue that the vaccination and women's and children's preventive care requirements that have been promulgated since the ACA was enacted in 2010 should be thrown out as a violation of the Non-Delegation Clause. In the meantime, the federal government asked Judge O'Connor to put his nationwide orders on hold while the appeal is underway. The government has said that it would not apply the preventive services requirements to the half dozen actual plaintiffs in this case, but the requirements should otherwise remain in effect for the 150 million other people that it affects. The government argues that it was inappropriate for Judge O'Connor to enter nationwide relief, since the plaintiffs themselves are fully protected and many people will be harmed by his order. The plaintiffs argue that they need universal relief, so at least some insurers will insure them insurance that does not require them to pay premiums for services they don't want to object to. Judge O'Connor has so far not ruled on this motion, so the federal government has gone above his head and asked the Fifth Circuit for a stay. The Fifth Circuit granted a temporary administrative stay, which simply puts the case on hold until the court can take a further look at it. A panel of Fifth Circuit judges will be able to hear oral arguments in about three hours as to whether it should leave this stay in place. If it lifts the stay and Judge O'Connor's rule does go into effect, the Supreme Court will likely be asked to stay the District Court's decision and leave the preventive care requirements in place. Next slide.

The Fifth Circuit, or ultimately, the Supreme Court, could reverse Judge O'Connor on several grounds. It could hold that the plaintiffs have not been injured by the preventive services requirement and then they had no basis for bringing the case. The court could alternatively hold that the remedy Judge O'Connor adopted, the universal vacating of agency rules affecting the preventive services requirement, was not appropriate. It is conceivable that the Court could hold that O'Connor was simply wrong in deciding that the USPSTF is unconstitutionally appointed. It's possible that the court could reinterpret the statute to give HHS final decision-making

authority on all preventive services, and thus dispose of the Appointments Clause problem. But it's possible that the courts will simply uphold Judge O'Connor and may even extend his decision to cover vaccines, women's and children's preventive services, and the whole preventive services requirement. If this happens, insurers may still be required to cover preventive services under state law. But state law does not apply to self-funded employer group plans under ERISA, although Massachusetts may have found a way around this, which we'll hear about later. Most insurers and employers may continue to cover these services because they're popular and they're relatively inexpensive, but many insurers and employers did not cover these services without cost-sharing before the ACA. We can expect that some of them will drop coverage or impose cost sharing if the legal requirement goes away. Back to Lisa.

### **Lisa Hunter**

Thanks so much, Tim. Okay, those were very complex legal steps there. Appreciate you walking us all through that. Next we have Dr. Fendrick, who's going to discuss the clinical implications at play here. Mark, why don't you go ahead and take it away!

### **A. Mark Fendrick, M.D.**

Lisa, thank you. It's an honor to share the virtual podium with Professor Jost. I'm Mark Fendrick. I'm a practicing general internist and a professor at the University of Michigan. I've devoted my career in enhancing access and affordability to high-value clinical services with an equity lens. Most of you have never heard about the term V-BID before today. Basically, it is an idea that changes the typical insurance consumer cost-sharing angle of setting your co-payment based on what things cost, such that cheap things are cheap and expensive things are expensive. What V-BID does is make the good things with few or no financial barriers, and the things that don't make you healthier, you should be able to pay more. The idea of V-BID goes back to the late last century. The great thing about Value-Based Insurance Design pre-ACA, it was largely driven by the private sector primarily, a idea that was focused by one particular party, and incorporated in hundreds of private and public payers before the idea of Value-Based Insurance Design, specifically about preventive services, was included in the Affordable Care Act. Having helped draft the preventive services provision, I take the equity and clinical considerations of this case personally, and I'm thrilled to have all of you to listen to understand what these implications might be.

