

# Targeting Precision Medicine: Evidence from Prenatal Screening

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July 5, 2022

## Abstract

Technological advances in medicine increasingly offer opportunities to target care to patients identified through screening, raising questions of how broadly to screen for potential cases of disease. We explore this trade-off empirically in the context of a new, non-invasive prenatal screening (cfDNA). cfDNA screening is used to target a follow-up, invasive test which is twice as costly and elevates the risk of miscarriage. Using Swedish administrative data on prenatal choices for pregnancies conceived between 2011 and 2019 – a period in which Swedish regions began providing coverage for the new screening – we document that cfDNA coverage has enormous effects both on increasing cfDNA screening and on reducing rates of invasive testing. To assess the impact of counterfactual targeting of cfDNA coverage, we develop and estimate a stylized model of prenatal choices. We find that narrow targeting of coverage for screening has the (rare) potential to improve outcomes and reduce costs, while broader coverage also improves outcomes but with increased costs. These findings point to the potential gains from well-designed targeting of screening, but at the same time highlight the importance of the targeting design.

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# 1 Introduction

“Big data” has the potential to transform all aspects of the economy, from retail to banking to marketing. Health care is no exception. Precision (or personalized) medicine – which targets treatments to patients based on their genetic, biological, or clinical characteristics – has been widely heralded for its potential to transform both the practice of medicine and the economics of health care. By identifying which patients are likely to benefit from certain treatments and – just as importantly – which are not, physicians can target effective treatments at the relevant sub-population, while sparing the rest the costs, side effects, and false hope of ineffective treatments.<sup>1</sup> Precision medicine thus dangles the tantalizing prospect of what has long been considered the holy grail of health care: improving patient health and well-being while simultaneously reducing health-care spending (Aspinall and Hamermesh 2007; Armstrong 2012). However, what is less appreciated – and certainly less celebrated – is that personalized medicine requires information that is needed for personalization, and acquiring such information typically entails costs.<sup>2</sup> Ironically, therefore, the availability of precision medicine in turn raises questions about how finely to target the acquisition of information that can be used for further targeting.

We analyze this issue in the context of prenatal testing, which accounts for the largest share of spending on genetic tests in the US (Phillips et al. 2018). For over half a century, invasive prenatal diagnostic tests – amniocentesis and chorionic villus sampling (CVS) – have been able to diagnose fetal chromosomal abnormalities, but at the cost of elevating the risk of miscarriage. Since the early 2000s, the development of non-invasive prenatal screening – nuchal translucency (NT) – has offered a lower-cost way to assess the likelihood of the most common chromosomal abnormalities without any risk of miscarriage, and thus inform the decision of whether to undertake invasive testing. We analyze the impact of a second-generation form of non-invasive screening – known as cell-free DNA (cfDNA) screening – which substantially increases the informativeness of the screening, but also considerably elevates screening costs. We empirically explore the costs and benefits of how to target the availability of this second-generation screening technology through public policy decisions of whether and when to cover its cost. This is currently an active – and evolving – policy debate

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<sup>1</sup>An example of this type of precision medicine is targeted therapy for the treatment of some cancers (Aspinall and Hamermesh 2007; Goldman et al. 2013; Berndt, Goldman, and Rowe 2018).

<sup>2</sup>Several recent papers have studied targeting of either screening or treatment technologies based on readily – and hence costlessly – observable individual characteristics, such as age (Einav et al. 2020) or family medical history (Persson, Qiu, and Rossin-Slater 2021). Our focus, however, is on information that is costly to acquire. Examples under active discussion include the possibility of recommending mammogram screening based on breast density rather than (or in addition to) age (Trentham-Dietz et al. 2016) or using biomarkers and genetic testing to tailor cancer treatment (Banerjee et al. 2020).

in both the US and in many European countries (Minear et al. 2015; Gadsbøll et al. 2020; GenomeWeb 2020).

Our analysis draws on detailed Swedish administrative data for pregnancies that received the first-generation screening between 2011 and 2019. They thus all have a risk score: the predicted probability of fetal chromosomal abnormalities. This risk score is used by parents to make further testing decisions and by the government to determine coverage for the second-generation screening. Crucially, we observe this risk score, as well as subsequent screening and testing decisions. In our study population, first-generation screening and invasive diagnostic tests are available for free for all pregnancies, as are downstream medical procedures. Over our study period, various regions in Sweden introduce coverage for the new cfDNA screening, making different choices about how narrowly they define the set of risk scores that are eligible for free cfDNA screening. Our data and setting thus provide a rare opportunity to empirically evaluate the impacts of targeting a new screening tool and the implications for optimal policy design.

We begin by documenting descriptive evidence that the introduction of coverage for cfDNA screening has enormous effects, both on increasing cfDNA screening and on reducing invasive testing; these effects are concentrated in the risk scores that receive coverage. In order to quantify welfare under alternative regimes, we then write down and estimate a stylized model of prenatal testing decisions. Each pregnancy has three possible outcomes: a live birth with no chromosomal abnormalities (the vast majority of births), a live birth with chromosomal abnormalities, or no live birth (due to miscarriage or abortion). All pregnancies receive the initial NT screen and its associated risk score. Parents then face three sequential choices: whether to undergo cfDNA screening (which provides more precise information about risk), whether to conduct an invasive diagnostic test (which provides definitive information about chromosomal abnormalities but carries a miscarriage risk), and whether to terminate the pregnancy. The privately optimal decisions depend on the risk score, the parents' relative utilities from the possible pregnancy outcomes, and the out-of-pocket cost they face for cfDNA screening. The socially optimal decision regarding cfDNA screening coverage depends on the parents' expected utility with and without coverage, as well as the impact of coverage on government costs. The impact of coverage on government costs is a priori ambiguous: the screening itself entails costs, but can decrease spending on subsequent invasive testing, which is about twice as expensive.

We restrict our analysis to pregnancies with risk scores that are high enough to have the cfDNA screening covered under the recommendation of the relevant Swedish advisory body; this is also the most expansive coverage regime we observe. While this limits our analysis to about 13% of pregnancies in the data, they account (in expectation) for almost

all (97%) pregnancies with chromosomal abnormalities. We estimate the model using method of moments, matching the cfDNA screening and invasive testing decisions for different risk scores and different coverage regimes. Despite the fairly stylized nature of the model, it fits the data remarkably well.

We then apply these estimates to consider outcomes under alternative coverage regimes. We analyze a variety of outcomes, including screening and testing rates, the three possible pregnancy outcomes, government spending, consumer surplus, and the rate of what we term (ex-post) inefficient outcomes. There are two forms of inefficient outcomes: no live birth of a baby that had no chromosomal abnormalities (due to miscarriage resulting from invasive testing), and live births of babies with chromosomal abnormalities born to parents who would have preferred no live birth (had they known about the chromosomal abnormalities in advance).

In the absence of the new cfDNA screening technology, about one-quarter of parents opt to do invasive testing, despite the miscarriage risk that comes with it. Spending per pregnancy on this testing is \$311 US, and 0.3% of the pregnancies result in an (ex-post) inefficient outcome. If the new screening technology covered all studied pregnancies,<sup>3</sup> cfDNA screening rates would be 75%, the rate of invasive testing would fall to 5% (an 80% decline), and the rate of inefficient outcomes would fall to 0.03% (a 90% decline). Consumer surplus would be \$224 higher per pregnancy, but government spending on screening and testing per pregnancy would rise by \$180; that is, the increased spending on cfDNA screening is not fully offset by the decreased spending on invasive testing. Thus, with broad coverage, the introduction of cfDNA screening would follow the pattern of most new medical technologies: improving patient welfare but also increasing health-care cost.

By contrast, we find that if the government instead introduced more targeted coverage for the new cfDNA screening technology, it could both improve patient welfare and lower health-care costs. For example, if – as is the case in several of the Swedish regions – the screening technology is covered for only the highest one-third of the risk scores in our sample, cfDNA screening rates would be less than 30%, and invasive testing would be less than 6%. As a result, this more narrowly targeted cfDNA coverage both increases consumer surplus (by \$133 per pregnancy relative to the case where the new technology is not available) *and* reduces government spending (by \$90 per pregnancy).<sup>4</sup>

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<sup>3</sup>Recall that these are the 13% of pregnancies that have the highest risk, and coverage for them is recommended in Sweden.

<sup>4</sup>Interestingly, we also find that the most common coverage regime implemented in Sweden turns out to be “too clever by half.” Under this regime, cfDNA screening is not covered for patients whose risk score is in the highest one-sixth (on the premise that they would opt into invasive testing no matter what the cfDNA screen revealed), yet it is covered for the second-highest one-sixth. We find that this policy produces lower consumer surplus and higher government spending relative to covering all of the risk scores within the top

Taken together, our findings illustrate both the promise and perils of screening technologies designed to guide the application of other medical interventions. Appropriately targeted, screening can provide that holy grail – improving patient well-being while saving money. However, if made more widely available, it becomes the more typical form of medical technology: raising both patient well-being as well as health-care spending.

Our findings speak to the large literature on the consequences of medical innovation, suggesting that those consequences are not innate, immutable characteristics of the technology, but can be shaped by public policies. In the United States, medical innovation is both widely credited for the dramatic secular improvements in health that have occurred over the last half century, and widely blamed for the equally dramatic rise in health-care spending over the same period (Newhouse 1992; Cutler 2004; Chandra and Skinner 2012). In this context, there is growing interest in the potential for precision medicine to transform technologies that are highly effective for a subset of patients but end up cost-increasing because they are applied too broadly (so-called “type II” technologies in the framework developed by Chandra and Skinner 2012) into “type I” technologies that are both highly health effective and highly cost effective, with little chance of overuse (Goldman et al. 2013; Berndt, Goldman, and Rowe 2018). Whether or not this transformation can be realized is a matter of some debate (Phillips et al. 2014); our findings suggest that the ultimate impact of precision medicine can depend critically on public policy regarding the prices patients face for screening.

In this sense, our paper complements the existing literature analyzing the optimal pricing of alternative, more expensive, treatment options (Hirth, Chernew, and Orzol 2000; Einav, Finkelstein, and Williams 2016; Hamilton et al. 2018). For therapeutic treatments, the value of information is increasing in the probability that the patient will be found appropriate for treatment, while for screening and diagnostics, the value of information may be highest for mid-range risks, where the information is most likely to affect subsequent medical decisions. Indeed, we see in our setting that the willingness to pay for the new cfDNA screening is hump-shaped with respect to risk.

More narrowly, our paper contributes to a literature at the intersection of medical innovation, family economics, and bioethics concerns over health technologies that offer the promise of learning more about a pregnancy. Such technologies enable parents to act on their preferences over children’s characteristics – including, but not limited to, child health – but also raise concerns about “designer babies” and the potential eradication of certain traits in the population (Ball 2017; Devlin 2019; Hercher 2021). For example, the development of non-invasive prenatal screening has been accompanied by a substantial decline in the number of babies born with Down Syndrome, prompting an ethical debate over the

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possible “end of Down Syndrome,” with an oft-cited statistic that more than 95% of fetuses who are prenatally diagnosed with the condition are aborted (Conner et al. 2012; Zhang 2020).<sup>5</sup> Another well-documented example is the introduction of ultrasound technology in prenatal care – originally intended as a tool to monitor high-risk pregnancies (Hvistendahl 2021) – which permitted parents with a preference over the child’s gender to implement sex-selective abortion, and thereby contributed to a sex ratio imbalance involving over 160 million “missing females” in Asia and elsewhere (Sen 1990; Bongaarts and Guilmoto 2015; Hvistendahl 2021).

The rest of the paper proceeds as follows. Section 2 describes our setting and data, and Section 3 presents the descriptive patterns. Section 4 lays out the model and its estimation. Section 5 describes our results, and the final section concludes.

## 2 Setting and data

### 2.1 Technological developments in prenatal testing

There has been remarkable progress over the last half-century in prenatal testing. Since the 1970s, invasive diagnostic procedures have been able to provide a definitive diagnosis of any fetal chromosomal abnormalities. Amniocentesis, which was developed first, is typically done at 15-20 weeks of the pregnancy, and chorionic villus sampling (CVS), which came into use a couple of decades later, can be done as early as the 10th week (Akolekar et al. 2015). Both involve inserting a needle into the womb to extract fetal cells (from which fetal DNA is subsequently extracted) from the amniotic fluid (amniocentesis) or placenta (CVS). Because they are invasive, they carry a miscarriage risk – a risk that is estimated to be around 0.5% during our sample period (Akolekar et al. 2015).

More recently, from the 2000s on, advances in genetics have contributed to the development of *non*-invasive screenings. These screen for the three most common chromosomal abnormalities: Trisomy 21 (Down syndrome), Trisomy 13 (Patau syndrome), and Trisomy 18 (Edwards syndrome). Down syndrome, which causes mental retardation and structural deformations, is estimated to occur (in our empirical setting) in approximately 1 in 700 pregnancies that are carried at least 11 weeks, with the risk increasing with age (Conner and Malcus 2017). Patau and Edwards syndromes are 3 and 7 times less common, respectively,

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<sup>5</sup>Interestingly, our results suggest that this statistic may over-state parental preferences for terminating pregnancies diagnosed with Down Syndrome. We estimate that in our sample of pregnancies that receive an initial screen, expansive coverage of the new cfDNA screening would reduce the rate of live births with chromosomal abnormalities by only about one third. Moreover, this estimate only reflects the decisions of parents who choose to undergo screening to begin with, so the impact may be even lower in the entire population.

and are also more severe, with only 5-10% of all newborns surviving beyond the first year of their lives (GARD 2020; MedlinePlus 2021).<sup>6</sup> Compared to an invasive diagnostic test, non-invasive screening poses no risk of miscarriage and costs less, but it is also less informative about the presence of chromosomal abnormalities. In particular, unlike invasive testing, non-invasive screening only provides a risk assessment, not a definitive diagnosis.<sup>7</sup> Non-invasive screening is therefore typically used to inform decisions about whether to conduct a subsequent invasive test.

Within non-invasive screening there has been further technological progress. The first generation non-invasive screen – called nuchal translucency (NT) – uses information from an ultrasound and maternal blood work (together with maternal age and exact gestational age at screening) to give a predicted probability of specific chromosomal abnormalities. Our analysis focuses on the second generation of non-invasive prenatal screening – known as cell-free DNA screening (cfDNA).<sup>8</sup> It was revolutionary in enabling analysis of fetal DNA without extracting fetal cells, and thus without any miscarriage risk. The screening involves a simple blood draw from the mother, from which the laboratory extracts fragments of the fetus’ genetic material that are circulating in the mother’s blood.

Like many new medical technologies, cfDNA screening is both more expensive and better than its earlier counterpart. It is about three times more expensive than NT screening – reflecting the higher expense of the lab work involved.<sup>9</sup> It is also more accurate in identifying pregnancies associated with a high risk for chromosomal abnormalities. In our setting, cfDNA screening has a 1% false positive rate and a 1% false negative rate for Trisomy 21 (Down syndrome), relative to NT rates of (respectively) 8% and 4%.<sup>10</sup>

Perhaps not surprisingly, there is no consensus on recommended practice. By the early 2000s, many countries in Europe (including Sweden) and several states in the United States had adopted a universal two-step prenatal testing program. These typically make the NT screening available for free or at a highly subsidized rate, with coverage for subsequent additional services – including provision of detailed information about the test result and free

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<sup>6</sup>More recently, screens have been developed for other, much rarer chromosomal abnormalities (Kliff and Bhatia 2022), but these are outside the scope of our study.

<sup>7</sup>In addition, invasive testing can diagnose all chromosomal abnormalities, whereas non-invasive screening only provides information about the three most common abnormalities described above, and about very rare abnormalities in gender chromosomes.

<sup>8</sup>cfDNA is sometimes also referred to as non-invasive prenatal testing or screening, or NIPT.

<sup>9</sup>In our setting, costs run from about 1,500 SEK (\$174) for NT screening to 5,000 SEK (\$567.60) for cfDNA, to 11,000 SEK (\$1,248.50) for an invasive test (SBU 2016; Ingvaldstad-Malmgren et al. 2017).

<sup>10</sup>These rates are computed by converting NT risk scores to positive if they are greater than or equal to  $\frac{1}{200}$  and negative otherwise. The accuracy advantage is similar for (the less common) Trisomy 13/18 (Patau or Edwards syndromes), with cfDNA false negative and false positive rates of 3% and 1% relative to 27% and 1% for NT (Conner and Malcus 2017).

follow-up diagnostic testing – if the fetal risk score were above some threshold (Flessel and Lorey 2011; Crombag et al. 2014; Gifford et al. 2017).<sup>11</sup> With the advent of cfDNA screening, different countries’ medical associations made different recommendations. For example, the American College of Obstetricians and Gynaecologists recommends that cfDNA screening be made available universally as a first step, instead of NT screening (GenomeWeb 2020). However, Sweden’s counterpart, the Svensk Förening för Obstetrik och Gynekologi (SFOG), instead recommends universal NT screening, followed by coverage for cfDNA screening only for certain NT risk scores (SFOG 2016).<sup>12</sup> In both the US and Sweden, the recommending body recognizes that cfDNA screening dominates NT screening for predicting the likelihood of chromosomal abnormalities. The Swedish recommendation, however, also takes into account the significant cost difference between NT and cfDNA screening (SFOG 2016). The cost of cfDNA screening relative to the information it provides is therefore key for deciding how to design optimal coverage policy for cfDNA screening, and is the focus of our paper.

## 2.2 Swedish policy environment

Sweden has universal and publicly financed health insurance, in which covered services are provided essentially for free, but there are some differences in covered services across its 21 regions.<sup>13</sup> At the start of our study period in 2011, many regions provided free NT screening for all pregnancies. Swedish law<sup>14</sup> stipulates that all women with a heightened likelihood of fetal chromosomal abnormalities be offered additional information about diagnostic testing; and an NT score of  $\frac{1}{200}$  (or higher) is defined as heightened risk (Kublickas, Crossley, and Aitken 2009), or a “positive” test result.<sup>15</sup>

With the development of the second-generation non-invasive screen, the SFOG issued a national recommendation to offer universal NT screening, followed by cfDNA screening to women with NT risk scores that fall between  $\frac{1}{1,000}$  and  $\frac{1}{51}$ , while the highest-risk pregnancies (risk score of  $\frac{1}{50}$  or higher) are recommended to “skip” cfDNA screening and obtain a definite diagnosis via invasive testing (SFOG 2016). The logic behind not offering cfDNA screening to low-risk pregnancies (below  $\frac{1}{1,000}$ ) is intuitive: they are unlikely to have chromosomal

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<sup>11</sup>In some contexts, including Sweden, invasive testing is also covered for women who wished to go straight to such testing without doing the NT screen or even with a low NT score.

<sup>12</sup>Other European countries’ recommendations are mixed, with many adopting a recommendation similar to the one in Sweden, but a few recommending universal cfDNA screening like the American approach (Gadsbøll et al. 2020).

<sup>13</sup>Throughout we use the word “free” somewhat loosely. In practice, in some cases, covered services may require a small copay from the patient, but relative to the full cost of the service this copay is negligible.

<sup>14</sup>Lag (2006:351) om genetisk integritet.

<sup>15</sup>In principle, invasive testing was available for free for all pregnancies, regardless of NT score or of whether an NT screening was undertaken, but initiating a follow-up discussion with the patient was only recommended for risk scores of  $\frac{1}{200}$  or higher.

abnormalities, so the cost effectiveness of (the more expensive) cfDNA screening is lower. The logic behind not offering cfDNA screening for high-risk pregnancies is more nuanced. It reflects an assumption that women receiving this risk score are very likely to undertake an invasive test regardless of the cfDNA screening result. If this is indeed the case then incurring the (non-trivial) cost associated with cfDNA screening would be wasteful (SFOG 2016).

The SFOG recommendations do not map directly into policy regarding cfDNA coverage.<sup>16</sup> In particular, in the first few years after the 2016 national recommendation, different Swedish regions made different choices about which pregnancies to cover for cfDNA screening. The most common policy regime covered cfDNA screening for NT risk scores between  $\frac{1}{200}$  and  $\frac{1}{51}$ .<sup>17</sup> Other regions chose to cover all risk scores above  $\frac{1}{200}$ , all risk scores above  $\frac{1}{1,000}$ , or (in the case of one region) to follow the national recommendation and cover risk scores between  $\frac{1}{1,000}$  and  $\frac{1}{51}$ .