It's really important that you saw that number that Lisa showed. 150 million Americans have been impacted from enhanced coverage. That was pre-COVID. Many of you may not know that it was section 2713, another preventive services provision, that was amended to allow most of us to get COVID tests, vaccines, and treatments for free. No one's really estimated from the federal government, but most people are suggesting that about 250 million Americans have benefited to some extent from the preventive services provision. It's really important to re-emphasize what Tim said. Every survey ever done has shown that free preventive services has polled very highly, even in the highest intensity discussions about repealing and replacing the ACA a decade ago. The preventive services provision was incorporated in all but 3 of the 40+ repeal and replace attempts of the ACA, suggesting that would be the case. It's important also to point out that 40% of people in a Morning Consult poll showed that if they're asked to pay for the services they previously had got at no cost, they would not get them. A plurality of Republicans actually have

been polled to show that they're against the *Braidwood v. Becerra* ruling. I'm hopeful that we're going to be able to get a rare, multi-stakeholder, bipartisan support to be able to have in perpetuity, codify, or guarantee these really impactful, equity-enhancing and basically no cost to public payers, private payers and the government, given that preventive care is such a small sliver, probably less than 2% of our total healthcare spend. Next slide, please.

I've been asked to talk about these clinical and equity implications, because on March 30, when the ruling came down, a whole number of public health advocates beat the drum on a point that Tim made silently, which is the statement that the United States Preventive Services Task Force recommendations that were given an A and B before the passage of the ACA must continue to be covered with zero cost-sharing. While most people were heralding that as a positive, as a practicing clinician and following the task force recommendations extremely closely in my own clinical work, I did not think that was such a great thing. I'm going to summarize a table that we've been continuing to update as the task force makes new recommendations. The preventive services provisions have always been described by me as a gift that keeps on giving. Unlike other health care rules that put the list of services around a fence, every time ACIP, HRSA, or most importantly, USPSTF would give an A or B rating, all non-grandfathered plans had one year to put in place any new A and B rating with zero cost sharing for the specific populations involved. As of the ruling date, there were 46 Task Force recommendations that had an A or B rating. What's really important is that almost a third, 15 of 46, would no longer require coverage without cost sharing, because they were given that recommendation after the passage of the ACA. 10 of the 15 that would no longer be covered, had been given a rating from the taskforce, but not an A or B. For example, Hepatitis C screening, which now has an A and B for all adults. Prior to 2010, it did not have an A or B, so payers would not have to cover this very important public health recommendation. 31 services received an A or B rating before 2010, and they would require coverage without cost sharing, but really importantly, they had to use pre-2010 recommendations. 14 of the 46 are pretty much the same recommendations today as they were pre-ACA. So that's less than a third, understanding then that two thirds of the A and B either are new or substantially changed. 17 of the services that have an A or B before 2010 had been significantly updated. A really good example of this is Colorectal Cancer screening. In the recommendations prior to the ACA, average-risk individuals between the ages of 50 and 75 were able to get multi-modality types of screening for colorectal cancer at no cost to them. The most recent update of the colorectal cancer recommendation from the USPSTF lowers that age to 45. Now, there are 20 million Americans who have access to free colorectal cancer screening based on important new evidence about showing younger people being diagnosed with colorectal cancer. If the ruling were to be upheld, those 20 million Americans would not have a mandate to have their colorectal cancer screening covered. Those are the 46 currently in place. But one of the things that very few people are writing about is this gift that keeps on giving. There are currently six services that have a draft A or B rating. I am worried that even though Tim cited the Wall Street Journal article saying that plans would continue to cover the existing services until the court case is finished, I am not as confident given our own research to suggest that if a new A or B rating, such as that for anxiety screening in adults, or even within the last month the new recommendation that the age to begin breast cancer screening biannually for women dropped from 50 to 40 years of age, suggesting that 22 million Americans who may benefit from breast cancer screening are would be significantly less

likely to have new coverage and zero cost-sharing if many of these public and private payers didn't have to.

I am very, very concerned about this, particularly this issue that Tim raised at the end. There are legal scholars that I have spoken with that said not only will these 46 services come into place, but also the HRSA and ACIP recommendations, which bring into the issues of vaccines, child issues as well as reproductive care. So if we could somehow do what Tim mentioned is the case for ACIP and HRSA, to have the recommendations approved by the Secretary, the concerns of the Appointment Cause will go away. I'm not speaking for any of the other organizations who I'm so thankful are joining me today, but I have been working through the V-BID center as hard as I can to convince key policymakers in both houses of the US Congress on both sides of the aisle to consider a one sentence fix to allow the USPSTF recommendations to be approved by the Secretary, understanding that the Secretary is a political appointee, allowing the party in charge to make decisions of whether to place those A & B recommendations in the no-cost category or not. Back to you, Lisa.