## 2.3 Data and sample construction

We provide a brief overview of our data and variable definitions. [Appendix A](#) provides more detail on both.

**Data.** The backbone of our data is Sweden’s *NT database* of pregnancies from 2011-2019, which is part of the Swedish Pregnancy Register. It contains prenatal testing data reported by clinics that perform approximately 80% of the NT screenings during this period; the selection of clinics into the database is based on which algorithm they use to compute the NT risk score.

The database only contains pregnancies that received an NT screening, which is performed during weeks 11-14 of pregnancy. Women who terminate their pregnancy prior to the NT screening do not enter our sample. Given that more than 90% of all abortions are performed by the end of week 12 (Socialstyrelsen 2021), and that later abortions are often

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<sup>16</sup>The same is true for the recommendations of medical authorities in other countries. In the US, for example, the country’s largest Medicaid managed care organization recently updated their coverage policy, making cfDNA screening available for free to enrollees across 24 states (ACOG 2020), though far from all women are currently offered this screening. In Europe, the out-of-pocket price for cfDNA varies considerably, with different countries offering coverage for cfDNA screening for all pregnancies, for no pregnancies, or for pregnancies with certain risk scores (Gadsbøll et al. 2020).

<sup>17</sup>This is similar to the nationally recommended coverage policy except that it uses  $\frac{1}{200}$  as the lower bound for covering cfDNA screening instead of the nationally recommended  $\frac{1}{1,000}$  lower bound. The regions presumably chose this higher risk score for the lower bound because the recommending body also states that its estimates suggest that offering cfDNA screening is only cost effective for pregnancies with a positive NT result, i.e., with a risk score of  $\frac{1}{200}$  or higher (Ingvaldstad-Malmgren et al. 2017).

performed after the discovery of chromosomal abnormalities (Graviditetsregistret 2020), we assume that the pregnancies are all desired pregnancies.

For each pregnancy we observe the date of the NT screening, gestational age at screening, mother’s age at the due date, the number of fetuses, and the region where the clinic is located. Crucially, we also observe the result of the NT screening: a risk score  $q$  for each fetus that is a cardinal measure of the probability of chromosomal abnormalities.<sup>18</sup> The risk score is censored from below at  $\frac{1}{20,000}$  and from above at  $\frac{1}{2}$ . Finally, we observe whether the NT screening was followed by a subsequent cfDNA screening, and/or an invasive test.

We link the data from the NT database to population-wide health records from the National Board of Health and Welfare. For each mother, we observe all births recorded in the Medical Birth Register (MBR) from 1985 through 2019 and all inpatient and specialist outpatient visits from 2001 through 2019. The MBR contain all pregnancies carried 22 weeks or longer and record the pregnancy outcome (live birth or stillbirth), gestational age at birth, the baby’s diagnoses codes (ICD-10 codes), and whether the baby dies within 28 days of birth. We use the MBR to track the outcomes of each pregnancy in the NT database; we code the pregnancy as terminated if we do not observe it in the MBR after week 22 of gestation (we cannot distinguish between miscarriages and abortions). We also use the MBR to characterize the *prior* pregnancy history of the mother of each pregnancy in the NT database; specifically, we measure whether the woman has had a *prior* pregnancy that resulted in a stillbirth, a live birth where the infant died within 28 days of birth, or a pre-term live birth (prior to 38 weeks of gestation). Likewise, the inpatient and specialist outpatient records allow us to measure whether the woman had a prior miscarriage late in a pregnancy.<sup>19</sup>

Finally, we link these data to information on maternal demographics from several Swedish population registers from 2009-2019. We record the mother’s education and marital status in the year of the due date, her household income in the two years prior to the due date, her household income rank, previous birth history (including prior births and prior pregnancy outcomes), and whether she is foreign born.<sup>20</sup>

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<sup>18</sup>We define  $q$  as the maximum of the two risk scores that the screening produces per fetus: the estimated Down Syndrome risk ( $q_1$ ), and the estimated risk that the fetus has either Edward or Patau Syndrome ( $q_2$ ). The relevant risk is the risk of either syndrome, which is  $q = q_1 + q_2 - q_1q_2$ , but since it is extremely rare for both risks to be meaningful, we (as well as physicians) use the approximation  $q \approx \max\{q_1, q_2\}$ .

<sup>19</sup>Many early miscarriages will not make it into these data because they are either handled at home or through the primary care system.

<sup>20</sup>To calculate household income rank we take the maximum of the household income percentile measured one and two years before the (year of the) due date, with percentiles defined relative to other mothers who give birth in the year of the due date.

**Sample construction.** We focus on pregnancies in the NT database from 2011 through 2019. We limit the sample to the approximately 97% of all pregnancies that are singleton pregnancies. We also limit our sample to the approximately one-half of pregnancies that occur in region-months that provide universal NT screening (see Appendix Table A1). When NT screening is universally covered, we estimate that about 72% of pregnancies receive an NT screen (see Appendix A). Our results and their interpretation therefore apply to the (large) subset of women who choose to get NT screening when it is available for free.<sup>21</sup>

After these restrictions, our data contain 234,817 pregnancies, carried by 180,697 unique women. We refer to this as our "full sample." For most analyses, we further restrict attention to a "baseline sample" of the 13% of these pregnancies with a risk score  $q$  of  $\frac{1}{1,000}$  or higher; this is the lowest risk score for which cfDNA screening is covered in any region, at any point in time during our sample period. This baseline sample includes 30,479 pregnancies, carried by 28,512 unique women. Although this sample excludes the majority of pregnancies, the variation in risk score in the excluded range is not very meaningful; indeed, using the distribution of risk scores in our data, we estimate that the pregnancies in our baseline sample cover almost all (97%) of the pregnancies in the full sample that are associated with chromosomal abnormalities.<sup>22</sup>

## 3 Descriptive evidence

### 3.1 Summary statistics

Table 1 presents summary statistics for three samples: all singleton pregnancies, the baseline sample (pregnancies with an NT risk score of  $\frac{1}{1,000}$  or higher), and the approximately 80% of pregnancies in the baseline sample that are in region-months that adopt the most common cfDNA coverage regime – which covers cfDNA for NT risk scores between  $\frac{1}{200}$  and  $\frac{1}{51}$  – which we will sometimes analyze separately. In the full sample of singleton pregnancies (column (1)), average maternal age is 32, 42% of the pregnancies are carried by married women, 45% by college graduates, and 23% by women who are foreign-born. About half the sample has had a prior birth, and about one-quarter have had a prior pregnancy issue (a previous miscarriage, stillbirth, death within 28 days of birth, or a pre-term live birth). Two percent have had a prior birth associated with congenital deformation or chromosomal abnormality.

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<sup>21</sup>Appendix Table A3 shows how these restrictions affect the sample composition. Compared to all live births (column (1)), limiting to region-months with universal NT (column (2)) has little impact on the sample composition. Requiring an NT screen within those region-months (column (3)) results in a sample that is slightly older, more educated, and higher income.

<sup>22</sup>To compute this share, we assume that the NT risk score reflects (as it is intended) the actual probability of chromosomal abnormalities for each pregnancy. 97% is then given by the ratio  $\sum_{q_i \geq \frac{1}{1,000}} q_i / \sum_{q_i \geq \frac{1}{20,000}} q_i$ .

The pregnant women in our baseline sample (column (2)) are older on average than women in the full sample (maternal age of 35 relative to 32), which is to be expected given the relationship between maternal age and the risk of chromosomal abnormalities. They are also associated with slightly higher income and educational attainment, and are slightly more likely to have had previous pregnancy or birth issue. About one third of our baseline sample does some post-NT testing, compared with about 5% in the full sample. Pregnancies in our baseline sample are also more likely to result in no live birth (8% vs. 3%). Despite higher rates of testing and pregnancy termination, women in our baseline sample are more likely to have a live birth with chromosomal abnormalities (0.3% vs 0.1%), as would be expected given the much higher risk of chromosomal abnormalities for pregnancies in the baseline sample.

Figure 1 shows the distribution of NT risk scores and the rate of any post-NT testing (cfDNA screening and/or invasive testing) by risk score. We show this separately for the full sample (panels (a) and (c)) and for the baseline sample (panels (b) and (d)). Low-risk pregnancies that are excluded from our baseline sample (that is, pregnancies with a risk score lower than  $\frac{1}{1,000}$ ) are associated with an extremely low post-NT testing rate. Post-NT testing rates also rise sharply at the risk score of  $\frac{1}{200}$ ; as noted earlier, risk scores of  $\frac{1}{200}$  or higher are considered “heightened risk,” and (throughout our study period) Swedish law stipulates that all women with a heightened likelihood of chromosomal abnormalities be offered additional information about diagnostic testing.

The risk score from the NT screening is a key predictor of further prenatal testing, but other factors, such as maternal age, income and education, and prior pregnancy experiences may also play a role. To investigate this, Figure 2 shows post-NT testing rates by various maternal demographics. The top two panels show the results for the full sample, with panel (a) showing results unconditionally, and panel (b) showing results conditional on the NT risk score. Panel (a) shows that post-NT testing rates rise sharply with age, from 3.4% for pregnant women who are 25-35, to 10% for pregnant women over 35. Testing rates also increase with education and income, and are higher for women who have had previous children and women who had previous pregnancy or birth complications (specifically, a previous miscarriage, stillbirth, death within 28 days of birth, a pre-term live birth, or a live birth with chromosomal abnormality or congenital deformation). Panel (b) shows that these gradients are substantially attenuated once we condition on NT risk score. For example, the 6.6 percentage point difference in post-NT testing rates for pregnant women over age 35 compared to 25-35 shrinks to only a 0.5 percentage point difference conditional on risk score. This is not surprising since the algorithm determining the NT risk score takes maternal age into account. But the reduction in the other demographic gradients suggests that much of the

differences in testing across women of different demographics reflects underlying differences in risk scores, not preferences conditional on risk score. Not surprisingly, therefore, in our baseline sample (which conditions on an NT risk score of  $\frac{1}{1,000}$  or higher), post-NT testing rates are fairly uncorrelated with demographics (panel (c)). This is especially true after conditioning on the NT score (panel (d)), although there remains a slightly higher post-NT testing rate for college graduates, unmarried women, and Swedish-born women.

### 3.2 Testing decisions by risk score and policy regime

Figure 3 plots some initial, descriptive evidence of how the coverage of the new cfDNA screening technology affects screening and testing decisions for individuals with different risk scores. We show decisions before and after the introduction of the most common cfDNA screening coverage policy: cfDNA coverage for NT risk scores in  $[\frac{1}{200}, \frac{1}{51}]$ . Slightly over 80% of our baseline sample is in regions which adopted this policy in 2016 or 2017 (Appendix Table A2).<sup>23</sup> Moving from left to right along the x-axis in each panel, the NT risk score – the probability of chromosomal abnormalities – rises from  $\frac{1}{1,000}$  to  $\frac{1}{2}$ .<sup>24</sup> The gray dots show testing decisions when cfDNA screening is not covered for anyone, while the black dots show behavior after cfDNA coverage is introduced for NT risk scores in  $[\frac{1}{200}, \frac{1}{51}]$ .

When cfDNA screening is not covered for anyone (gray dots), both cfDNA screening rates (panel (a)) and invasive testing rates (panel (b)) are essentially zero for risk scores below  $\frac{1}{200}$ , and jump sharply at the  $\frac{1}{200}$  threshold; these sharp jumps likely reflect the medical practice of describing pregnancies with an NT risk score greater than  $\frac{1}{200}$  as a positive test result, and the SFOG recommendation that such patients be offered the opportunity to discuss further testing. Interestingly, as the risk score increases further above  $\frac{1}{200}$ , rates of cfDNA screening fall, and reach essentially zero again for the highest risk score bin, while rates of invasive testing rise. As risk scores rise above  $\frac{1}{200}$ , more and more patients plan to do invasive testing regardless of the cfDNA screening result; they therefore “skip” cfDNA screening (and its associated cost to the patient of about \$567.50 in this initial period) and move directly to invasive testing.

When coverage for cfDNA screening is introduced for risk scores between  $\frac{1}{200}$  and  $\frac{1}{51}$ , rates of cfDNA screening jump from about 20% (gray dots) to 90% (black dots) in the covered region, but drop sharply once coverage ends at  $\frac{1}{50}$ .<sup>25</sup> The pronounced increase in cfDNA

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<sup>23</sup>Appendix Figures A2, A3, and A4 reproduce the corresponding descriptive figures for the three other cfDNA coverage regimes that we observe in the data.

<sup>24</sup>As noted, the risk scores are censored (also in practice and in communication with the patient) so that all those above  $\frac{1}{2}$  receive a risk score of  $\frac{1}{2}$ .

<sup>25</sup>Rates of cfDNA screening also rise slightly for risk scores outside of the covered range. This reflects a general time trend in increasing use of the new screening technology, which is likely due to growing awareness

screening in the covered range is mirrored by a pronounced drop in the rate of invasive testing in that range; however, once cfDNA coverage ends at  $\frac{1}{50}$ , the rate of invasive testing jumps up sharply to over 60% (panel (b)).

Thus, coverage of cfDNA screening in the risk score range of  $\frac{1}{200}$  to  $\frac{1}{51}$  switches the dominant form of information acquisition in that range from invasive testing to cfDNA screening. It also increases the probability of *any* testing after the NT screening (that is, either cfDNA screening or invasive testing or both) to virtually 100% (panel (c)). The reduction in invasive testing illustrates the key value of the new screening technology: targeting follow-up testing where it is likely most valuable. Given the high false-positive rate of the NT screening and the higher accuracy of the cfDNA screening, many of the pregnancies that were flagged as “positive” for chromosomal abnormalities via the NT screening (i.e. an NT risk score of  $\frac{1}{200}$  or greater) now get a more accurate negative prediction from the cfDNA screening; equipped with that additional information, many patients then choose to avoid the invasive test (which is also more costly to the government) and its associated miscarriage risk. However, the net impact on government spending is unclear, since cfDNA screening rates rise substantially. The model that we develop and estimate below allows us to understand and rationalize these substitution patterns in the data, map demand for cfDNA screening into willingness to pay and patient welfare, and quantify consumer surplus and government spending under observed and counterfactual cfDNA coverage policies.

## 4 An empirical model of prenatal testing choices

All pregnancies in our baseline sample receive an NT screen and the resultant risk score; parents then face a sequence of decisions about whether to do additional (cfDNA) screening (if it is available), whether to do invasive testing, and whether to terminate the pregnancy. These decisions are therefore interdependent, and in order to account for this interdependence we write down a simple dynamic model that describes the sequence of choices parents face. We then estimate the model using the baseline sample, allowing us to quantify the implications of various counterfactual regimes on birth outcomes, public spending, and consumer surplus.

The key counterfactuals we will examine (in Section 5) are associated with the introduction of cfDNA screening (i.e. technological change) and with policies regarding the coverage of cfDNA screening. That is, whether to offer cfDNA screening for free or require patients to pay out of pocket, and the extent to which this policy should be targeted at particular

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of and comfort with the technology among patients and physicians. Some of this may be the natural rate of secular diffusion of a new technology, and some may be accelerated by the increase use of the technology in the covered risk score range.

patients. All these analyses occur in a setting in which all other medical choices (such as invasive testing and termination) are available for free. The policy design choice thus mirrors many similar choices made by public insurance systems regarding coverage of a new technology in the context of an existing insurance system, taking as given any potential pre-existing price distortions.

## 4.1 Model

**Setting and notation.** The unit of observation is a pregnancy, denoted by  $i$ , which is associated with three possible outcomes: a birth of a baby with no chromosomal abnormalities, a birth of a baby with chromosomal abnormalities, or no live birth (due to miscarriage or abortion). We normalize the utility of the expecting woman from having a baby with no chromosomal abnormalities to zero, and denote the (monetized) utility from having a baby with chromosomal abnormalities by  $c_i$  and the (monetized) utility from losing the baby by  $a_i$ . Throughout, we assume that  $a_i < 0$ . This assumption seems natural in our context, as it implies that all the pregnancies in our sample are desired pregnancies, which (as discussed in Section 2) seems likely.

We denote by  $q_i$  the risk score that all pregnancies receive from the NT screening; we assume that it is known to all expecting women in our sample, which seems like a reasonable assumption given that clinicians typically discuss the NT results with their patients. We assume that  $q_i$  provides an unbiased prediction of the probability that pregnancy  $i$  carries a fetus with chromosomal abnormalities. This assumption is critical for our subsequent analyses since it allows us to simulate counterfactual pregnancy outcomes. It is also a realistic assumption as the risk score in our data is produced by an algorithm that is calibrated off of the Swedish pregnancies in our database (Kublickas, Crossley, and Aitken 2009). Finally, we assume that all women are risk neutral and maximize their expected monetized utility.

Consistent with the institutional setting, we assume that both termination and invasive testing are free to the patient, and that invasive testing is associated with a (known) miscarriage risk  $g$ .<sup>26</sup> We denote the out-of-pocket cost of cfDNA screening by  $f_i$ ; this will depend on the NT risk score and on the cfDNA coverage policy regime. For expositional clarity, we omit the  $i$  subscripts for the rest of this section.

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<sup>26</sup> We abstract from miscarriages that occur without being induced by invasive testing. While such spontaneous miscarriages are very common in the beginning of pregnancy, recall that our sample only includes pregnancies that are carried at least 11-14 weeks, when the NT screening is done; among such pregnancies, the miscarriage rate (which includes both miscarriages induced by invasive testing and spontaneous miscarriages) is lower than 2% (Oster 2014).

**Invasive testing decision in the absence of cfDNA screening.** We first consider the invasive testing decision in a world where cfDNA screening does not exist; this captures the technology available at the start of our sample period. In this case, the patient only needs to make two sequential binary decisions. In period 1, she decides whether to do an invasive test or not; if she does the test, she receives the (binary) result. In period 2, she decides whether to terminate the pregnancy as a function of the test result (if she did it). We can then solve the model backwards to derive optimal choices.

The patient’s expected utility in period 2 is given by (recall, we omit  $i$  subscripts to ease the exposition)

$$v_2(p) = \max\{a, pc\}, \quad (1)$$

where  $p$  is her belief about the probability her fetus has chromosomal abnormalities. Intuitively, she faces a decision between abortion (which yields utility of  $a$ ) and having a baby, which has a  $p$  probability of having chromosomal abnormalities, thus yielding expected utility of  $pc$  (recall that the utility from a baby with no chromosomal abnormalities is normalized to zero).

In period 1, the patient chooses whether or not to have an invasive test. Without it, her expected utility is defined by  $v_2(p = q)$  in equation (1), where  $q$  (her NT risk score) is her beliefs (absent any additional information). If she does an invasive test, the (definitive) test result implies either  $p = 0$  (if negative) or  $p = 1$  (if positive). Taken together, and accounting for the miscarriage risk associated with invasive testing, expected utility from taking an invasive test is therefore given by

$$v_{1|inv}(p) = ga + (1 - g)(pv_2(1) + (1 - p)v_2(0)) = ga + (1 - g)p \max\{a, c\}, \quad (2)$$

where  $p$  is the probability of fetal chromosomal abnormalities.<sup>27</sup> The expected utility from an invasive test thus factors in the risk of miscarriage  $g$  and its associated dis-utility  $a$ , as well as – in the absence of miscarriage – the utility from the patient’s optimal choice  $\max\{a, c\}$  if the fetus is found to have chromosomal abnormalities.

Thus, in period 1, the patient chooses an invasive test if and only if

$$v_{1|inv}(p) > v_2(p). \quad (3)$$

This optimal decision rule reflects a natural trade-off: the test provides information about the presence of chromosomal abnormalities but entails a risk of losing the pregnancy. The

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<sup>27</sup>In the absence of cfDNA screening,  $p = q$ . However, we keep the notation general so that it will still apply when we introduce cfDNA screening below.

patient must trade off the risk of a miscarriage with her preference for (not) having a child with chromosomal abnormalities, equipped only with a noisy estimate of the fetus’ underlying risk.