### **Lisa Hunter**

Thanks so much, Mark. Those are pretty astounding figures. I'm glad that you all are tracking that closely and certainly it isn't lost on us how impactful this decision could be if it really does if the ruling does prevail. I'm going to turn it over to my colleague Kelsey in a minute. She is going to look at what states are actually doing in response to this ruling and the proactive legislative pathways that some states are starting to pursue. So with that, Kelsey, please take it away.

### **Kelsey Wulfkuhle**

Thank you, Lisa. My name is Kelsey. I am the State External Affairs Manager here at USofCare. I will have you go to the next slide. This next slide shows a snapshot of states responses to this ruling in 2023. As you can see, the states that are in that blue, teal-ish color this year put into place protections that codify access to free preventive services. However, as you can see, a majority of states in the US do not have those protections in place. Currently, several other states did take action to codify productions. Five of those have passed, as I said, and then others such as Massachusetts, you'll hear from in just a moment, still have bills under consideration, which you can see in the darker blue and purple. Next slide, please.

Many of the bills introduced this year would require insurers to cover at no cost services and recommendations made by the USPSTF, HRSA, and ACIP. This comprehensive approach will make sure that all preventive services are protected at no cost, even if future court decisions result in weakening the remaining protections for preventive services recommended by ACIP and HSRSA, as the plaintiffs are seeking. As Tim said, it's important to note while these protections will apply to the individual and small group market as well as state employee benefit plans, state legislatures do not have jurisdiction over fully-insured and self insured plans under ERISA. Those are federally regulated, so states have gotten creative on how they are seeking to maintain free access to preventive services for the 1/3 to 1/2 of residents in states typically who are covered under their employer's plans. USofCare, to help states that are considering legislation to codify the ACA as preventive services requirements, has put together template legislation as a guide for states to make sure that these protections remain in place, as well as

include protections for services recommended by all three of those agencies. After this webinar, feel free to reach out to us. It's also important to note that in addition to the legislation you see here on screen, states have also put out notices and resources for consumers to make sure that they remain up to speed about what's covered and what's not. Some states such as Michigan went so far as to secure commitments from all the insurers in their state that they will continue to maintain access to no-cost preventive services while the case is in motion. I am now going to hand it over to Lisa to hear from one of our state advocates here.

### **Lisa Hunter**

Great, thanks, Kelsey. Just to reiterate, we do have template legislation that states can use in their own ways and leverage back home. I will say this is not something that USofCare did on our own. We also were really grateful to partners for helping with that, including Community Catalyst, Georgetown, Tim, as well as others who fed into that document. I just want to recognize that this was a team effort. We will include a link to the legislative template language in our follow up. I think everyone will benefit from the experience that we know Massachusetts is having right now in pursuing legislative action on this. I'm going to turn it over to Ashley from Massachusetts Health Care For All and she's going to walk through exactly how this materialized for her organization and how it's going. Go ahead, Ashley.

### **Ashley Blackburn**

Thank you, Lisa, and hi, everyone. My name is Ashley Blackburn and I'm the Director of Policy and Government Relations and Health Care For All in Massachusetts. Before I get into the mechanics of our legislative language, I want to set the stage with a few pieces of context that will be helpful to know about our legislative process and how things are moving this session. First of all, Massachusetts is a two year session. That means we have to file all of our bills at the outset of the session. They do allow for some late filings, but generally the rule of thumb is if you want your bill to move through the legislative process, you get your bill filed by January 20 of the start of that year. Over the course of the last summer and last fall, we were planning our legislative agenda for the 2023-2024 session. As we were narrowing down what our legislative agenda would be, it was actually even before the initial district court decision came out, we had been following this case. We knew this was potentially going to be an issue because Massachusetts is not one of the early adopter states that codified these protections back when the ACA originally passed. We were coming up with this language and trying to figure out what to do before a lot of people were talking about state action on the issue.

What we decided to do is file something that I call a copy and paste of the federal statute. We decided it would be a placeholder bill for us because it's a two year session, knowing that this case would not likely make its way through the federal court process until probably spring of 2024. We wanted to make sure we had a bill that was ready to go. We also assumed that legislators weren't going to be super keen on moving the legislation until they really understood that it was a problem. We felt like we were probably going to have to get through a little bit further in the court process to make that point clear. What we did was we got to the members that sponsored our legislation, the two chairs of our Joint Committee on Health Care Financing. They are both in leadership. We knew that if we needed to move these bills quickly that these two members, Representative Lawn and Senator Friedman, would be able to shepherd this bill

through the process quickly if we needed to. We filed these bills, as placeholders, with just codifying the exact language as written in federal statute. We really didn't talk to a lot of stakeholders heading into the legislative session because we thought we were gonna put it on the backburner and see how things progress through the federal court system. But as it turns out, the second and final decision out of the federal District Court came out earlier this spring, right as our budget session was kicking into gear. We actually got a fair amount of media coverage on the decision when this happened. The sponsors of our bills thought, "Hey, why don't we just include this in an outside section in our budget bill, which will be the first bill that passes in this two year legislative cycle." We obviously were thrilled with that idea and let the chairs run with it. This did mean that we had to kick things into high gear and start to talk to some stakeholders about this language, because we really hadn't done so yet.

The first place we went when we started having conversations was with our carriers in the state. Just to pause and note, this is Massachusetts, so while we did have to do some negotiation with the carriers to get the language in a place where they felt comfortable, we largely entered into these conversations with the same goal in mind. The carriers did not want us to end up in a place where preventive services are no longer covered in Massachusetts. We all had a shared goal. We just had to get to a place where they felt comfortable about the language, and that's where the crux of our negotiations landed as we were working to get legislative language into the budget process. The bullets that I reflect here on the slides actually are not reflective of the bills we introduced, but of the language that exists in our budget, which is currently working its way to the conference committee right now. We were able to get this language in both the House budget and the Senate budget. For those of you who work with state legislators, I'm sure many of you can empathize with this. We have a lot of intra-chamber politics that goes between our House and our Senate. It's not often that a provision actually makes it into both the House Budget and the Senate budget, especially an outside section like this, that is somewhat political. I think that really speaks to how important the issue is and just how ubiquitously the legislature feels like this is something we have to tackle in Massachusetts. The language does actually exist in both our House budget and the Senate budget. We are pretty confident, although I will knock on wood as I say that, that the outside section that protects preventive services in Massachusetts will not get stripped out during the conference committee. We feel pretty good about the fact that this language will become law on July 1, when our budget will be signed.

But just to talk through a few mechanical pieces about what it does in large part. It is still codifying what the federal statute lays out, which is naming the three entities – USPSTF, ACIP, and HRSA – as the entities that are describing what the preventive services are that will be covered at no cost sharing. I will say the primary concern that our carriers had was that when we originally did the copy and paste from the federal statute, that language was too broad, and if codified in the state law, it would leave them open to interpretation that goes beyond what these three entities actually spell out should be covered in at no cost. In part, that's because there is a lot of further definition on what preventive services should be required without cost-sharing in sub-regulatory guidance that comes out of these entities that doesn't show up obviously in the federal statute. We took care of that concern by merely just making mention of that sub-regulatory guidance coming out of USPSTF, ACIP, and HRSA to make sure that if the state down the road does need to implement this, these provisions of the federal statute goes away.



We're also making sure that we're paying attention to that large body of guidance that has come out over the course of the last 10 years as this provision has been implemented federally. That was one of their primary concerns. The way that it's written, it encapsulates a snapshot of the preventive services and all of the regulatory guidance that exists around it up until July 1 of 2023. We use July 1 2023, because that's when our budget will pass. We give the Division of Insurance the authority to refer back to ACIP, USPSTF, and HRSA as they are continually updating those recommendations to make sure that we are staying current in Massachusetts as those guidelines evolve, if it comes down to the place where the state is actually implementing these provisions or enforcing these provisions. That is essentially the legislative language that was included in our budget bills. As I said, we are not quite there yet, but we are hopeful that we will move forward in the next month with that language passing into law. Next slide, please.