To gain intuition, consider first a case where  $c > a$ , so that the patient prefers having a baby with chromosomal abnormalities to losing the baby. In this case, she would not abort a baby with a confirmed chromosomal abnormality, so she has no benefit from invasive testing for any value of  $p$ . In contrast, a patient with  $c < a$  strictly prefers to abort a baby with confirmed chromosomal abnormalities, so there are potential benefits from additional information. Under the optimal decision rule, she chooses to do invasive testing when her preference for abortion relative to giving birth to a baby with chromosomal abnormalities is strong enough relative to her risk. Note that under our assumptions, all women who have an invasive test and detect the presence of chromosomal abnormalities will terminate the pregnancy; this is consistent with the evidence in our setting that pregnancies are terminated in 99% of the cases in which invasive testing reveals chromosomal abnormalities (Conner et al. 2012).<sup>28</sup>

**Decisions in the presence of cfDNA screening.** Once cfDNA screening exists, the patient can choose whether to do cfDNA screening after observing her NT risk score  $q$ , but before making the invasive testing decision. We thus add an initial, “period 0,” binary decision regarding cfDNA screening. The cfDNA screening generates a binary result (positive or negative), with a false positive rate of  $k^{FP}$  and a false negative rate of  $k^{FN}$ . Recall that cfDNA screening carries no miscarriage risk. Figure 4 illustrates the decision tree in this expanded setting. We can again solve for optimal decisions backwards, by appending the period 0 decision regarding cfDNA screening to the earlier model (regarding invasive testing) presented above.

It is convenient to define  $v_1(p) = \max\{v_{1|inv}(p), v_2(p)\}$ , which is the period 1 continuation value of the patient, conditional on having a probability  $p$  of fetal chromosomal abnormalities, where  $v_{1|inv}(p)$  and  $v_2(p)$  were defined in equations (2) and (1), respectively. If the patient chooses no cfDNA screening, then  $p = q$  and her expected utility is given by  $v_1(q)$ .

If she chooses cfDNA screening in period 0, the result provides additional information about the risk of chromosomal abnormalities. We assume Bayesian updating, and denote the patient’s posterior (after cfDNA screening) by  $p(q, +)$  and  $p(q, -)$  for, respectively, positive and negative cfDNA screening results. Naturally, the Bayesian updating depends on the precision of the cfDNA screening as measured by the false positive rate  $k^{FP}$  and the false

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<sup>28</sup>This suggests that in our setting, our decision to abstract from potential benefits of knowledge of chromosomal abnormalities even for a couple who wishes to keep the baby - e.g. it may help in preparing for the baby’s arrival - is a reasonable one

negative rate  $k^{FN}$ .<sup>29</sup> Her expected utility from cfDNA screening is therefore given by:

$$v_{0|screen}(q) = Pr(+|q)v_1(p(q, +)) + Pr(-|q)v_1(p(q, -)) - f, \quad (4)$$

where  $Pr(+|q) = q(1 - k^{FN}) + (1 - q)k^{FP}$  and  $Pr(-|q) = qk^{FN} + (1 - q)(1 - k^{FP})$  are the ex-ante probabilities (that depend on  $q$ ) of the two potential outcomes of the cfDNA screening, and the last component,  $f$ , is the out-of-pocket cost of cfDNA screening (which depends on  $q$  and on the cfDNA coverage regime).

Given the expected utility from cfDNA screening in equation (4), the patient chooses cfDNA screening in period 0 if and only if

$$v_{0|screen}(q) > v_1(q). \quad (5)$$

The trade-off is simple: the cfDNA screening result allows the patient to base her invasive testing decision on more precise information about the fetal risk of chromosomal abnormalities without harming the fetus, but obtaining this information may not be free due to the associated out-of-pocket cost  $f$ .

We note that when cfDNA screening is free (i.e.  $f = 0$ ) and the result is inconsequential to the patient's choice of whether to follow up with invasive testing, the patient will be indifferent between choosing cfDNA screening or not (that is,  $v_{0|screen}(q) = v_1(q)$ ). We make the (tie-breaking) assumption that patients do not do cfDNA screening when it is inconsequential.<sup>30</sup> As a result, the model implies that patients who do cfDNA screening follow up with invasive testing if and only if the cfDNA screening result is positive.

**Econometric specification.** The key estimable object of interest is the joint distribution of  $a_i$  and  $c_i$ , which we assume to be drawn from a truncated bivariate normal distribution. That is,

$$\begin{pmatrix} a_i \\ c_i \end{pmatrix} \sim N \left( \begin{pmatrix} x_i' \beta^a \\ x_i' \beta^c \end{pmatrix}, \begin{pmatrix} \sigma_a^2 & \rho \sigma_a \sigma_c \\ \rho \sigma_a \sigma_c & \sigma_c^2 \end{pmatrix} \middle| a_i < 0 \right), \quad (6)$$

where  $x_i$  is a vector of observable characteristics of pregnancy  $i$ , and the  $\beta$ s,  $\sigma$ s, and  $\rho$  are parameters to be estimated. We include as covariates a series of indicator variables for whether the pregnant woman is a college graduate, in the highest income quartile, married, foreign born, and had previous pregnancy or birth complications (as defined in Table 1).<sup>31</sup>

<sup>29</sup>That is,  $p(q, +) = \frac{q(1-k^{FN})}{q(1-k^{FN})+(1-q)k^{FP}}$  and  $p(q, -) = \frac{qk^{FN}}{qk^{FN}+(1-q)(1-k^{FP})}$ .

<sup>30</sup>This assumption is consistent with the data. Approximately 10% of pregnancies in the  $[\frac{1}{200}, \frac{1}{51}]$  policy regime with risk in the covered range still choose not to receive the test even though it is free (Figure 3).

<sup>31</sup>The first four are covariates for which there is some residual gradient in post-NT testing rates in our baseline sample, even after conditioning on NT risk score (see Figure 2, panel (d)).

The values of all other parameters of the model are calibrated based on the institutional setting described in Section 2. Specifically, we assume that the miscarriage risk associated with invasive testing is  $g = 0.5\%$ , that the false positive rate from cfDNA screening  $k^{FP}$  and false negative rate from cfDNA screening  $k^{FN}$  are both equal to  $1\%$ , and that these rates are all known to the patient. We set the medical cost of invasive testing and cfDNA screening at \$1,248.50 and \$567.50, respectively. Costs of invasive testing are always born by the government. cfDNA screening costs are either born by the government or the patient, depending on the policy regime, so the patient’s out-of-pocket cost of cfDNA screening ( $f$ ) is either 0 or \$567.50.

A final tweak to the model arises from the observed impact of a medical recommendation to take invasive testing. As we discussed in Section 2, patients with what is referred to as a “positive” NT screening result (that is, NT risk of  $\frac{1}{200}$  or higher) receive more information about chromosomal abnormalities and are explicitly offered the opportunity to discuss follow-up testing. As we saw in Figure 3(b) (gray circles), prior to coverage of cfDNA screening, presumably because of this consultation, there is a large – approximately 40 percentage point – jump in the propensity of invasive testing around an NT score of  $\frac{1}{200}$ . This occurs even though invasive testing is free for everyone in the sample, both below and above  $q = \frac{1}{200}$ . In order to empirically account for this effect in the data in a way that is consistent with the model, we introduce one more parameter,  $\psi \in (0, 1]$ , and assume that for those who receive a risk score  $q_i \geq \frac{1}{200}$ , their belief about the probability that the fetus has chromosomal abnormalities is  $q_i^\psi$  instead of  $q_i$ . In other words, we model the impact of the recommendation as equivalent to the patient revising upwards (toward 1) their post-NT screening prior about the probability of chromosomal abnormalities. This “tweak” helps us fit much better the jump in invasive testing rates at  $q = \frac{1}{200}$  prior to the introduction of cfDNA coverage. After cfDNA coverage is introduced, the sharp jump at  $\frac{1}{200}$  is a combination of the same consultation effect and the fact that cfDNA coverage changes discontinuously at  $q = \frac{1}{200}$ .<sup>32</sup>

**Estimation and identification.** We estimate the model using method of moments, matching the propensity to do cfDNA screening and invasive testing for each NT risk bin, before and after the introduction of cfDNA screening and by different coverage policy regimes (which vary across regions). We bin the data by risk score into 20 bins, each of width 50.

As seen in Appendix Table A2, there are four distinct cfDNA screening policy regimes in our analysis sample. Figure 3 illustrated the moments we match (using a finer bin width of 25) for the most common cfDNA coverage policy, which covers cfDNA coverage for  $q \in$

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<sup>32</sup>While this adjustment to the model is only needed (from a model fit perspective) before the introduction of cfDNA, the definition of a “positive” NT screening remains constant over our analysis period, so we apply this adjustment throughout.

$[\frac{1}{200}, \frac{1}{51}]$ . About 80% of our baseline sample is in regions which adopt this coverage policy. The remaining sample is roughly evenly split across regions that adopt three other policy regimes: covering cfDNA when  $q \geq \frac{1}{200}$ , when  $q \in [\frac{1}{1,000}, \frac{1}{51}]$ , and when  $q \geq \frac{1}{1,000}$ .

For each policy regime separately, we match (a) the share of pregnancies that received cfDNA screening once cfDNA screening is covered, by NT risk bin; (b) the share of pregnancies that received invasive testing conditional on doing cfDNA screening (again, measured only once cfDNA is covered), by NT risk bin; and (c) the share of pregnancies that received invasive testing conditional on *not* doing cfDNA screening, by NT risk bin. This last moment is also measurable in the pre-coverage period.<sup>33</sup>

Thus, overall, we have 260 distinct testing moments that we try to match: 20 bins by 3 outcomes by 4 policy regimes, in addition to 20 bins of the rate of invasive testing prior to the introduction of cfDNA coverage. To do so, we simulate testing decisions using the model and a given set of parameter values, and search for the parameters that minimize the distance between the observed moments and the simulated moments. We use a (standard) squared distance objective function and weight moments by the number of pregnancies associated with each moment. The optimization is done in two steps, first we run a global search, and then a derivative-based local search. Appendix B.1 provides more details.

To gain intuition for identification, we can consider different types of variation in the data. The recommendation parameter  $\psi$  is identified off the sharp jump in the propensity to do invasive testing during the pre-coverage regime (recall that this jump was the motivation to include this parameter). All else equal, the decision to do invasive testing trades off the increased miscarriage risk against the value of obtaining additional information about the risk of the fetus having chromosomal abnormalities. Patients who want the baby regardless (that is,  $c_i > a_i$ ) prefer to avoid the miscarriage risk, while parents who get a large amount of dis-utility from having a baby with chromosomal abnormalities relative to not having the baby at all (that is,  $c_i$  much smaller than  $a_i$ ) do invasive testing for sure, so the propensity to do invasive testing identifies the *relative* importance of  $a_i$  and  $c_i$ . The extent to which cfDNA coverage (which lowers the cost to the patient from \$567.50 to 0) increases the cfDNA screening rates identifies the (monetized) magnitude of these preferences, and the extents to which cfDNA screening and invasive testing rates change with  $q_i$  identify their relative variance and the correlation parameter  $\rho$ .

Crucially, with these parameter estimates, the NT risk score  $q$  will allow us to simulate the distribution of pregnancy outcomes – live birth without chromosomal abnormalities, live

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<sup>33</sup>For estimation, we assume that cfDNA screening rates are zero in the pre-coverage period, when the cfDNA screening technology is not broadly available. Although, as seen in Figure 3(a), there is some cfDNA screening that occurs in the pre-coverage period, we abstract from it in estimation.

birth with chromosomal abnormalities, and no live birth – under counterfactual decisions. Although we can also observe pregnancy outcomes directly (Table 1), we do not use them as moments in the estimation. Given our sample size, and that the vast majority of pregnancies result in a live birth with no chromosomal abnormalities, the risk score  $q$  provides a more accurate estimate of pregnancy outcomes than our data.<sup>34</sup>

## 5 Results

### 5.1 Model fit and parameter estimates

Figure 5 shows the fit of our model. It plots various testing rates in the data and as predicted by the model, using the estimated parameters. Specifically, it plots (as a function of the NT risk score  $q$ ) the probability of an invasive test, both before (panel (a)) and after (panel (b)) the introduction of cfDNA coverage, and the probability of cfDNA screening after it is covered (panel (c)). We note that while we match the moments separately by policy regime, for expositional clarity Figure 5 aggregates the estimation moments across the different regimes.<sup>35</sup> The model fits the data remarkably well, especially given the parsimonious parameterization of the model.<sup>36</sup>

Table 2 presents the parameter estimates. They imply that the average monetized dis-utility of losing the baby is approximately \$139,000, and that the average dis-utility of having a baby with chromosomal abnormalities is about \$154,000, or roughly 10% greater (in absolute value).<sup>37</sup> With two exceptions – of foreign-born women and women with previous pregnancy or birth complications, which are both associated with lower desirability of babies with chromosomal abnormalities – the coefficients on maternal characteristics are relatively small, which may not be surprising given the descriptive results in panel (d) of Figure 2. We do estimate a modest level of heterogeneity in the dis-utility from having a baby with

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<sup>34</sup>For example, in our baseline sample of more than 40,000 pregnancies, only 147 pregnancies (that is, 36 basis points) result in a live birth with chromosomal abnormalities. To further illustrate this point, Appendix Figure A1 shows the analog of Figure 3 for birth outcomes. The rates of live births with chromosomal abnormalities (panel (b)) or no live birth (panel (c)) are too small to detect any meaningful changes associated with the coverage regime.

<sup>35</sup>Appendix Figures A6, A7, A8, and A9 present the model fit separately for each cfDNA coverage policy regime.

<sup>36</sup>We also note that Figure 5 plots the data and model predictions by bins of risk score with a width of 25, while we estimate the model by matching moments defined by bins of width 50. That is, the predictions of the model for adjacent 25-width bins (within each bin of 50) is not a targeted moment, and this fit is quite reassuring.

<sup>37</sup>Recall that we estimate a joint normal distribution, which is truncated from above at zero for  $a$ . However, given that we estimate that  $\sigma_a$  is about one-sixth of the average  $a$ , this assumed truncation is not binding.

chromosomal abnormalities ( $\sigma_c$  of approximately \$36,000 relative to the mean of \$154,000) and slightly less heterogeneity in the dis-utility from losing the baby ( $\sigma_a$  of approximately \$25,000 relative to the mean of \$138,000). We estimate that  $c_i > a_i$  for 21.5% of the sample, implying that under perfect information more than one-fifth of pregnancies in our sample are carried by women who would prefer a live birth with chromosomal abnormalities over losing the baby.<sup>38</sup> We estimate that  $\rho$  is very close to zero, implying that  $c_i$  and  $a_i$  are nearly independent of each other (conditional on covariates). Finally, we estimate  $\psi$  to be 0.915, which creates the impact of the consultation that is triggered by “positive” ( $q \geq \frac{1}{200}$ ) NT results. For example, it implies that a patient with an NT risk score of  $\frac{1}{200}$  (which is when the consultation kicks in) behaves as if her score is in fact  $\frac{1}{127}$ .

To provide more intuition for these estimates, the top panel of Figure 6 plots their implications for consumer willingness to pay for cfDNA screening as a function of  $q_i$ . We calculate willingness to pay as the difference between expected utility conditional on cfDNA screening and the expected utility conditional on not receiving cfDNA screening. The figure shows that willingness to pay for cfDNA screening is hump-shaped in  $q_i$ . This non-monotone value of information as a function of the appropriateness for the “treatment” (invasive testing) is, as we emphasized in the Introduction, quite different for therapeutic treatments where the value of information is increasing in the probability that the patient will be found appropriate for treatment. To see why the value of information from screening is non-monotonic, recall that for low-risk pregnancies ( $q_i < \frac{1}{200}$ ), most patients would not do invasive testing without the cfDNA screening (see Figure 3); the main value of cfDNA screening for these patients therefore comes from detecting fetuses that very likely have chromosomal abnormalities, so it is natural that willingness to pay is monotonically increasing in  $q_i$ . In contrast, for higher-risk pregnancies, we saw that most patients would do invasive testing absent cfDNA screening. For these patients, therefore, the value of cfDNA screening stems from detecting pregnancies that do not require invasive testing (due to a negative cfDNA result); this is (ex ante) more likely for lower risk pregnancies, which is why the willingness to pay is decreasing in  $q_i$  in this range.<sup>39</sup> Panel (b) of Figure 6 shows how the average willingness to pay by  $q_i$  for cfDNA screening varies with  $c_i$  (holding everything else fixed). In most cases, as we make  $c_i$  lower (higher in absolute value), invasive testing becomes more desirable and the value of cfDNA

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<sup>38</sup>Note that this estimate applies to the approximately three-quarters of pregnancies that undergo the initial non-invasive NT screening when it is freely available. Our estimates cannot speak to the preferences of the remaining one-quarter of the sample that do not do so, and thus do not receive a risk score.

<sup>39</sup>Appendix Figure A5 may be instructive here. It presents the Bayesian updating of patients in response to the cfDNA screening result, as a function of their priors ( $q_i$ ). A positive result causes quantitatively important updating throughout the distribution of prior beliefs (top panel). By contrast, a negative cfDNA screening result causes quantitatively meaningful updating only for the highest-risk pregnancies (bottom panel).

increases. However, for higher-risk pregnancies this pattern does not hold, and willingness to pay for cfDNA declines as  $c_i$  declines. Indeed, for the highest  $q_i$  bin, willingness to pay for cfDNA is increasing in  $c_i$ ; for women with very high dis-utility from having a baby with chromosomal abnormality (very low  $c_i$ ), invasive testing is desirable regardless of the result of the cfDNA test and therefore willingness to pay for cfDNA is low.

We will use these model estimates to analyze outcomes under counterfactual scenarios. Specifically, we simulate pregnancies based on the observable variables in the data (including  $q_i$ ) and the estimated parameters, and then use the model to generate decisions and outcomes. Appendix B.2 provides more details about these counterfactual calculations.

## 5.2 The value of (information) technology

Our first set of counterfactual exercises uses the model estimates to explore the consequences – and value – of information about the fetus and the technologies that can provide that information. To do so, Table 3 presents outcomes under four scenarios. The first two – “no post-NT testing” (column (1)) and “first best” (column (2)) – are hypothetical worst-case and best-case benchmarks, respectively. The key comparison is between a world with only invasive testing (column (3)) and a world that has cfDNA screening available as well (column (4)); for both we assume that any available technologies are covered and free to the patient.

In the “no post-NT testing” scenario (column (1)), we assume that neither cfDNA screening nor invasive testing are available. Patients must therefore make the decision of whether or not to terminate the pregnancy using only the information provided by the NT risk score  $q$  and their preferences. In this hypothetical “worst case,” we estimate that 0.88 out of 100 pregnancies would be terminated due to the risk of having a baby with chromosomal abnormalities, thus generating 99.12 live births out of 100 pregnancies.<sup>40</sup> All of the terminations occur among patients who prefer no live birth to a birth with chromosomal abnormalities (i.e.  $a_i > c_i$ ). Of the 0.88 terminations, we estimate that half (that is, 0.44) are inefficient: the fetus had no chromosomal abnormalities, so under perfect information the patient would have preferred not to terminate. A second type of inefficiency that arises in this “no post-NT testing” scenario is the live birth of babies with chromosomal abnormalities born to patients who would have preferred to terminate the pregnancy had they known (i.e.  $a_i > c_i$ ); we estimate that there are 2.73 such occurrences per 100 pregnancies, accounting for 2.75% of live births and 87% of live births with chromosomal abnormalities. We measure consumer surplus

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<sup>40</sup>This baseline number is artificially much higher than the typical “industry figure” (of, for example, 62 live births per 100 pregnancies (CDC 1999)) for two reasons. First, as described in Section 2, most pregnancies that do not result in a live birth end prior to weeks 11-14, and thus do not enter our sample. Second, recall that our model abstracts from spontaneous miscarriages that are not induced by invasive testing (see footnote 26).

in this scenario using our model, and normalize it to zero so it can serve as a benchmark.