If it all goes well, we will actually end up with double protection in Massachusetts. That's in large part thanks to the Massachusetts Health Connector Board. The Health Connector Board is the board that oversees our state-based marketplace. Several weeks ago, they proposed a change at a Health Connector Board meeting that would amend the definition of minimum creditable coverage in Massachusetts. Massachusetts has had an individual mandate for almost 20 years now. Massachusetts has had an individual mandate prior to the Affordable Care Act passing. The Massachusetts Health Connector Board has broad authority to define what types of coverage meet that individual mandate in the state. What they've proposed to do here is to amend that definition of minimum creditable coverage in Massachusetts, so that it includes all of the preventive services that are currently covered under federal law at no cost-sharing for consumers. Because plans in Massachusetts want to offer coverage that meets this standard, the hope here is that ERISA plans on the self-insured market will actually follow suit. Just to underscore what Tim and Mark have said previously, we cannot reach those plans without state legislation. We also aren't technically regulating those plans through this Connector Board decision, either. It is incumbent on an individual to have health insurance that meets these standards. But the influential factor here is that plans in Massachusetts want to offer coverage that meet these standards. I did ask the Connector Board folks, in large part, do we see that the ERISA plans follow suit with minimum creditable coverage as it stands today? That answer is yes. They really do think that we should be able to reach that 50 plus percent of our market by making this tweak to our definition of minimum creditable coverage for our individual mandate in the state. Now, again, I will recognize that we are in a unique position here, because we do have that individual mandate and because our Connector Board does have broad authority to amend that definition. For states that do have an individual mandate, I would say definitely look at this as an option. It is not completely done yet. The board did vote to amend but we have to go through a public hearing process before it can formally be adopted. If all goes well, on this side of things, the minimum creditable coverage definition should be changed, I believe by August. We're looking at a place where the legislative language could be in place by July 1, and then the Connector Board decision would go into effect in late summer. Recognizing that this is a path forward for Massachusetts that doesn't necessarily carve a path for everyone in the country who doesn't have an individual mandate here, but definitely wanted to note it in case anyone is joining who does have an individual mandate in your state.

A couple of key takeaways that I'll offer before I pass it back to our hosts here. For our friends here who might be operating in states with less friendly political environments, I just want to note that we really didn't have to do a lot of convincing on why this is important or all of the reasons that Dr. Fendrick was talking about why we need preventive services without cost sharing and the clinical importance of that. We really didn't have to do a lot of arguing around those parameters, and found that universally, it was pretty well understood that this is something we should be doing in Massachusetts. It really was just a technical negotiation with our carriers to make sure that they were on board. That's really my second point that I will make if you are in the beginning stages of filing state legislation and you think your carriers could be a problem or you think that they could be helpful, I would definitely recommend talking to your carriers earlier in the process. It was definitely noted and well received by our legislature how well we worked with the carriers on this. We testified at a hearing together and I think it was impactful that we all quickly came together on this language and did a nice public showing that this is not just a consumer issue in Massachusetts, but that the carriers are on board as well. That was hugely helpful in driving us to be able to get the language in both chambers during our budget process. Just to underscore what's been mentioned in the legal conversations, I would also push for covering the services from all three entities. As Tim pointed out, the District Court decision really is centered around USPSTF, but we were very clear from the beginning with our bill sponsors and with the carriers who were thankfully on board, that the dial could be turned up here in this case. We felt strongly that if we're going to codify these protections in Massachusetts, we really should do the full suite and make sure that we are not leaving a stone unturned as the case moves through the court process and the decision expands. Finally, I will just note the ERISA piece is obviously a huge barrier here if you do not have an individual mandate to think about this in the creative way that we're doing it here in Massachusetts. We anticipated we would get some pushback from legislators like, "Why should we move forward with this process if we're only covering half of the market at best?" I think people felt compelled to protect consumers in Massachusetts as best as we could. It just so happens that we're lucky enough to have this other avenue to hopefully protect the entire market as we move forward. I will share resources as the team at USofCare sends out resources today. I'll make sure to include language from Massachusetts for folks to refer to and also be happy to talk to anyone in any state that's considering moving on this in their upcoming legislative sessions. I'm happy to be a resource as you move forward. Thank you.

### **Lisa Hunter**

Thanks, Ashley. That was such a great overview of all the stuff that you guys are doing. We were getting questions live while you're speaking around what kinds of ways you had to work with carriers in order to neutralize things. It sounded like it was getting in there early, finding alignment early, and being able to negotiate some of these pieces was really helpful for you all. I think Colin is going to address a little bit of the carrier aspect as well in the community engagement section, which is coming up next. Why don't I just go ahead and kick it over to Colin to talk through community engagement?

### **Colin Reusch**

Thanks, Lisa. I'll try to make this as quick as possible, because we want to make sure that there's time for Q&A. We'll go to the next slide. As others have outlined already, there's a lot in flux in

this case. Our advocacy strategies and our community engagement strategies are going to need to adapt as this moves forward and audience and partner dependent. But I think one of the best things that we can be doing right now is encouraging people to continue to seek the care that they need, using those no-cost preventive services that are already enshrined in law and ensuring that as this case moves forward, it doesn't have a chilling effect on people's access to care.

As has already been stated, this is one of the most popular provisions of the law. While recent Kaiser Family Foundation polling shows that most people aren't aware of the *Braidwood* case and its implications right now, what people are aware of is the benefits that they are entitled to, the benefits that provide them access to life saving care that does not pose a financial barrier. A Couple of things that we can be doing and encouraging, depending on the partners that we're working with in our states and in our communities, is one, figuring out how to leverage the power that already exists in these communities. Black, Brown, tribal communities, the disability community, all of these organizations that already exist, the infrastructure that already exists, have long been championing these efforts and ensuring that people are aware of the coverage that they're entitled to and encouraging people to get things like vaccines, cancer, screenings, PrEP, etc. These are really the trusted messengers that we should be looking to work with as this case moves forward, not only in terms of encouraging people to continue to seek care and to pressure insurers to commit to preserving coverage of no-cost burden of services, but also to activate folks in joining efforts to enshrine protections at the state level and to lift up the stories of how the ACA and preventive services have helped save lives. In addition to the organizations that I met that I've outlined here, I think we can also be looking to partner more closely with provider communities, who are the provider groups who work in these communities, to understand the implications of these services being taken away. I also want to point out, as Tim said, the state level protections, depending on how they're structured, may not cover all the bases, in terms of the insurers that we want to see continuing to cover no-cost preventive services. I think it's also important to be looking to partner with large employers and employers that have self-funded health plans in your states and communities. In addition to the typical large employers, looking to unions and even state employee health plans, who have a lot of influence over what they can ask their insurance plans to continue to cover. We're really looking to leverage the power that already exists in communities and among community-based organizations who are already engaging with patient, individual and family storytelling efforts. These are groups that have long been working to protect Medicaid coverage to protect against the repeal and replace of the Affordable Care Act over the last decade and who already have the infrastructure and connections and the trusted relationships to be able to lift up the voices of people who have benefited from these services and who will be disproportionately affected if they're taken away. All of that said, I think it's also important to be mindful of the cost and burden of asking people to engage in advocacy and asking people to tell their stories, being mindful of the time that people have to take out of their days and lives to do that, and reimbursing them as necessary. But the last thing I'll say is that it is important right now for us to be leaning into the life-saving benefits of no-cost preventive services. We want to be able to underscore what everyone already knows, which is it's common sense. It's cost effective. It's a matter of equity, and overall health and economic well being for millions of people across the

country. We also want to make sure that folks are prepared to activate around what they might stand to lose, should this case move in the wrong direction. Lisa, back to you.

**Lisa Hunter**

Excellent. Thanks, Colin. I think that gets us to our Q&A, so we can go ahead and move to the next slide here. The fabulous news is that you all had lots of questions that you put into the chat already or sent along to the panelists. We've been trying to answer those as we've been going through here. But I do want to highlight a few that have some answers, just to make sure that folks aren't missing some of the good content here. Let's talk about prenatal visits or prenatal visits at risk here. I'm gonna bounce it over to Colin to start answering that question, but I know that Mark and Tim might also have some thoughts too.

**Colin Reusch**

The current guidelines around prenatal visits and well-woman visits live under the HRSA preventive services guidelines. They have clarified that prenatal visits are considered well-woman visits and are therefore no-nost preventive services. Furthermore, it's likely to take more than one prenatal visit in order to attend to all of the preventive services that need to happen during that prenatal period. That said, some of the individual tests and services that would occur during those visits, whether that's certain cancer screenings or other tests, some of those do live under the US Preventive Services Task Force recommendations. Those are certainly implicated here in this case, in addition to the broader threat to preventive services across the board.

**Lisa Hunter**

Great, in the interest of time, I think I'm gonna keep us moving. How about the effect on Medicare and Medicaid? Kelsey, do you want to weigh in? I know you responded in the chat.