The hypothetical “first best” scenario in column (2) assumes that the patient knows for sure whether their fetus has chromosomal abnormalities or not. In other words, there exists some technology that perfectly identifies the fetus type without any miscarriage risk or cost (to the individual or to the government). Therefore, no testing is necessary, and patients only terminate the pregnancy if the fetus has chromosomal abnormalities *and* they prefer no live birth to a baby with chromosomal abnormalities (i.e.  $a_i > c_i$ ). We estimate that 3.16 out of 100 pregnancies end in termination, and 0.42 out of 100 pregnancies result in a live birth with chromosomal abnormalities. By design, in this “first best” scenario there are no inefficient outcomes, but there are fewer live births (96.84 compared to 99.12 in the no post-NT testing scenario in column (1)). The avoidance of inefficient outcomes implies a large increase in consumer surplus relative to the no post-NT testing scenario in column (1), of \$2,245 per pregnancy, or approximately \$70,000 per “affected” pregnancy (i.e. the 3.17 (=2.73+0.44) per 100 pregnancies in column (1) that result in an inefficient outcome).<sup>41</sup>

In column (3) we return to the imperfect information world but introduce an option for invasive testing after receiving the NT risk score. We assume (as in the data) that invasive testing is fully covered for everyone, and is paid out of government budget (at a cost of \$1,248.50 per test). From the patient perspective, the invasive test provides a definitive diagnosis regarding the fetal chromosomal abnormalities, but elevates the risk of miscarriage. We estimate that 25% of patients elect to do an invasive test, with the probability of invasive testing increasing in NT risk score. The introduction of the invasive testing technology has a big effect on outcomes, eliminating most of the inefficient outcomes that would have occurred in the “no post-NT testing” scenario (column (1)). Of the 0.44 fetuses per 100 that do not have chromosomal abnormalities and are “mistakenly” aborted without testing (see column (1)), 75% of them now have a live birth; the remaining 0.11 (10%) have no live birth because of the miscarriage risk that accompanies invasive testing. Similarly, the invasive testing allows most patients who would prefer to terminate a pregnancy associated with chromosomal abnormalities to do so: 93% of the 2.73 babies with chromosomal abnormalities who are born to parents who would have preferred to have no live birth are now aborted (after they are identified as having chromosomal abnormalities by invasive testing), and only 0.19 (7%) of them are born (because their mothers preferred to avoid invasive testing miscarriage risk, so could not know that the fetus had chromosomal abnormalities). Overall, relative to no post-NT testing, invasive testing eliminates 91% of the inefficient outcomes from the “no

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<sup>41</sup>Note that our estimate that 3.58 (=3.16+0.42) out of 100 pregnancies have chromosomal abnormalities is occurring in the set of pregnancies with risk scores above  $\frac{1}{1,000}$ , which, as already discussed in Section 2, are only 13% of pregnancies but account for almost all (97%) of pregnancies with chromosomal abnormalities.

post-NT testing” scenario (2.87 out of 3.17) and generates 89% (\$2,001 out of \$2,245) of the potential consumer surplus from the first best, at a cost of \$311 (per pregnancy) to the government. Indeed, invasive testing revolutionized prenatal care when it was introduced in the 1970s, and likely had a bigger impact than we estimate here since it was introduced in a world where NT screening did not yet exist.

Finally, in column (4) we introduce the option of cfDNA screening prior to invasive testing. For now, we assume that cfDNA screening is paid for out of the government budget (at a cost to the government of \$567.50 per test) and is therefore available to the patient for free (we relax this assumption in the next section). Because cfDNA screening is free to the patient and has no risk associated with it, the vast majority of patients (75%) use it.<sup>42</sup> Out of these 75 (per 100) pregnancies that do cfDNA screening, 2.97 have a positive result and therefore follow up with invasive testing (in addition to the 2.22 per 100 who go immediately to invasive testing without cfDNA screening). We thus estimate that the introduction of (covered) cfDNA screening reduces the rate of invasive testing from 25% (column (3)) to 5.2% (column (4)). This decline in invasive testing in turn reduces by more than 90% (from 0.11 to 0.01 per 100 pregnancies) the rate of inefficient miscarriages from invasive testing (fetuses with no chromosomal abnormalities that are miscarried). Similarly, the improved targeting of the invasive testing (due to the information obtained from the cfDNA screening) reduces the rate of inefficient births (babies born with chromosomal abnormalities to patients who preferred no live birth by almost 90%, from 0.19 per 100 pregnancies to 0.02. As it turns out, the quantitative impact of both effects is broadly similar, so the rate of live births is barely affected (96.92% in column (3) compared to 96.85% in column (4)).

The results imply that cfDNA screening leads to a 28% reduction (from 0.61 to 0.44) in the rate of live births with chromosomal abnormalities. This figure is interesting in light of the ethical debate over the possible “end of Down Syndrome” due to the arrival of prenatal screening technologies (Zhang 2020). Our estimate of the reduction in live births with chromosomal abnormalities is far below 100% because, while cfDNA allows those who prefer no live birth over a live birth with chromosomal abnormalities to detect and terminate such pregnancies, recall that our estimates imply that a sizeable share of our sample (21.5%)

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<sup>42</sup>The 25% of patients who do not do the cfDNA screening even when it’s offered for free are predominantly patients who prefer having a baby with chromosomal abnormalities to no baby ( $c_i > a_i$ ). These patients would always avoid the miscarriage risk associated with invasive testing regardless of the cfDNA result, so they have no value from the cfDNA screening. In addition to these patients, there are two other cases that lead patients to avoid (free) cfDNA. One is when the NT risk score  $q$  is sufficiently high to make the patient want an invasive test even after a negative cfDNA result (due to the possibility of a false negative and a much greater  $a_i$  than  $c_i$ ). A second case is when the patient has low enough  $q$  (and sufficiently close values of  $a_i$  and  $c_i$  even though  $a_i > c_i$ ) that they would avoid invasive testing even after a positive cfDNA result (due to the possibility of false positive).

would prefer a live birth with chromosomal abnormalities over no live birth. Thus, our results suggest that making cfDNA widely available would not eradicate live births with detectable chromosomal abnormalities – if anything, it would (nearly) eradicate *undesired* live births with such abnormalities. Indeed, column (4) shows that under expansive coverage of cfDNA, almost all (95%) of live births with chromosomal abnormalities are born to patients who prefer this outcome to no birth.

Taken together, the introduction of cfDNA screening in addition to invasive testing (i.e. column (4) vs. column (3)) eliminates 90% of the inefficient outcomes (0.27 out of 0.30) and generates 92% ( $\$224 = 2,225 - 2,001$  out of  $\$244 = 2,245 - 2,001$ ) of the potential (remaining) consumer surplus. This comes at an incremental cost of \$180 ( $=\$491-\$311$ ) (per pregnancy) to the government. In other words, full coverage of cfDNA screening reproduces the well-known impact of most technological progress in medicine: improved patient well-being and higher health-care cost. We now turn to examining whether more targeted coverage of cfDNA screening can improve on this outcome.

### 5.3 Optimal targeting

To get some initial intuition for optimal targeting of cfDNA coverage, Figure 7 plots, by NT risk score, the cfDNA screening rate (top panel) and the invasive testing rate (bottom panel) when that risk score is not covered for cfDNA screening (gray line) and when it is (black line). For cfDNA screening, these rates correspond to the share of the population whose willingness to pay for cfDNA screening is above 0 (when there is full coverage) or above the out-of-pocket price (when there is no coverage). For lower risks, cfDNA screening increases dramatically with coverage, and invasive testing goes slightly up, mostly due to false positives for pregnancies that otherwise would not have bothered with invasive testing. For intermediate risks, cfDNA screening increases but there is little reduction in the (already low) rate of invasive testing. For higher risks, coverage of cfDNA screening creates a fair amount of substitution from invasive testing to cfDNA.

Table 4 explores the impacts of alternative targeting of cfDNA coverage. In doing so, we take as given the coverage of invasive testing. As noted in the Introduction, this is a specific example of the types of coverage decisions that public insurance programs frequently have to make regarding coverage for new medical technologies. The first two columns reproduce the results from columns (3) and (4) in Table 3, which provide benchmarks for the extremes of no cfDNA technology (column (1)) and full coverage of cfDNA (column (2)). As already seen, relative to cfDNA screening not existing, full coverage for cfDNA screening improves consumer welfare but also increases government spending. The remaining columns therefore

explore more targeted coverage policies.

Column (3) introduces the cfDNA technology but without any coverage for it, so that individuals must pay the full cost out of pocket (\$567.50). Rates of cfDNA screening drop to 14%, compared to 75% when it was free (column (2)). Most (82%) of the patients who now forgo cfDNA screening substitute to doing no testing at all, while the rest substitute to invasive testing (which is free, but has a miscarriage risk). As a result, the vast majority of the 0.19 (per 100 pregnancies) inefficient live births (those with chromosomal abnormalities born to parents who would prefer no live birth) that occur without the cfDNA technology (in column (1)) are not identified and therefore continue to occur (0.17 out of 0.19, or 89%), but the reduced invasive testing rate (14%, relative to 25% when cfDNA screening is not available) reduces by more than 50% the rate of miscarriages among babies with no chromosomal abnormalities (0.05 instead of 0.11). A comparison of column (3) and column (1) shows that the introduction of the cfDNA screening – even without insurance coverage – is able to both increase consumer surplus (by a small amount of \$13 per pregnancy) and reduce government spending (by \$137 per pregnancy).

The last two columns consider the impact of more targeted coverage of cfDNA screening rather than full coverage (shown in column (2))<sup>43</sup> or no coverage (shown in column (3)). For patients whose risk score falls within the covered range, cfDNA coverage is available for free; other patients can still access cfDNA screening but must pay its full cost out of pocket.

Column (4) shows the results of providing cfDNA coverage to patients whose risk score is  $\frac{1}{200}$  or higher, which is the risk score at which an NT score is labelled “positive.” Compared to no coverage of cfDNA screening (column (3)), there is an increase in cfDNA screening (from 14% to 29%) and a decrease in invasive testing (from 14% to 5.7%). This has two effects. It reduces the rate of live births with chromosomal abnormalities to parents who prefer no birth (from 0.17 to 0.11 per 100 pregnancies) because more patients are doing cfDNA screening and detecting fetuses with chromosomal abnormalities. At the same time, it also reduces the risk of miscarriage of babies without chromosomal abnormalities (from 0.05 to 0.01 per 100 pregnancies) because there is less invasive testing. This increases consumer surplus by \$120 per pregnancy (from \$2,014 to \$2,134) but also increases spending per pregnancy (from \$174 to \$221), because the decreased spending on invasive testing is not enough to offset the increased spending on cfDNA screening.

Perhaps most interestingly, the targeted coverage regime in column (4) both increases consumer surplus and lowers government spending relative to the absence of cfDNA technology (column (1)), unlike full cfDNA coverage (column (2)), which increases consumer

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<sup>43</sup>Recall that given our construction of the baseline, “full coverage” in practice means covering all pregnancies with NT risk score of  $\frac{1}{1,000}$  and above.

surplus but also increases government health-care spending. In other words, more narrowly targeting the coverage of cfDNA screening turns this new technology from one of Chandra and Skinner’s common “type II” technologies to the more desirable – and much less common – “type I” technology. Of course, we saw in column (3) that merely introducing the technology without coverage also reduces spending while raising surplus, but targeted coverage increases surplus by \$120 more while raising government cost by only \$47, so for any reasonable assumption about the social cost of public funds, total welfare is higher with targeted coverage.

Finally, in column (5) we consider even more targeting, and assume that cfDNA screening is covered not for any  $q_i \geq \frac{1}{200}$  as in column (4), but only for  $q_i \in [\frac{1}{200}, \frac{1}{51}]$ . This latter policy is the most common one in our data, covering about 70% of pregnancies (see Appendix Table A2). The comparison of column (4) and column (5) is instructive. The motivation for the greater targeting in column (5) is the assumption that for the very highest risk pregnancies ( $q_i \geq \frac{1}{50}$ ), patients are likely to do an invasive test regardless of the result of the cfDNA screening, so that incurring the (non-trivial) cost associated with cfDNA screening would be wasteful. Recall that for this reason the Swedish recommendation is not to cover cfDNA screening in this highest risk range. However, the results in column (5) compared to column (4) suggest that, in practice, this assumption is flawed: cfDNA coverage of the very highest risk pregnancies (in column (4) compared to column (5)) in fact causes substantial substitution from invasive testing to cfDNA screening; this results in fewer miscarriages of babies without chromosomal abnormalities (0.01 per 100 pregnancies instead of 0.03) and higher consumer surplus (by \$42 per pregnancy), while saving the government money (\$5 per pregnancy). Consistent with this, the bottom panel of Figure 7 shows that the invasive testing rate is far below 100% even in the top NT risk score bin when it is covered for cfDNA.

Figure 8 summarizes these results visually, by representing the five scenarios presented in Table 4 in terms of their impacts on consumer surplus (y-axis) and government spending (x-axis). Total welfare is higher to the north-east (higher consumer surplus and lower government spending). Introducing the cfDNA technology with full coverage both raises consumer surplus and government spending, the typical pattern for technological change in health care. By contrast, introducing cfDNA technology with either no coverage or partial coverage achieves the holy grail of lowering spending while simultaneously increasing consumer surplus. Within partial coverage regimes, covering risk scores of  $\frac{1}{200}$  and higher dominates (on both these dimensions) covering risk scores in  $[\frac{1}{200}, \frac{1}{51}]$ , which is by far the most common policy during our study period (see Appendix Table A2). To evaluate alternative policies were there is no clear dominance (i.e. higher consumer surplus and lower government spending), the figure also shows iso-social welfare curves. We define social welfare per pregnancy

as consumer surplus minus  $(1 + \lambda)G$ , where  $G$  denotes government spending and  $\lambda$  denotes the marginal cost of public funds; we use 0.3 as the (standard estimate of) marginal cost of public funds (Poterba 1996). Covering risk scores of  $\frac{1}{200}$  and higher leads to greater social welfare than either no cfDNA coverage or full cfDNA coverage.

Of course, there are many other possible ranges for partial coverage of cfDNA screening. Figure 9 therefore examines more granularly the optimal targeting of cfDNA coverage. We explore policies that cover cfDNA screening for all pregnancies with  $q_i \geq x$ , where  $x$  varies from  $\frac{1}{1,000}$  (full coverage) to 1 (no coverage). We report both consumer surplus and government spending, and also a measure of total welfare, which assumes (as earlier) a 0.3 marginal cost of public funds (Poterba 1996). Total welfare is increasing in coverage until  $q_i$  is  $\frac{1}{160}$ , and then starts declining. This result suggests that targeting is quite important, and that the existing targeted policies that offer cfDNA coverage for  $q_i \geq \frac{1}{200}$  come very close to the optimal policy. At the same time, offering no coverage at all is highly inefficient: many of the highest-risk patients would substitute to invasive testing, thus increasing cost and reducing consumer surplus. As shown in the bottom panel of Figure 9, the reduction in consumer surplus associated with more stringent cfDNA coverage is coming almost entirely from an increase in live births with chromosomal abnormalities to parents who would prefer no birth (bottom panel). In contrast, the low rates of invasive testing (except for the very highest NT risk scores) make the second type of inefficiency – miscarriage (due to invasive testing) of babies with no chromosomal abnormalities – quantitatively small and not sensitive to cfDNA targeting policies.

## 5.4 The impact of entirely removing NT screening

Thus far, we have considered the consequences of introducing cfDNA screening and coverage for that screening in a regime in which NT screening is universally offered as the first (free) step in the screening process. As discussed in Section 2, this type of two-step policy is common in Europe. However, the American College of Obstetricians and Gynaecologists recommends skipping NT screening entirely, and instead making cfDNA screening universally available. In this section, we therefore analyze the implications of “skipping” NT screening altogether, and instead offering cfDNA for free as a first step (followed by an option to do invasive testing).

To do so, we must now analyze decisions and outcomes for the full sample of singleton pregnancies (column (1) in Table 1) rather than our baseline sample, which is selected on the basis of the NT score (since now the NT score is not known).<sup>44</sup> In addition, to consider a

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<sup>44</sup>For completeness, Appendix Tables A4 and A5 replicate the analyses in Table 3 and Table 4 for the

policy in which cfDNA screening replaces NT screening, we must model the patient’s belief of the probability her fetus has a chromosomal abnormality in the absence of an NT score. It seems likely that patients have considerable uncertainty about the risk of chromosomal abnormalities, both in the overall population and for their particular risk profile. It is also possible that their beliefs are biased. To proceed, we make the (strong) assumption that the individual’s prior – even in the absence of NT screening – is her NT risk score (i.e. we continue to assume  $p = q$  as in Section 4.1).

While this assumption presents the most optimistic case for the benefits of the US-style one-step policy relative to the European-style two-step policy, we still find that the US-style policy of full cfDNA screening without any NT screening performs poorly relative to the European-style two-step policies of free NT screening followed by cfDNA coverage targeted at certain NT risk scores. As shown in Appendix Table 4, under the US-style policy, almost half the population opts to get cfDNA testing (column (2)), considerably more than the 3-4% who do so under the European-style policies (columns (4) and (5)). Because cfDNA is about three times more expensive than NT screening, the increased government spending on cfDNA screening swamps the government savings from forgoing the cost associated with NT testing. As a result, although the additional information provided by the much greater use of cfDNA screening in the US-style policy generates an additional \$21 in consumer surplus per pregnancy relative to the European-style policy – this is swamped by the increase in government spending of about \$77 per pregnancy, thus illustrating the value of using the less expensive NT technology to target the use of the more expensive cfDNA technology.

## 6 Conclusions

We develop and estimate a simple model of decision making and use it to analyze the welfare gains from coverage of a new (and costly) technology that can improve targeting of downstream procedures. Empirically, coverage of a new screening technology for fetal chromosomal abnormalities substantially increases its use, and substantially decreases the use of subsequent invasive testing, which is twice as costly and elevates the risk of miscarriage. The model estimates illustrate that the value of the new technology is largest in the middle of the risk range, where the screening result is most likely to influence decisions regarding subsequent invasive testing. Our counterfactual analyses suggest that narrow targeting of coverage for the screening has the potential to improve patient well-being and reduce gov-

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full sample. Compared to the (higher-risk) baseline sample, expanding to the full sample not surprisingly produces much lower testing rates and higher rates of live births, but the comparative statics across different technologies and different cfDNA coverage policies remain qualitatively similar.

ernment health-care cost, while broader coverage creates the familiar pattern of the new technology increasing both patient well-being and government cost.

A frequent subject of health-care policy – in both the US and other countries – is whether and when to provide coverage for new medical technologies.<sup>45</sup> Our findings suggest that appropriate coverage decisions have the potential to transform technologies from the more-common cost-increasing and health-improving type described by Chandra and Skinner (2012), to their more elusive cost-decreasing and health-improving type. They also underscore the point that the development of “precision medicine” – which offers the possibility of targeting medical care to the most appropriate patients – in turn creates important policy questions regarding how finely or broadly to screen patients for appropriateness, thus kicking the “precision” can further down the road.

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<sup>45</sup>Countries employ different decision-making frameworks with some, like England, trying to employ a strict cost-effectiveness criteria, while others, like Sweden and the Netherlands, also take account of societal values, such as the “principle of need” (Sabik and Lie 2008). In the US, Medicare is prohibited by law from considering costs in its coverage decisions, although many have argued that this is misguided (Chandra, Jena, and Skinner 2011).

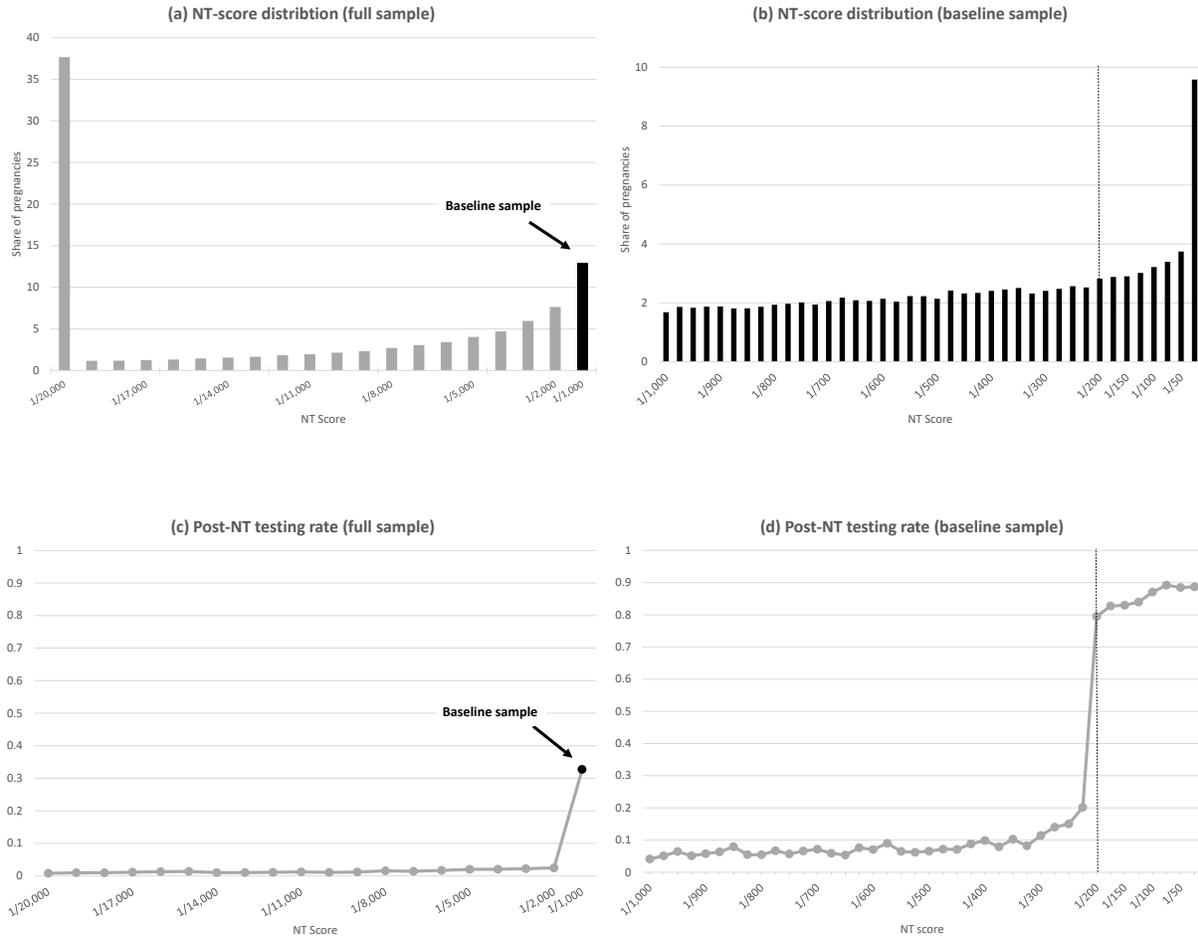
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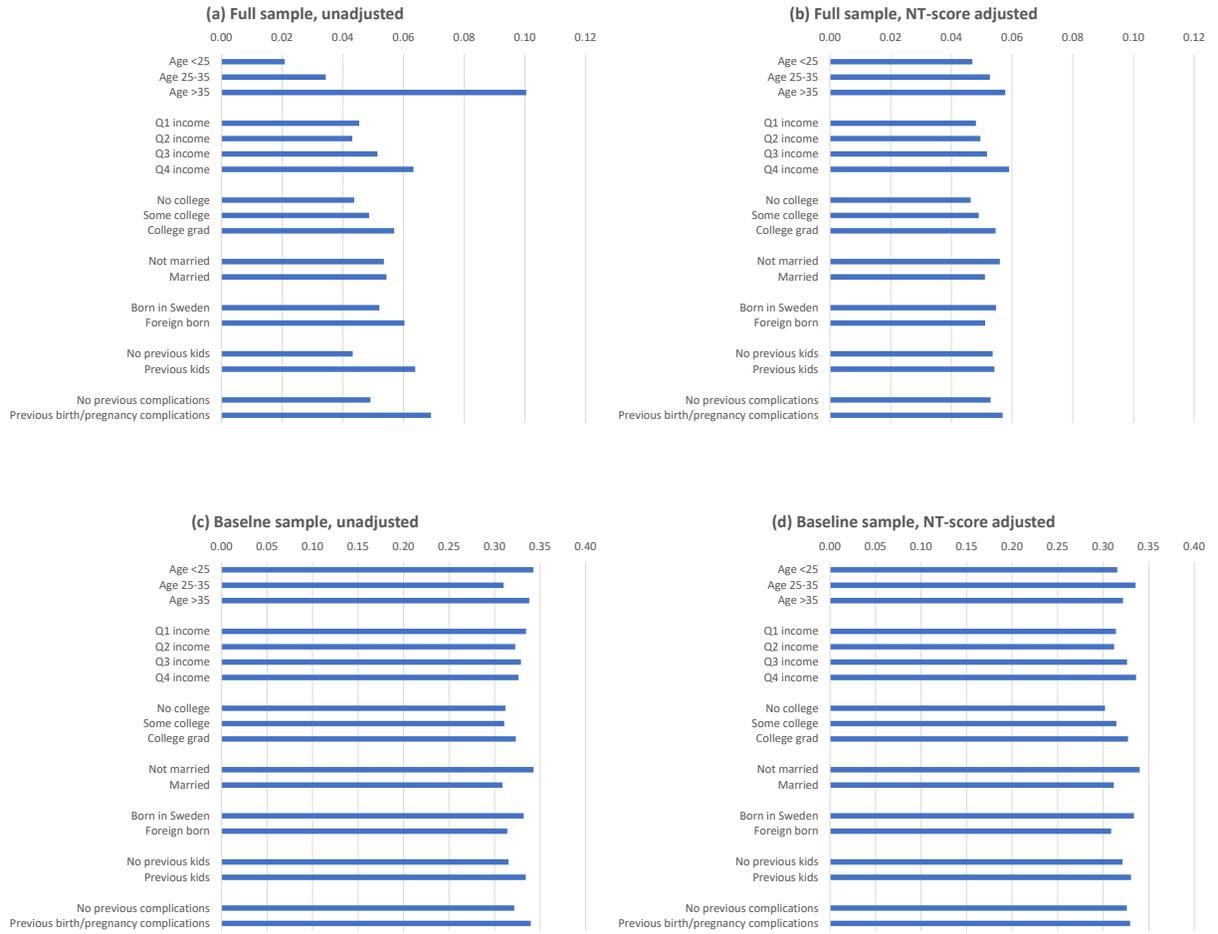
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Figure 1: NT risk-score distribution and post-NT testing rates



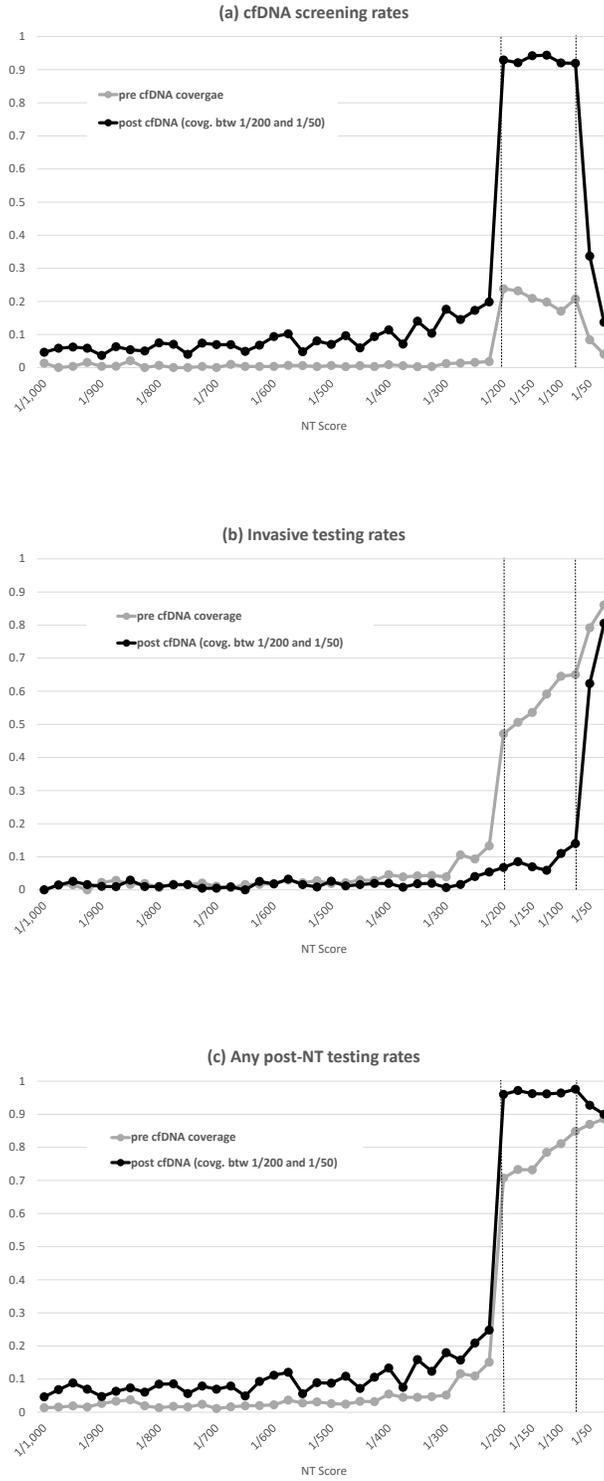
Note: Figure shows the distribution of NT risk scores and post-NT testing rates for the full sample (all singleton pregnancies in universal NT coverage region-months) in panels (a) and (c), and for the baseline sample (all pregnancies in the full sample with NT risk scores of  $\frac{1}{1,000}$  and higher) in panels (b) and (d). In panels (a) and (c), each bin has width 1,000; in panels (b) and (d) each bin has width 25; x-axis labels show the lower end of each bin. The vertical line in panels (b) and (d) denotes the risk score above which the NT screening result is considered “positive” and Sweden recommends that the patient be offered the opportunity to discuss follow-up testing. Full sample includes 234,817 pregnancies; baseline sample includes 30,479 pregnancies.

Figure 2: Post-NT testing rates by demographics



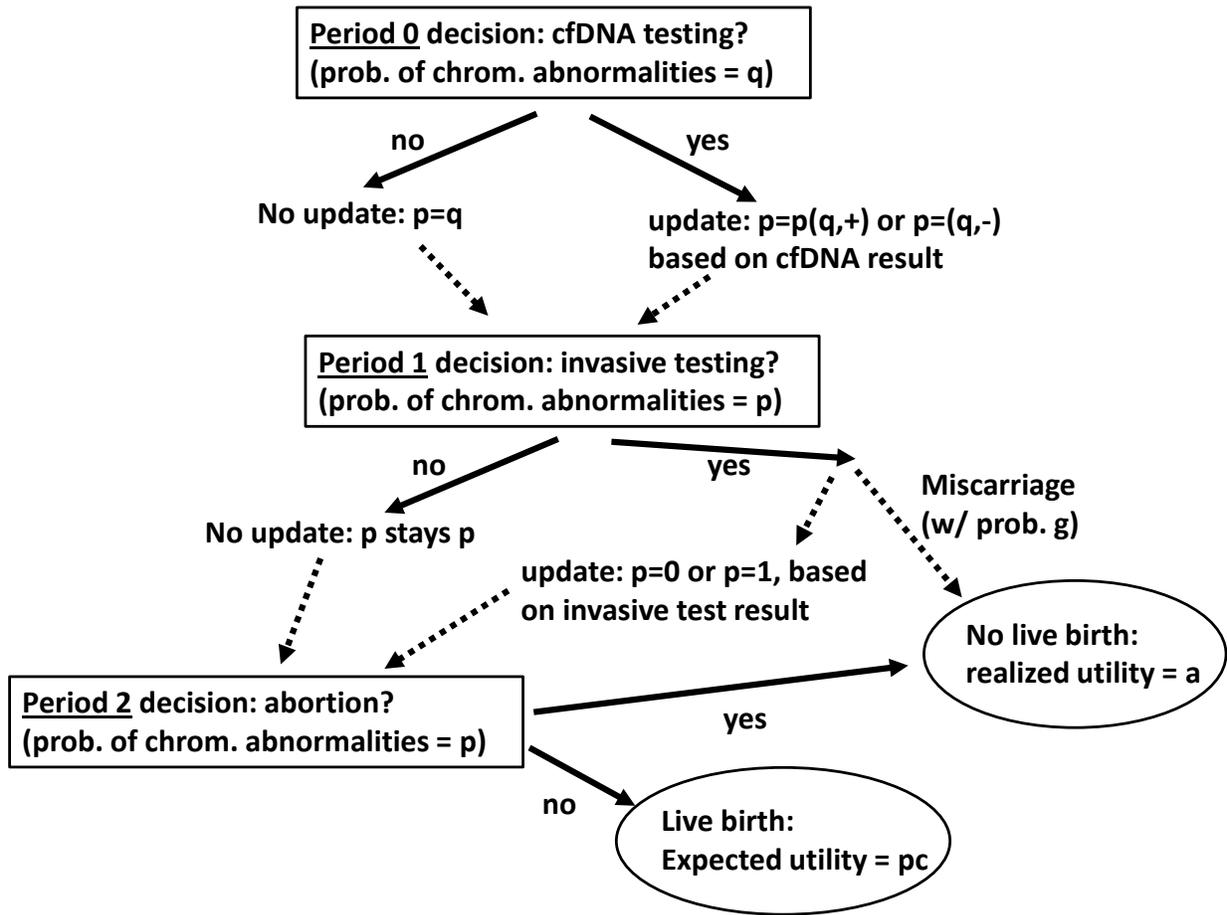
Note: Figure shows post-NT testing rate by various demographics. Panel (a) and (b) use the full sample ( $N = 234,817$ ), while panels (c) and (d) use the baseline sample ( $N = 30,479$ ). The two left panels (panels (a) and (c)) report “raw” post-NT testing rates. The two right panels (panels (b) and (d)) show rates conditional on the NT risk score; to do this conditioning, we regress testing rates on the inverse of the NT score, and then report the average (by demographic characteristics) residual, adding back the overall sample mean.

Figure 3: Changes in testing before and after adoption of cfDNA coverage



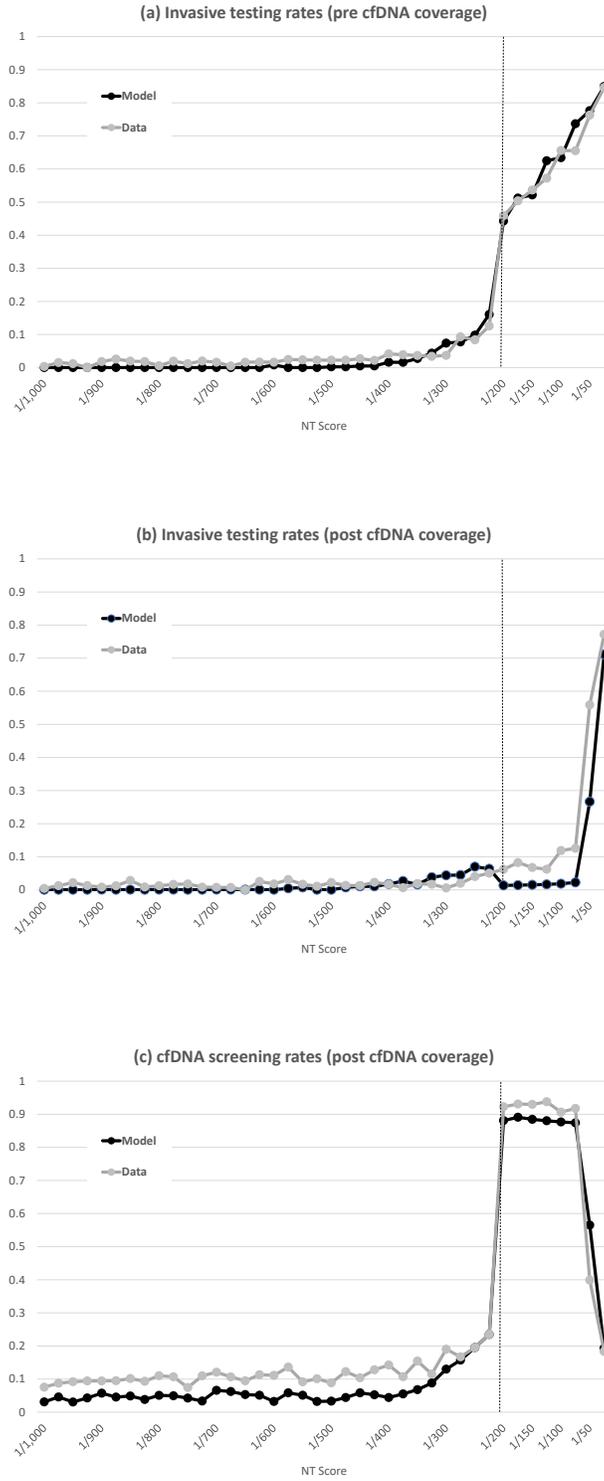
Note: Figure shows testing rates by NT risk score separately before and after the introduction of coverage for cfDNA for the subset of the baseline sample that is in regions where the modal cfDNA policy regime is introduced (Table 1, column (3)); this regime covered cfDNA for NT risk score in  $[\frac{1}{200}, \frac{1}{51}]$ . Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Vertical lines denote the range of risk scores for which coverage of cfDNA screening is introduced.  $N = 24,732$

Figure 4: Decision tree



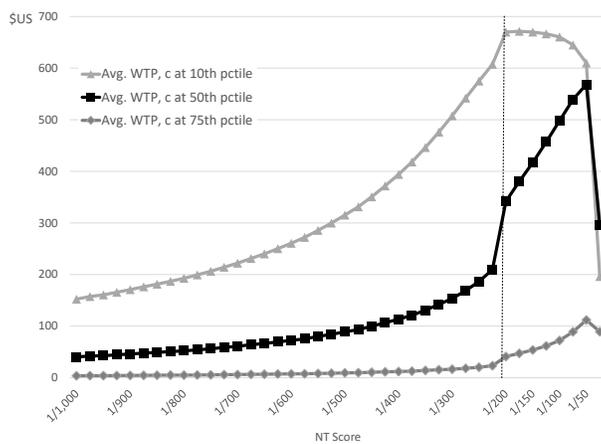
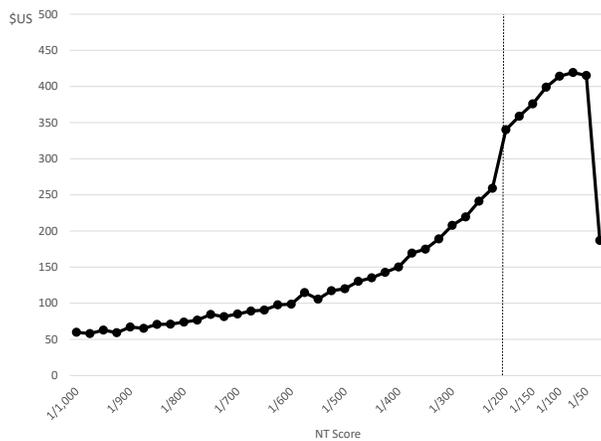
Note: Figure shows the decision tree associated with the model of prenatal testing choices described in Section 4.1.

Figure 5: Model fit, pooled across regimes



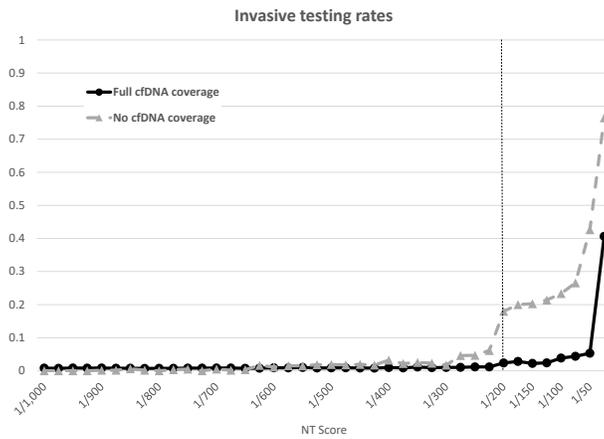
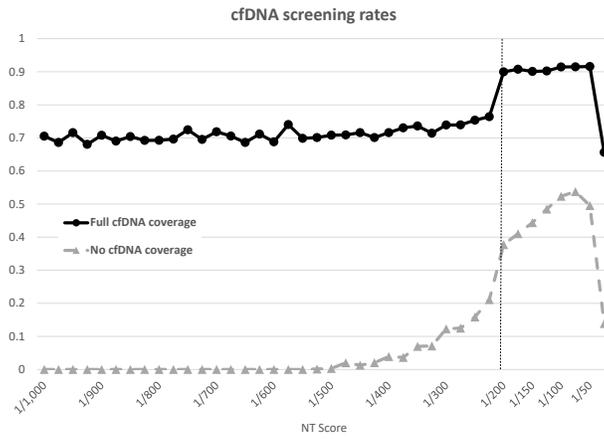
Note: Figure shows testing rates by NT risk score in the data and as predicted by the model, using the estimated parameters from Table 2. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Vertical line denotes the risk score above which the NT screen is considered “positive” and Sweden recommends that the patient be offered the opportunity to discuss follow-up testing. Panels (a) and (b) show invasive testing rates prior to and after the introduction of cfDNA coverage, respectively. Panel (c) shows cfDNA testing rates after the introduction of cfDNA coverage. Testing rates shown are pooled across policy regimes, although we match moments separately by policy regime (see Appendix Figures A6, A7, A8, and A9 for the fit of the moments separately, by coverage regime). Sample: Baseline sample, N = 30,479.