**Kelsey Wulfsuhle**

Let's start with Tim first, actually.

**Tim Jost**

Medicaid coverage, as I think Kelsey said, is determined by what the states cover in their Medicaid plan. For the expansion population, the states have to cover essential health benefits. That could be one way of HHS getting some control over that, although it doesn't pertain to cost sharing. Medicare, it's unclear to me there. There are provisions in the Medicare statute that require coverage of USPSTF, HRSA, and ACIP services, although those are enforced through HHS. I think that the Braidwood plaintiffs don't want to touch Medicare for obvious political reasons, but I would not say it's completely invulnerable.

**Lisa Hunter**

Other additions from the panel? Okay. I do want to raise one other one here, and I guess this one's open to anybody on the panel here. The strongest opposition to state legislative action in Rhode Island has come from anti-choice and anti-LGBTQ organizations who have tried to use our state bill to expand religious exemption provisions. Have others experienced this and what

specific advocacy organizing strategies are recommended to counter this? Who wants to take the first crack here?

**Ashley Blackburn**

This won't be super helpful, but this did not come up in Massachusetts at all. We honestly didn't have anybody testify in opposition to our bill when it did have a hearing. Obviously, since the language is now moving to the budget process, it's slightly different than going through the normal hearing process of a regular bill introduced in the course of the session, but we did have a hearing on our introduced legislation as well. We only had people testifying in support and nobody really coming out of the woodwork trying to impact it negatively. That just has not been something that's come up, fortunately. If that's helpful at all to point to your neighbor to the north to say that that has not been a prevailing argument against our legislation.

**Tim Jost**

One thing, I'd say in response to this, and I touched on it, but I think it's a really important point: the *Braidwood* plaintiffs are returning actors, they've sued a bunch of times on a bunch of issues, usually involving reproductive choice and LGBT and trans issues. They have won a number of those cases under the Religious Freedom Restoration Act. But the problem that they have is that even though they have the right to not have to pay for those services, if they can find an insurer that doesn't cover them, all of their available insurers cover those services because they're required to cover them for everybody. Nobody can sell special insurance policies just to the anti-trans, anti-gay, anti-abortion people. Now they're trying to wipe out the coverage protection for everybody, for all services, even though it's really a pretty small group of people who object to a pretty small number of preventive services. That's going to be the issue this afternoon in the state hearing, because the government is saying, "Look, we're not keeping you from getting whatever you want." And they say, "Yes, you are, because nobody can sell this stuff because of the law."

**Lisa Hunter**

Thanks, Tim. Colin, is there anything here in terms of community organizing that might address this?

**Colin Reusch**

Yeah, that's a great question. I don't know if I have a great answer for that. I do think as we look to activate community organizations around this, it's important to keep in mind that this case is grounded in discrimination. This is not just about the cost of providing no-cost preventive services through employer health plans. This really stems from someone taking issue with services that are critical to the LGBTQ community. I think it's worth calling that out.

**Ashley Blackburn**

I would also just add: try your other stakeholders. If you can get carriers, hospitals, the traditional stakeholders that tend to have the ears of most legislators, hopefully, they can crowd out those sorts of fringe voices. I think that's really been the case in Massachusetts. It's hard to argue when you have this strong coalition of stakeholders that oftentimes are at odds with each

other on healthcare legislation, all coming together and saying that we need to do this. Hopefully, it crowds out those fringe voices.

**Lisa Hunter**

I think that's time. Some resources on the next slide here just to call out, we'll be sending an email out to everybody who registered here. We will also include some links to sign on, one of them being the petition that Colin referenced during his segment. We also know that several groups are filing amicus briefs for the end of the month. If you are interested in signing on to an amicus brief, United States of Cre is working with a few partners to draft and prepare and file with a focus on the consumer impact and taking note of the state advocacy lens on this, since we're able to see how this is panning and playing out. If you're interested in learning more about that, please feel free to sign on. Lots of other resources here from Mark and others, and I know Ashley is going to follow up with some of the bill language too. Thank you all so much for joining. Thank you to Community Catalyst for co-hosting. Thank you to this amazing panel of colleagues here who are doing yeoman's work on advocating and supporting one another. And with that, I think I'll go ahead and sign us off. Take care everyone and thanks again. Bye.