Figure 6: Willingness to pay for cfDNA



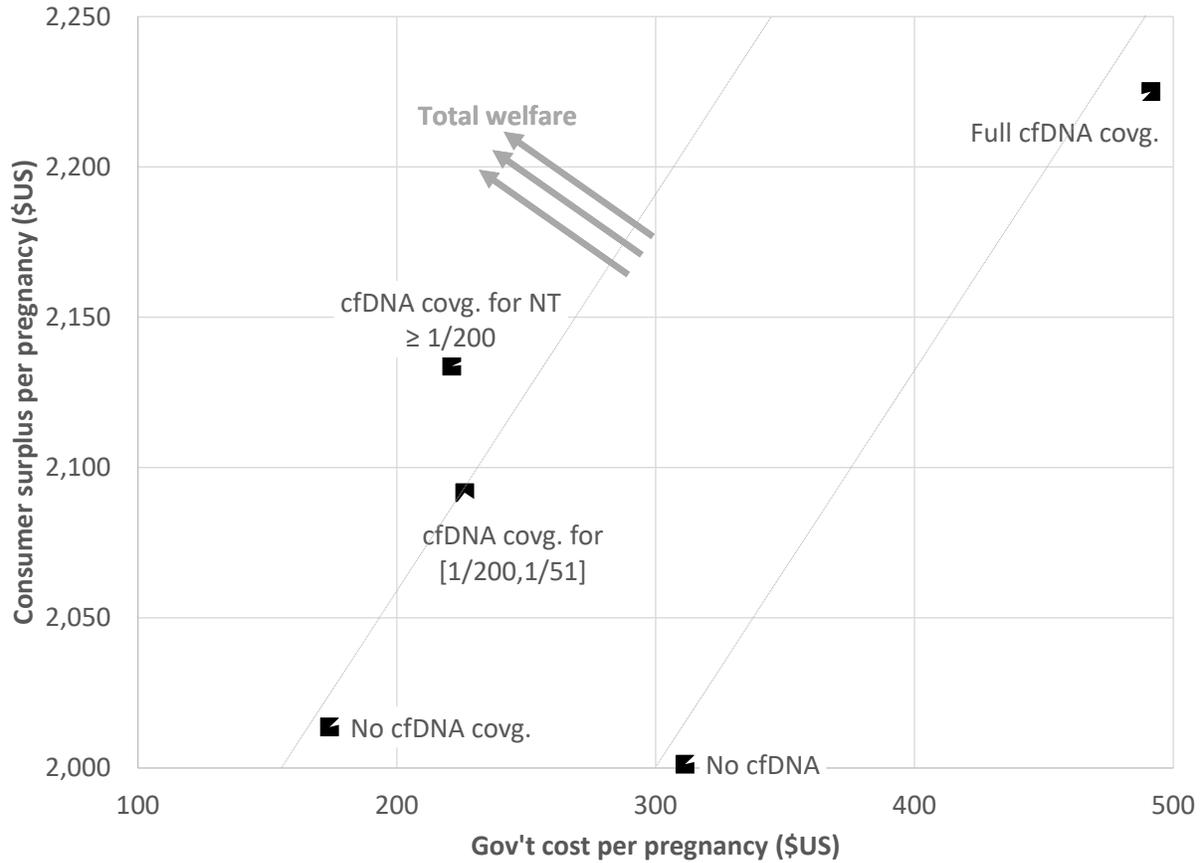
Note: Using the estimated parameters from [Table 2](#), figure shows the average willingness to pay for cfDNA by NT screening risk (top panel), and comparative statics in this average willingness to pay after setting the  $c_i$  of all pregnancies to the 10th, 50th, and 75th percentile of the estimated distribution of  $c_i$  (bottom panel);  $c_i$  is the utility from a live birth with chromosomal abnormalities.

Figure 7: Counterfactual screening and testing rates with and without cfDNA coverage



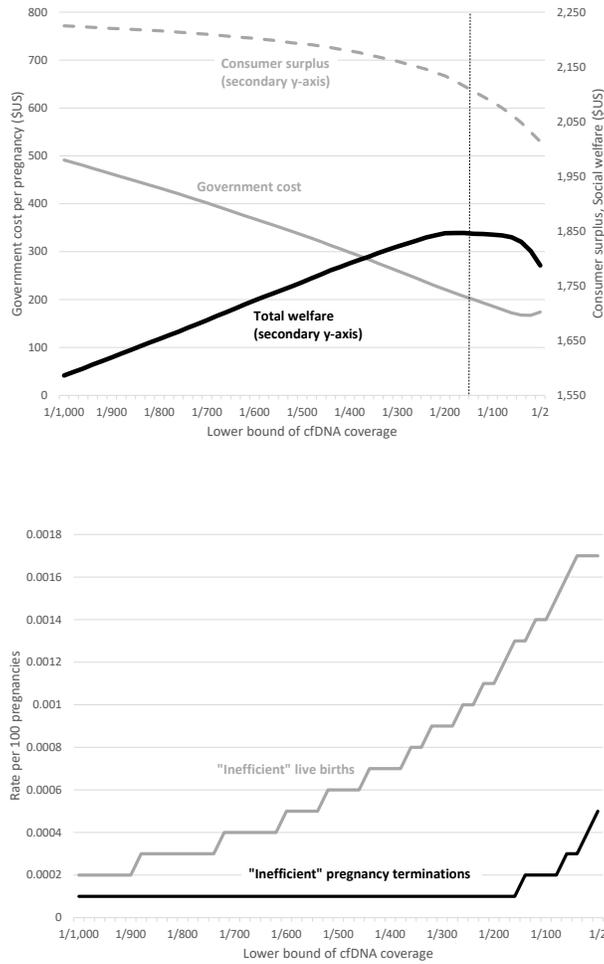
Note: Using the estimated parameters from Table 2, figure shows counterfactual cfDNA screening (top panel) and invasive testing rates (bottom panel) by NT risk under two different cfDNA coverage regimes: no cfDNA coverage, and full cfDNA coverage (i.e coverage for all NT risk scores of  $\frac{1}{1,000}$  and higher).

Figure 8: Visualizing trade-offs for counterfactual cfDNA coverage policies



Note: Figure plots estimated average (per pregnancy) consumer surplus and government costs of prenatal testing (in \$US) under counterfactual cfDNA insurance coverage policies for pregnancies in the baseline sample (i.e. risk score  $\geq \frac{1}{1,000}$ ). “Full cfDNA coverage” denotes coverage for all pregnancies with risk score  $\geq \frac{1}{1,000}$ , while other scenarios show cfDNA coverage for no risk scores (“No cfDNA coverage,”) coverage for risk scores  $\geq \frac{1}{200}$  or coverage for risk scores between  $\frac{1}{200}$  and  $\frac{1}{51}$  (inclusive). In all of these scenarios, patients whose cfDNA screening is not covered have the option to pay for it out of pocket. By contrast, the “no cfDNA” scenario assumes that cfDNA screening is unavailable. Average consumer surplus is normalized to zero in the scenario where there is neither cfDNA screening nor invasive testing available (i.e. Table 3, column (1)). The dotted gray lines represent iso-social welfare curves, where social welfare is defined as consumer surplus minus 1.3 times the government cost (thus assuming that the marginal cost of public funds is 0.3).

Figure 9: Optimal cfDNA coverage



Note: Top panel plots the counterfactual government cost of prenatal testing per pregnancy (left y-axis), average consumer surplus per pregnancy (right y-axis), and total welfare per pregnancy (right y-axis), under different potential lower bounds for the NT score at which cfDNA coverage begins. Total welfare is defined as consumer surplus minus 1.3 times the government cost (thus assuming that the marginal cost of public funds is 0.3). The dotted vertical line shows the welfare-maximizing lower bound of the NT score that qualifies for cfDNA coverage. Average consumer surplus is normalized to zero in the scenario where there is neither cfDNA screening nor invasive testing available (i.e. Table 3, column (1)). Bottom panel shows counterfactual shares of two types of “inefficient” pregnancy outcomes under the same set of exercises performed in the top panel. “Inefficient” live births are live births with chromosomal abnormalities to patients who would have preferred to terminate the pregnancy. “Inefficient” pregnancy terminations are terminated pregnancies that would have resulted in a live birth without chromosomal abnormalities.

Table 1: Summary Statistics

	Full sample (all singleton pregnancies) (1)	Baseline sample (= NT score $\geq 1/1,000$ ) (2)	cfDNA covg. for NT in $[1/200, 1/51]$ (and NT score $\geq 1/1,000$ ) (3)
Number of pregnancies	234,817	30,479	24,732
<b>Demographics:</b>			
Married	0.423	0.459	0.473
Foreign-born	0.226	0.271	0.279
Maternal age:			
Average age	32.0	35.1	35.5
<25	0.063	0.024	0.016
25-35	0.628	0.389	0.368
>35	0.309	0.587	0.616
Household income:			
Average income (\$US)	75,960	81,370	86,162
Lowest quartile	0.121	0.108	0.094
Second quartile	0.217	0.179	0.171
Third quartile	0.237	0.234	0.223
Highest quartile	0.424	0.478	0.511
Missing	0.001	0.001	0.001
Education:			
No college	0.320	0.293	0.273
Some college	0.130	0.130	0.132
College graduate	0.453	0.482	0.501
Missing	0.098	0.095	0.093
Any previous children	0.517	0.626	0.618
Any previous pregnancy or birth complications	0.240	0.299	0.299
Miscarriage, stillbirth, pre-term, death w/in 28 days	0.226	0.281	0.281
Congenital deformation or chromosomal abnormalities	0.022	0.031	0.031
<b>Testing:</b>			
Any post-NT testing	0.054	0.327	0.315
cfDNA testing	0.027	0.152	0.141
Invasive testing	0.028	0.184	0.183
<b>Birth outcomes:</b>			
Live birth	0.969	0.918	0.920
Live birth, w/o chrom. abnormalities	0.969	0.915	0.917
Live birth, w/ chrom. abnormalities	0.001	0.003	0.003
No live birth	0.031	0.082	0.080
Ended before 22 weeks	0.028	0.078	0.077
Stillbirth	0.003	0.003	0.003

Note: Table shows summary statistics (means) for maternal characteristics, testing rates, and birth outcomes for the full sample (column (1)), the baseline sample (column (2)), and the sub-sample of pregnancies in the baseline sample that are in regions that ultimately introduce coverage for cfDNA screening for NT scores between  $\frac{1}{200}$  and  $\frac{1}{51}$  (inclusive, column (3)); Appendix Table A2 describes which regions are associated with each policy regime. Household income calculated as the average household income across the two years prior to the year of the pregnancy's expected birth date, in SEK CPI-adjusted to 2012. SEK are then converted to USD using a 1 USD to 8.81 SEK exchange rate. Household income quartiles are defined relative to other mothers who give birth in the year of the due date.

Table 2: Parameter estimates

<b>Panel A: Equation-Specific Parameters</b>				
	<i>a</i> equation		<i>c</i> equation	
	Coeff.	Std. Err.	Coeff.	Std. Err.
Constant*	-138,862	(tba)	-153,800	(tba)
College graduate	0	(tba)	-28,528	(tba)
Top income quartile	0	(tba)	-20,051	(tba)
Married	0	(tba)	0	(tba)
Foreign-born	-12,305	(tba)	-111,726	(tba)
Previous complications	0	(tba)	-66,904	(tba)
$\sigma$	25,155	(tba)	36,151	(tba)
<b>Panel B: Additional Model Parameters</b>				
	Estimate	Std. Err.		
$\psi$	0.915	(tba)		
$\rho$	-0.019	(tba)		

Note: Table shows the parameter estimates associated with the model described in Section 4. Standard errors will be populated in future versions.

\*We de-mean all the covarites, so the estimated constant can be interpreted as the (estimate of the) population average of  $a_i$  and  $c_i$ .

Table 3: Outcomes under counterfactual information and technology

	No post-NT testing (1)	First best (full information) (2)	Free invasive (No cfDNA) (3)	Free invasive & Full cfDNA covg. (4)
<b>Testing (per 100 pregnancies):</b>				
Any testing	0	--	24.94	77.38
cfDNA only	0	--	0	72.18
Invasive only	0	--	24.94	2.22
Both	0	--	0	2.97
<b>Birth outcomes (per 100 pregnancies):</b>				
Live birth	99.12	96.84	96.92	96.85
No chrom. Abnormalities	95.97	96.41	96.31	96.40
Chrom. Abnormalities, a > c	2.73	0.00	0.19	0.02
Chrom. Abnormalities, a < c	0.42	0.42	0.42	0.42
No live birth	0.88	3.16	3.08	3.15
No chrom. Abnormalities	0.44	0.00	0.11	0.01
Chrom. Abnormalities (& a>c)	0.44	3.16	2.98	3.14
<b>Cost and surplus (\$US per pregnancy):</b>				
Total government cost	0	--	311	491
cfDNA cost	0	--	0	427
Invasive testing cost	0	--	311	65
Consumer surplus	normalized to 0	2,245	2,001	2,225

Notes: Table shows counterfactual testing decisions and pregnancy outcomes (per 100 pregnancies), and average government spending and consumer surplus (per pregnancy) under alternative assumptions about available technology and information for pregnancies in the baseline sample (i.e. NT risk score  $\geq \frac{1}{1,000}$ ). Consumer surplus and government spending are in \$US. Consumer surplus is normalized to zero for the counterfactual with no testing (column 1). Government spending includes invasive testing (\$1,248.50 per test) and cfDNA screening (\$567.50 per screen). Outcomes that are (ex-post) inefficient are shaded in gray.

Table 4: Outcomes under counterfactual coverage of cfDNA

	No cfDNA	Full cfDNA covg.	No cfDNA covg.	cfDNA covg. For NT $\geq 1/200$	cfDNA covg. For NT in $[1/200, 1/51]$
	(1)	(2)	(3)	(4)	(5)
<b>Testing (per 100 pregnancies):</b>					
Any testing	24.94	77.38	27.39	32.01	31.82
cfDNA only	0	72.18	13.46	26.35	21.37
Invasive only	24.94	2.22	13.29	3.26	9.54
Both	0	2.97	0.65	2.40	0.92
<b>Birth outcomes (per 100 pregnancies):</b>					
Live birth	96.92	96.85	96.95	96.94	96.92
No chrom. Abnormalities	96.31	96.40	96.36	96.40	96.38
Chrom. Abnormalities, a > c	0.19	0.02	0.17	0.11	0.12
Chrom. Abnormalities, a < c	0.42	0.42	0.42	0.42	0.42
No live birth	3.08	3.15	3.05	3.06	3.08
No chrom. Abnormalities	0.11	0.01	0.05	0.01	0.03
Chrom. Abnormalities (& a>c)	2.98	3.14	3.00	3.05	3.05
<b>Cost and surplus (\$US per pregnancy):</b>					
Total government cost	311	491	174	221	226
cfDNA cost	0	427	0	151	96
Invasive testing cost	311	65	174	71	131
Consumer surplus	2,001	2,225	2,014	2,134	2,092

Notes: Table shows counterfactual testing decisions and pregnancy outcomes (per 100 pregnancies), and average government spending and consumer surplus (per pregnancy) under alternative assumptions about cfDNA coverage for pregnancies in the baseline sample (i.e. NT risk score  $\geq \frac{1}{1,000}$ ). Throughout, invasive testing is assumed to be available for free. Consumer surplus and government spending are in \$US. Consumer surplus is normalized to zero for the counterfactual with no testing from Table 3. Government spending includes invasive testing (\$1,248.50 per test) and cfDNA screening (\$567.50 per screen). Outcomes that are (ex-post) inefficient are shaded in gray.

# Online Appendix

## A Data and variable definitions

### A.1 Data

Our data use agreement allows us to observe women (and their children) who were registered in the Swedish Population Register (Skatteverket) between 2000 and 2016. The restrictions this sample imposes are to exclude women who immigrated to Sweden in 2017 or later, as well as women who emigrated out of Sweden before 2000. All linkages across data sets are performed using the mother’s individual identifier (which is observed in all data sources).<sup>46</sup>

The backbone of our data is the NT database of pregnancies from 2011 through 2019; it is part of the Swedish Pregnancy Register (Stephansson et al. 2018). It is compiled for the subset of clinics in Sweden which use the more common algorithm to compute NT scores (Graviditetsregistret 2020); see Kublickas, Crossley, and Aitken (2009) for more detailed information about this algorithm, which is calibrated to the Swedish population. The NT database covers about 80% of all NT screenings carried out in Sweden (Graviditetsregistret 2019).<sup>47</sup> Because health care in Sweden is provided by the region (county) in which a woman lives, this clinic-based restriction effectively translates into us observing NT screening data for the sub-sample of patients who live close to the clinics covered by this database.

We link each mother in the NT database to the Medical Birth Records (MBR) from the National Board of Health and Welfare (Socialstyrelsen 2019) for the years 1985 through 2019. The MBR contains the universe of births in Sweden (both live births and stillbirths) for pregnancies carried 22 weeks or longer. We also link every mother in the NT database to her records on inpatient and specialist outpatient medical care, also obtained from the National Board of Health and Welfare (Socialstyrelsen 2019), from 2001-2019, and to additional information in Swedish administrative data on maternal demographics. Specifically, we measure the mother’s month and year of birth in Statistics Sweden’s Total Population Register (RTB) (Swedish Research Council 2020), and we measure her education, her household income, her marital status, and whether she is foreign born from the 2009-2019 Statistics Sweden’s longitudinal database of individual administrative records (LISA) (Statistics Sweden, n.d.).

In addition to these existing administrative data, we compiled our own data to determine each region’s coverage policies for NT and cfDNA over our sample period. To do so, we engaged in e-mail exchanges with representatives of each health-care region during November 2020. We complemented (and cross checked) the information we obtained with information from [www.1177.se](http://www.1177.se), a website operated by Sweden’s health-care regions that provides information about health-care coverage, and with information from the health-care regions’ individual websites and news articles. Appendix Table A1 and Appendix Table A2 show the regions, years, and maternal ages in which NT and cfDNA were covered, respectively. We

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<sup>46</sup>This individual identifier is a scrambled version of the true social security number, and created by Statistics Sweden.

<sup>47</sup>The precise estimate is for 2019; similar estimates are not available for prior years.

determine which prenatal screenings were covered for the mother based on maternal age, the information in the NT database on the clinic’s region, and the date of NT screening.

Linkage of the (singleton) pregnancies in the NT database to those in the MBR uses both the maternal ID as well as information about the timing of pregnancy.<sup>48</sup> We start by defining matches based on the same maternal ID and an NT screening date that is no more than 250 days prior to the date of birth imputed from the MBR.<sup>49</sup> The NT screening is generally performed between week 11 (which begins on day 77,<sup>50</sup> 203 days until term) and week 14 (which begins on day 98, 182 days until term) of gestation, but we allow for a longer link period to account for the potential for earlier screenings and late births. We confirm that this procedure identifies a maximum of one correct match for each screening. For pregnancies in the NT database that do not have a match in the MBR using this procedure, we perform an additional step to ensure that our 250-day cutoff is not leading us to miss a correct match. Specifically, if the birth date is within 250 to 270 days of the screening date (i.e. close to our 250-day cutoff but not identified as a correct match by the primary matching step), and the due date variables from the MBR and NT screening database are within 45 days of each other, we determine that this screening-birth observation is a correct match.

We do not expect this procedure to match all NT screenings to a pregnancy in the MBR, as the NT screenings are performed early in pregnancy (weeks 11 through 14). The MBR contains all pregnancies carried 22 weeks or longer. Thus, we code as a termination (either by abortion or miscarriage) any pregnancy in the NT database that does not have a birth recorded in the MBR, since it did not survive to 22 weeks.

## A.2 Selection into the NT database

Since the point of entry into the NT database is an NT screen, all the pregnancies in the data have an NT screen and an NT score. Of course, not all pregnancies receive NT screening. It is difficult to determine precisely what share of pregnancies that reach the gestational age for NT screening (about 11-14 weeks) receive that screening, since we cannot observe many of the pregnancies that do not. Specifically, we can observe all pregnancies that survive until 22 weeks of gestation or longer in the Medical Birth Register (MBR). However, we have no record in the NT database of pregnancies that are terminated or miscarry before 22 weeks if they do not receive NT screening.

In our baseline sample, we limit our analyses to pregnancies in the NT database that are in region-months that provide universal NT coverage (see Appendix Table A1). To get

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<sup>48</sup>We limit to the approximately 97% of pregnancies that are singleton pregnancies because we cannot distinguish the different fetuses in a multi-fetal pregnancy when linking to the MBR. There are also a small number of cases (15 pregnancies) where the mother obtained two screenings for the same pregnancy. In these cases, we keep the screening with the later test date.

<sup>49</sup>We only observe the month and year of birth in MBR, not the exact date of birth. However, in MBR we also observe the exact pregnancy due date and the exact gestational age at birth. Using the fact that the due date is calculated as day 280 of gestational age, we impute the exact date of birth using the following formula: due date minus 280 plus gestational age at birth. If either the due date or the gestational age at birth is missing in the MBR, we impute the date of birth as the 15th of the (observed) month and year of birth.

<sup>50</sup>By convention, the first week of pregnancy is denoted as “week 0,” the second week as “week 1”, and so on.

a rough sense of what share of pregnancies in our region-months receive NT screening, we use our data for 2019 – where we have an estimate that 80% of NT screens are in the linked NT-MBR database (Graviditetsregistret 2019) – and inflate the number of NT screens we observe in each region in 2019 by 1.25 to reflect the fact that we only observe 80% of them. We estimate that about 72% of pregnancies in our universal NT coverage sample receive NT screening. This rate is naturally lower if NT coverage is limited by maternal age, which is why we limit our analysis to the universal NT coverage sample.

### A.3 Variable definitions

Here we provide more detail on the construction of some of the specific variables in our analysis.

**Insurance rules.** We assign the pregnancy to a universal NT region-month and to the relevant cfDNA policy regime based on the regime in place for the pregnancy’s region at the beginning of the 10th week of gestation, defined as 210 days prior to the pregnancy due date as calculated below.

**Pregnancy region.** Assigned based on the region of the NT screening clinic.

**Pregnancy due date.** We calculate a due date for all pregnancies. We start by calculating the due date from the NT database, defined as 280 days after the first day of last menstrual period.<sup>51</sup> If this date is missing, we assign the due date recorded in the MBR (if pregnancy was carried past 22 weeks); if the pregnancy is not in the MBR, we assign the due date as the NT screening date plus 196 days (which assumes that the NT test occurs at the beginning of 12th week).

**cfDNA screening.** In the NT database, we observe the cfDNA screening if it is done at the same clinic as the NT screen. We do not observe the result (positive or negative) of the cfDNA screening.

**Invasive test.** In the NT database, we observe if the pregnancy has an invasive test (i.e. CVS or amniocentesis) if the test occurs at the same clinic as the NT screen. . .

**Maternal age.** In the NT database, we observe maternal age at the due date. If this variable is missing, which it is for approximately XX% of our analysis sample, we instead calculate mother’s age at the due date using mother’s year and month of birth from Statistics Sweden’s Population Registry and assume that the mother was born on the 15th of that month.

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<sup>51</sup>For IVF pregnancies, which are separately flagged in the data, the due date is based on the date of the egg transfer.

**Chromosomal abnormality diagnoses.** The MBR contains (ICD-10) diagnosis codes determined at birth. We determine that a child has a chromosomal abnormality if the diagnosis codes contain any of Q90-Q99.

**Previous miscarriage/stillbirth/death within 28 days of birth/pre-term live birth.** Indicator that is equal to 1 if the mother has a prior pregnancy that resulted in a miscarriage, still birth, death within 28 days of birth, or a pre-term live birth ( $< 38$  weeks). We determine that a mother has had a previous miscarriage if there is a miscarriage recorded (ICD-10 code O00-O08) in either the inpatient or specialist outpatient registers prior to the date of conception of the pregnancy. That is, if there are diagnoses associated with a visit from 2001 (when our patient registry data starts) to the date of conception (either the secondary diagnoses or the main diagnosis) that includes a miscarriage ICD code. We further determine that a mother has had a previous pregnancy that resulted in a stillbirth, death within 28 days of birth, or a pre-term live birth ( $< 38$  weeks) if there is a birth recorded with any of these characteristics in the MBR from 1985 (when our MBR data starts) to the date of conception.

**Previous pregnancy with a congenital deformation or chromosomal abnormality.** Indicator that is equal to 1 if the mother has a prior pregnancy in the MBR with a diagnosed congenital deformation or chromosomal abnormality (any ICD code starting with Q).

**Mother's education.** Mother's education level (no college, some college, or completed college) measured in the year of the due date. Source: LISA (Statistics Sweden, [n.d.](#)).

**Income quartile.** Maximum of mother's household income quartile in year  $t - 1$  and  $t - 2$ . Income percentiles are defined relative to other mothers who give birth in year  $t$ . For 2020 births, we use 2019 as year  $t$  for calculating income (as we only have tax data through 2019). q1 is the lowest quartile, q4 is the highest.<sup>52</sup> Source: LISA (Statistics Sweden, [n.d.](#)).

**Married.** Indicator that is equal to 1 if the mother is married in the year of the due date. Source: LISA (Statistics Sweden, [n.d.](#)).

**Foreign-born.** Indicator that is equal to 1 for mothers that were born outside of Sweden. Source: Statistics Sweden Population Registry (Swedish Research Council [2020](#)).

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<sup>52</sup>Note that the distribution of income quartiles is skewed towards the highest income quartile because we take the higher percentile across  $t - 1$  and  $t - 2$ . Defining a mother's income percentile in year  $t - k$  as  $ptile_{t-k}$ , there are approximately 25% of pregnancies in each quartile of the  $ptile_{t-k}$  distribution. This is not exactly 25% as a few mothers have two pregnancies in the same calendar year and we take percentiles over mothers, not over pregnancies. However, once we take the maximum quartile a mother was in across more than one year, the distribution of quartiles across mothers will skew higher so long as some women changed quartiles across the years.

## B Model and estimation details

### B.1 Estimation details

We estimate the model using method of moments. We assume that  $a_i$  and  $c_i$  are jointly distributed via a bivariate normal distribution, with means  $x'_i \beta^a$  and  $x'_i \beta^c$ , standard deviations  $\sigma_a$  and  $\sigma_c$ , and correlation  $\rho$ , and  $a_i$  truncated from above at zero. That is,

$$\begin{pmatrix} a_i \\ c_i \end{pmatrix} \sim N \left( \begin{pmatrix} x'_i \beta^a \\ x'_i \beta^c \end{pmatrix}, \begin{pmatrix} \sigma_a^2 & \rho \sigma_a \sigma_c \\ \rho \sigma_a \sigma_c & \sigma_c^2 \end{pmatrix} \middle| a_i < 0 \right). \quad (7)$$

Let  $\theta = (\beta^a, \beta^c, \sigma_a, \sigma_c, \rho, \psi)$ , where  $\psi \in (0, 1]$  is the parameter that captures the impact of the recommendation to take invasive testing following a “positive” NT screening ( $q_i \geq \frac{1}{200}$ ). Let  $\aleph$  be the set of relevant observables in the data ( $q_i$ , policy regime, pre/post-cfDNA coverage introduced, patient characteristics).

We match four sets of observed moments,  $m(\aleph)$ . We bin the data by NT risk score into 20 bins, each of width 50 (i.e. pregnancies with  $q_i \in [\frac{1}{250}, \frac{1}{201}]$  comprise one of the bins). In the pre-cfDNA coverage period, we match the share of pregnancies that do invasive testing (conditional on *not* doing cfDNA) by NT risk bin. In the post-cfDNA coverage period, we match three sets of moments separately for each of the four coverage policy regimes (these regimes vary across regions, see Appendix Table A2 for details on these four regimes):

- Share who do cfDNA screening, by NT risk bin
- Share who do invasive testing conditional on doing cfDNA, by NT risk bin
- Share who do invasive testing conditional on *not* doing cfDNA, by NT risk bin

Thus, we have 260 distinct testing moments that we try to match: 20 bins by 3 outcomes by 4 policy regimes, in addition to 20 bins of the rate of invasive testing prior to the introduction of cfDNA coverage.

Given a fixed  $\theta$ , we create corresponding model-simulated moments,  $m(\widehat{\aleph} | \theta)$ , as follows. First, we set the out-of-pocket cost ( $f_i$ ) of cfDNA for each pregnancy  $i$  according to the policy regime in that pregnancy’s region. In the period with cfDNA coverage, for those with cfDNA covered,  $f_i = 0$ , otherwise  $f_i = \$567.50$ . If the region had not introduced coverage for cfDNA by the 10th week of the pregnancy, we set the out-of-pocket cost of cfDNA to infinity, imposing that a patient cannot do cfDNA in the pre-coverage period.<sup>53</sup> Second, for each pregnancy  $i$ , we draw  $(a_i, c_i)$  from the truncated bivariate normal distribution defined by  $\theta$ . We then apply our model to simulate testing decisions for each pregnancy. The model predicts a binary decision of whether or not to receive cfDNA screening and a probabilistic invasive testing decision.<sup>54</sup> Finally, we aggregate these predicted testing decisions to testing

<sup>53</sup>As seen in Figure 3(a), there is some cfDNA screening that occurs in the pre-coverage period. We abstract from it in our estimation, as rates are low and the screening is not widely available.

<sup>54</sup>The invasive testing decision is probabilistic because the cfDNA screening result is unobserved, thus from our perspective stochastic. Specifically, the predicted invasive decision for those who decide to do cfDNA screening is the  $Pr(+|q)$ (invasive decision conditional on positive cfDNA) +  $Pr(-|q)$ (invasive decision conditional on negative cfDNA). The predicted invasive decision for those who do not get cfDNA is deterministic.

shares at the NT risk bin by policy regime to calculate the simulated moments  $\widehat{m(\aleph | \theta)}$ .

We use a two-stage non-linear optimization procedure to search for the parameter set  $\hat{\theta}$  that minimizes the distance between the observed and simulated moments. In the first stage, we use a global search algorithm, the unscaled Dividing Rectangles method (Jones, Perttunen, and Stuckman 1993), with a search range of  $\mu_a \in [-300, 000, 0]$ ,  $\mu_c \in [-300, 000, 0]$ ,  $\sigma_a \in [1, 100, 000]$ ,  $\sigma_c \in [1, 100, 000]$ ,  $\rho \in [-0.9, 0.9]$ ,  $\psi \in [0.5, 1]$ , and  $\beta \in [-200, 000, 200, 000]$  for each covariate. In the second stage, we run an implementation of the Subplex algorithm (a variant of the Nelder-Mead algorithm, a derivative-based local search, on a sequence of subspaces) beginning from the parameter set identified in the first-stage (Rowan 1990). We use a squared distance objective function and weight moments by the number of pregnancies associated with each moment. More formally,

$$\hat{\theta} = \underset{\theta}{\operatorname{argmin}} \quad \|m(\aleph | \theta) - m(\aleph)\|$$

where

$$\|m(\aleph | \theta) - m(\aleph)\| \equiv (m(\aleph | \theta) - m(\aleph))' W (m(\aleph | \theta) - m(\aleph)),$$

where  $W$  is the weighting matrix with the number of observations associated with each moment.

Standard Errors will get computed in future versions.

## B.2 Counterfactual simulations

We generate counterfactual policy simulations for our analysis sample using our model of prenatal choices and the estimated parameters  $\hat{\theta}$ . To reduce simulation error, we create 100 duplicate observations ( $j = 1, 2, \dots, 100$ ) for each pregnancy  $i$  in the analysis sample. For each observation  $ij$  we simulate using binomial draws whether that observation has chromosomal abnormalities based on the NT risk  $q_i$ . We use this simulated chromosomal abnormality status and the false positive and false negative rates of cfDNA screening to simulate (again, using binomial draws) what the result of a cfDNA screening would be for each observation (if it were to receive cfDNA screening). Finally, we simulate (with a probability of 0.005) whether an observation would result in a miscarriage if it was to receive an invasive test.

Next, for each observation  $ij$ , we draw  $(a_{ij}, c_{ij})$  from the truncated bivariate normal distribution defined by  $\hat{\theta}$ . Combining this draw, its corresponding values of  $q_i$  and  $f_i$ , and the simulated cfDNA screening result, we use the model to infer optimal choices. We keep only simulations that are consistent with the observed choices in the data, so for each pregnancy  $i$  we only keep simulation  $ij$  if its implied choices are the same as the observed ones. If they are not, we reject the draw and redraw a new simulation  $j$  for pregnancy  $i$ .<sup>55</sup>

We try to redraw up to 250 times for each duplicate pregnancy  $ij$ . If, after the 250th draw, an observation does not have an accepted draw, we drop the observation and reweight other  $ij$  observations associated with the same pregnancy  $i$  (this happens in 14% of the

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<sup>55</sup>Recall that we do not model cfDNA screenings that occur before it is formally covered, so we only condition on cfDNA choices after it is formally covered (for at least some pregnancies in the region-year).

$ij$  observations). That is, in all counterfactual calculations, we weight observation  $ij$  by the inverse of the share of observations with accepted draws for pregnancy  $i$ , so that each pregnancy in the analysis sample is equally weighted.<sup>56</sup>

With these  $ij$  observations in hand, we simply adjust the availability and cost of testing (if the policy precludes a form of testing we set its cost to infinity) and apply our model to simulate the counterfactual policy exercises reported in the paper. If an observation has cfDNA covered,  $f_i = \$0$ , if cfDNA is available but not covered,  $f_i = \$1,248.50$ , and if it is not available we assume that  $f_i$  is equal to infinity. With prenatal choices given by the model and the known (simulated) outcomes associated with each duplicate pregnancy, we can read the the counterfactual results directly off the (simulated) data.<sup>57</sup>

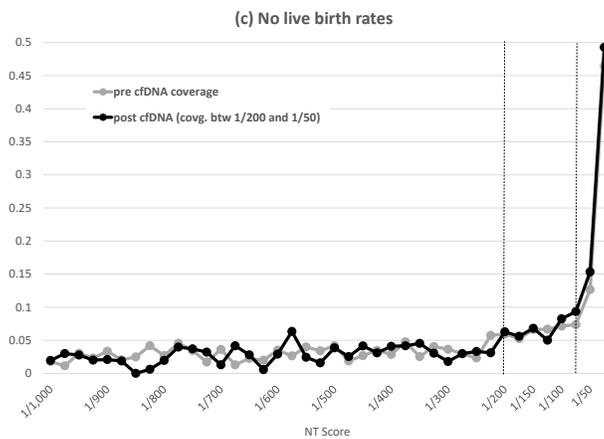
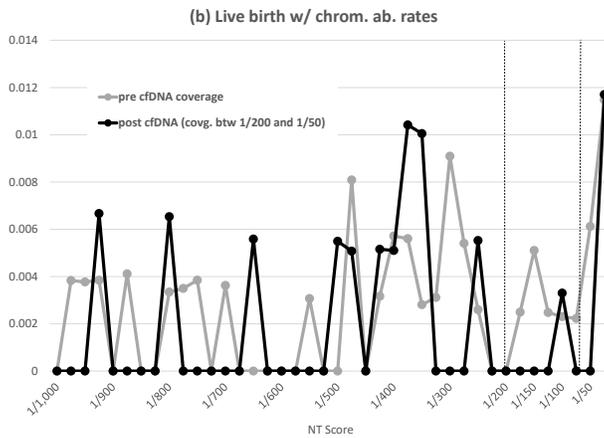
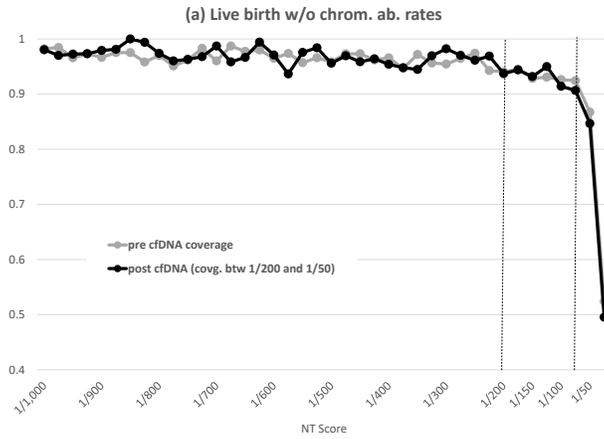
For each counterfactual, we aggregate these simulated testing decisions and pregnancy outcomes to calculate the estimates in [Table 3](#), [Table 4](#), [Figure 7](#), [Figure 8](#), and [Figure 9](#). To calculate government cost, we assume that the government pays \$567.50 for each cfDNA screening received by a covered pregnancy, and \$1,248.50 for each invasive test (invasive tests are covered for all pregnancies under all counterfactuals we consider). To calculate consumer surplus, we take the (monetized) utility of each pregnancy outcome (0 if observation  $ij$  resulted in a live birth without chromosomal abnormalities,  $a_{ij}$  if it ended in a termination, and  $c_{ij}$  if it resulted in a live birth with chromosomal abnormalities), subtract any out-of-pocket cost associated with cfDNA screening, and take the (weighted) sum across observations.

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<sup>56</sup>This procedure makes us drop 1% of pregnancies from the counterfactual exercise, as they do not have at least one accepted draw (that is, all 25,000 draws for these pregnancies were rejected). This 1% will become zero in future versions.

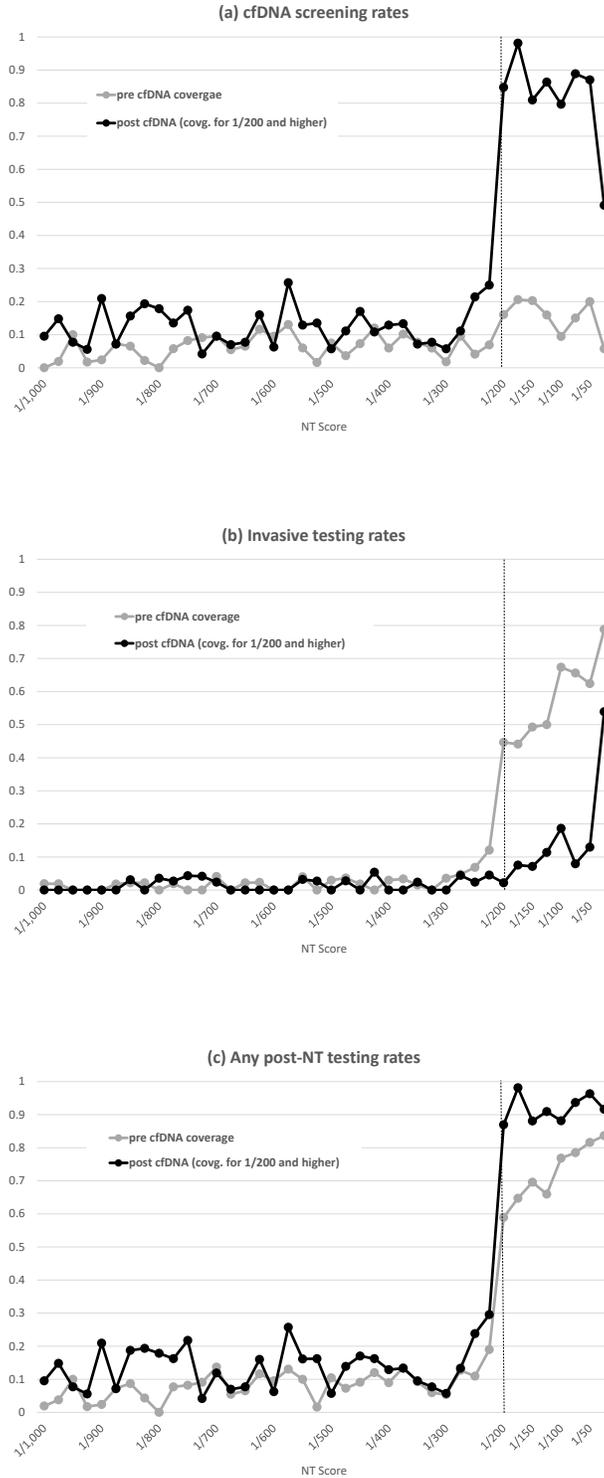
<sup>57</sup>The one exception is the “First best (full information)” counterfactual. In this scenario, all observations receive no testing, as the patient already knows the chromosomal abnormality status of the fetus. The patient thus chooses to terminate the pregnancy if and only if  $a_{ij} > c_{ij}$  and the fetus has chromosomal abnormalities.

Appendix Figure A1: Changes in pregnancy outcomes, before and after adoption of cfDNA coverage



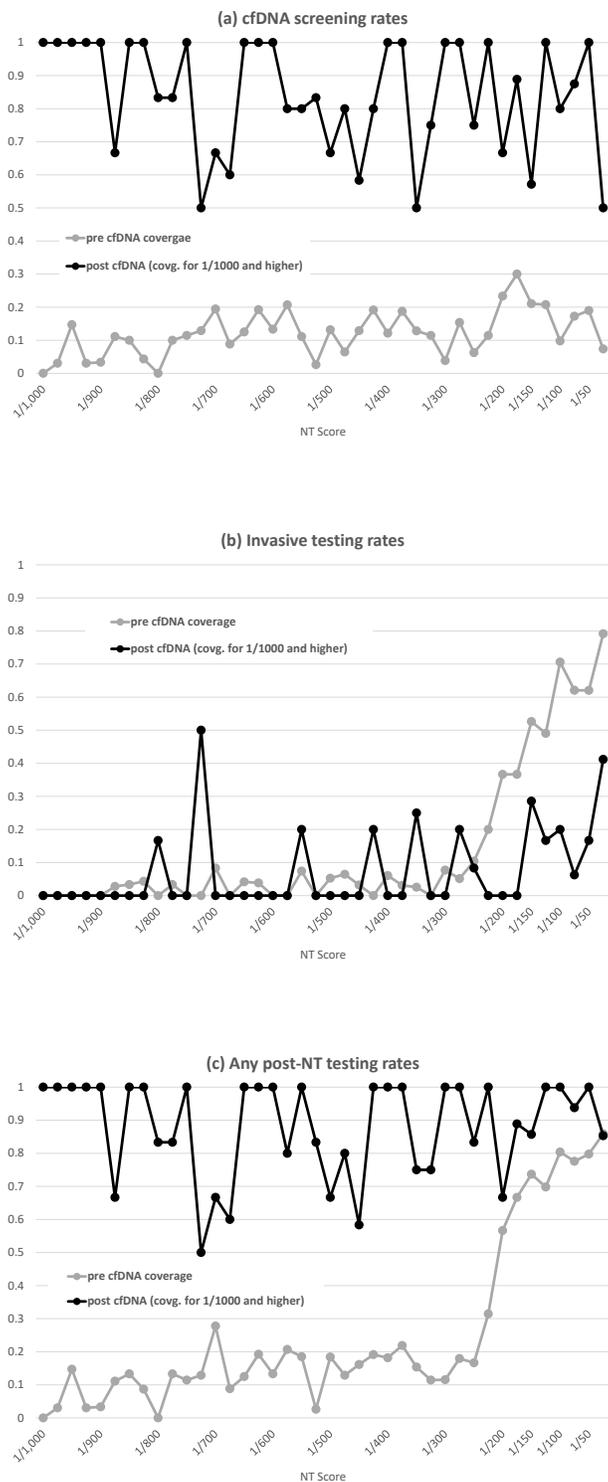
Note: Figure shows pregnancy outcomes by NT risk score separately before and after the introduction of coverage for cfDNA. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Vertical lines denote the range of risk scores for which coverage of cfDNA screening is introduced. Sample: Subset of baseline sample that is in regions where cfDNA coverage is introduced for  $q \in [\frac{1}{200}, \frac{1}{51}]$  (see Table 1 column 3.) N = 24,732.

Appendix Figure A2: Changes in testing before and after adoption of cfDNA coverage, under cfDNA coverage for  $\frac{1}{200}$  and higher



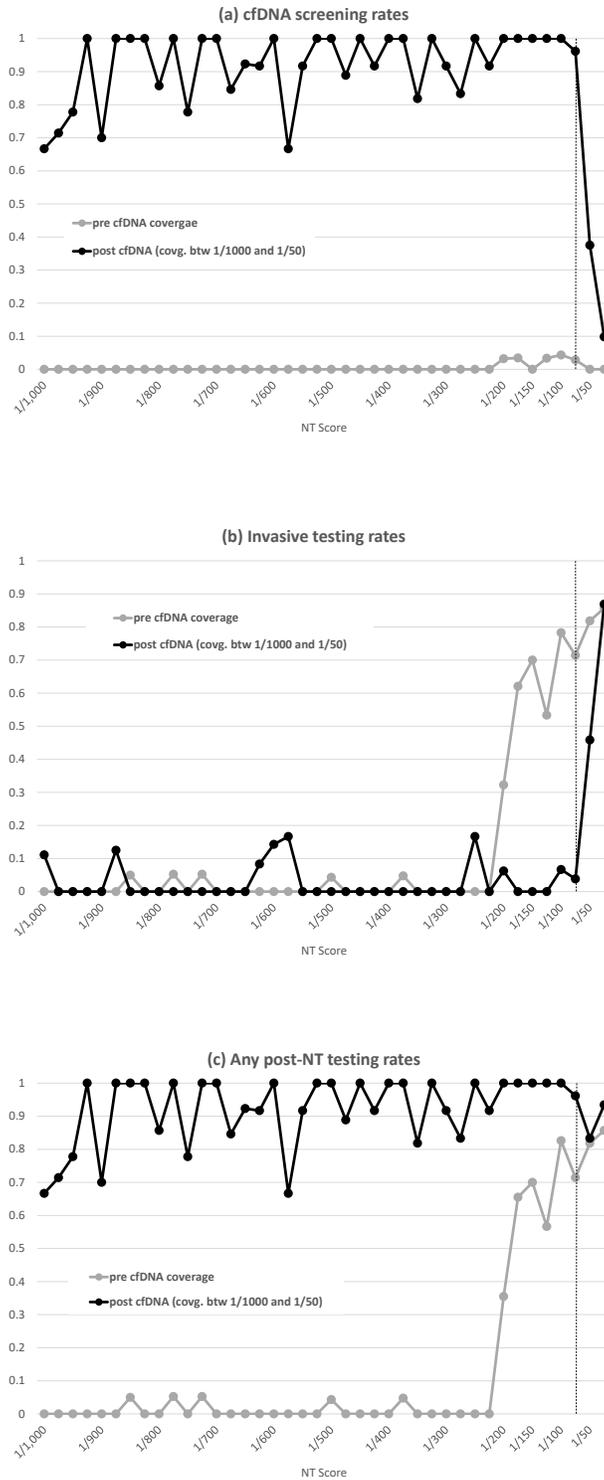
Note: Figure shows testing rates by NT risk score separately before and after the introduction of coverage for cfDNA. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Vertical lines denote the range of risk scores for which coverage of cfDNA screening is introduced. Sample: the subset of the baseline sample that is in regions where the cfDNA policy regime is introduced, covering cfDNA for NT risk score of  $[\frac{1}{200}]$  and higher.

Appendix Figure A3: Changes in testing before and after adoption of cfDNA coverage, under cfDNA coverage for  $\frac{1}{1,000}$  and higher



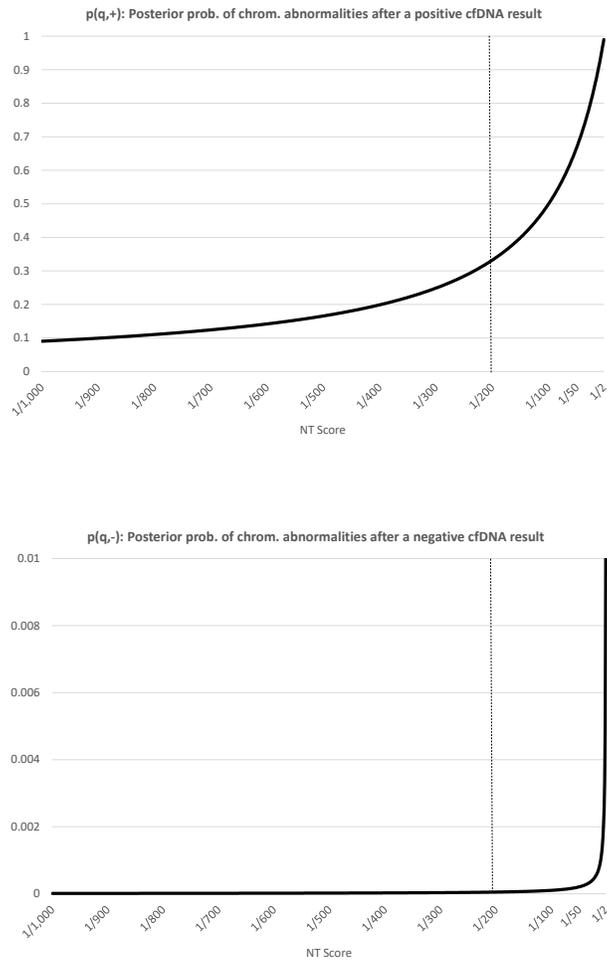
Note: Figure shows testing rates by NT risk score separately before and after the introduction of coverage for cfDNA. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Vertical lines denote the range of risk scores for which coverage of cfDNA screening is introduced. Sample: the subset of the baseline sample that is in regions where the cfDNA policy regime is introduced, covering cfDNA for NT risk score of  $[\frac{1}{1,000}]$  and higher.

Appendix Figure A4: Changes in testing before and after adoption of cfDNA coverage, under cfDNA coverage in  $[\frac{1}{1,000}, \frac{1}{51}]$



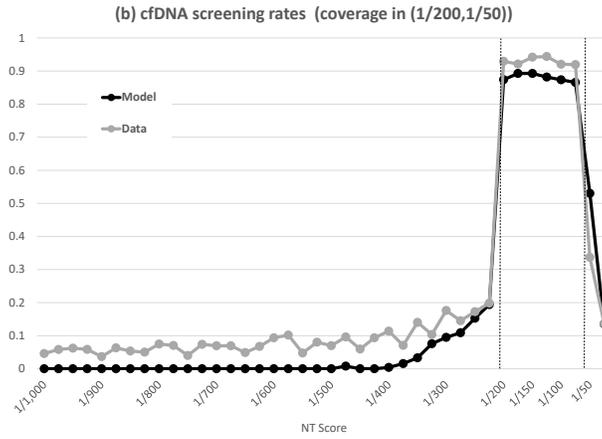
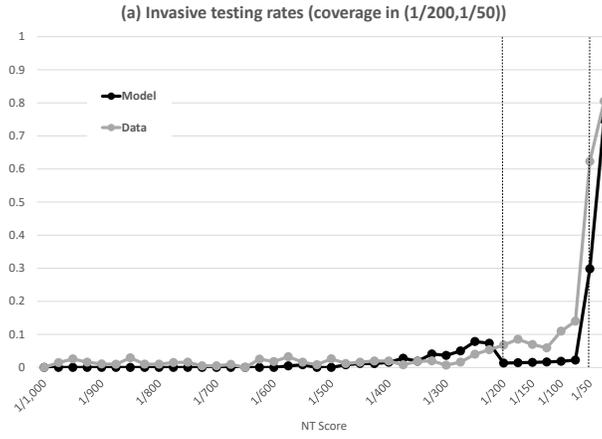
Note: Figure shows testing rates by NT risk score separately before and after the introduction of coverage for cfDNA. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Vertical lines denote the range of risk scores for which coverage of cfDNA screening is introduced. Sample: the subset of the baseline sample that is in regions where the cfDNA policy regime is introduced, covering cfDNA for NT risk score in  $[\frac{1}{1,000}, \frac{1}{51}]$ .

## Appendix Figure A5: Posterior beliefs after cfDNA screening results



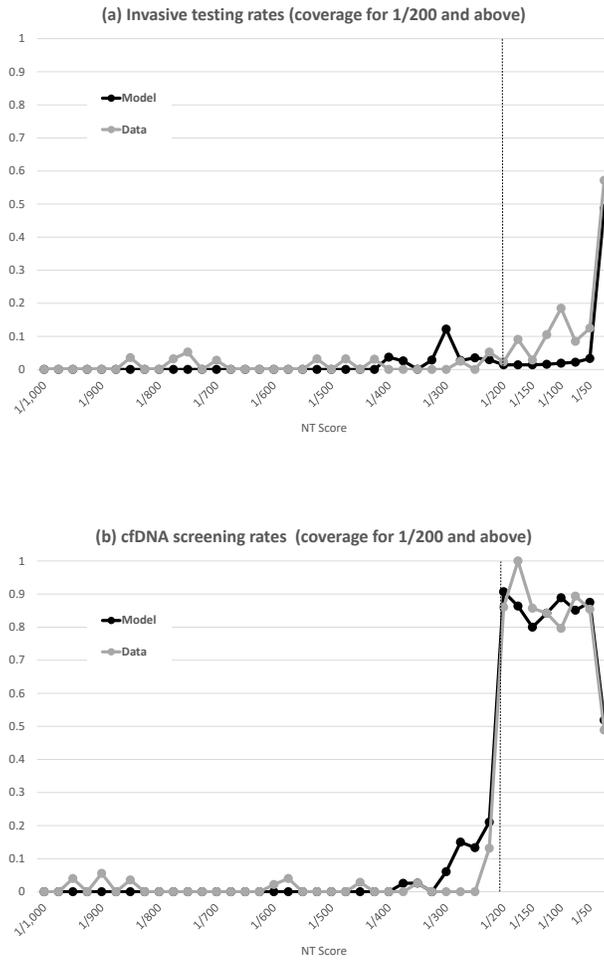
Note: Figure shows the posterior beliefs (see footnote 29) about the probability of chromosomal abnormalities, by NT risk score, for both positive cfDNA results (top panel) and negative ones (bottom panel).

Appendix Figure A6: Model fit, cfDNA coverage in  $[\frac{1}{200}, \frac{1}{51}]$



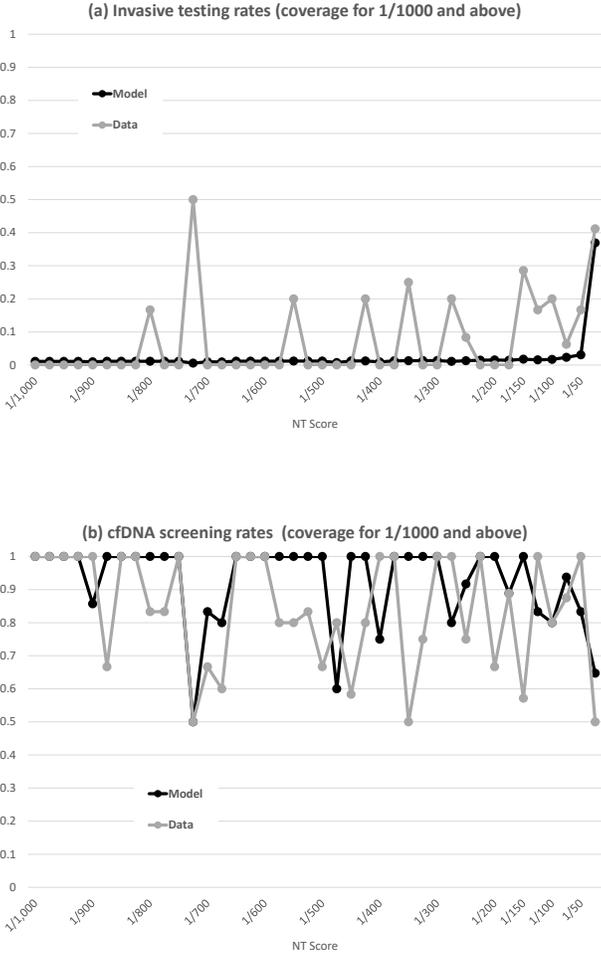
Note: Note: Figure shows testing rates by NT risk score in the data and as predicted by the model, using the estimated parameters from Table 2, for observation that are in the  $[\frac{1}{200}, \frac{1}{51}]$  cfDNA coverage regime. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Panel (a) shows invasive testing rates and panel (b) shows cfDNA screening rates.

Appendix Figure A7: Model fit, cfDNA coverage for  $\frac{1}{200}$  and above



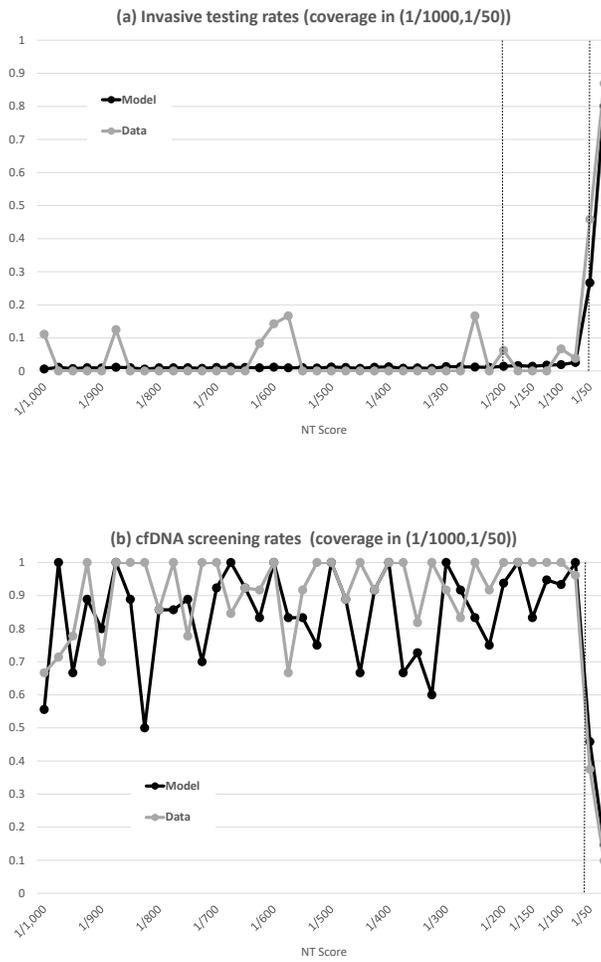
Note: Note: Figure shows testing rates by NT risk score in the data and as predicted by the model, using the estimated parameters from Table 2, for observation that are in the “ $\frac{1}{200}$  and above” cfDNA coverage regime. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Panel (a) shows invasive testing rates and panel (b) shows cfDNA screening rates.

Appendix Figure A8: Model fit, cfDNA coverage for  $\frac{1}{1,000}$  and above



Note: Note: Figure shows testing rates by NT risk score in the data and as predicted by the model, using the estimated parameters from Table 2, for observation that are in the “ $\frac{1}{1,000}$  and above” cfDNA coverage regime. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Panel (a) shows invasive testing rates and panel (b) shows cfDNA screening rates.

Appendix Figure A9: Model fit, cfDNA coverage in  $[\frac{1}{1,000}, \frac{1}{51}]$



Note: Note: Figure shows testing rates by NT risk score in the data and as predicted by the model, using the estimated parameters from Table 2, for observation that are in the  $[\frac{1}{1,000}, \frac{1}{51}]$  cfDNA coverage regime. Each bin has a risk score width of 25, with the x-axis labels showing the lower end of that bin. Panel (a) shows invasive testing rates and panel (b) shows cfDNA screening rates.

Appendix Table A1: NT coverage policies

NT coverage regime	Region	Months (within 2011-19)	Share of pregnancies	
			in 2011-19	in 2019
<b>Universal NT coverage</b>			0.548	0.552
	Stockholm	01/2011 - 12/2019		
	Uppsala	01/2016 - 12/2019		
	Östergötland	01/2011 - 12/2019		
	Jönköping	01/2011 - 12/2019		
	Kronoberg	03/2012 - 12/2019		
	Kalmar	01/2012 - 12/2019		
	Dalarna	11/2017 - 12/2019		
	Halland	05/2017 - 12/2019		
	Värmland	01/2011 - 12/2019		
	Örebro	01/2011 - 12/2019		
	Västernorrland	01/2015 - 12/2019		
	Jämtland	04/2016 - 12/2019		
<b>Age 35 and higher</b>			0.413	0.413
	Uppsala	01/2011 - 01/2016		
	Sörmland	01/2012 - 12/2019		
	Gotland	01/2011 - 12/2019		
	Blekinge	01/2011 - 06/2016		
	Skane	01/2011 - 12/2019		
	Västra Götaland	01/2011 - 12/2019		
	Dalarna	01/2011 - 12/2019		
	Gävleborg	01/2011 - 12/2019		
	Västernorrland	03/2012 - 12/2014		
	Jämtland	01/2011 - 03/2016		
	Västerbotten	01/2011 - 12/2019		
<b>Age 38 and higher</b>			0.001	0.000
	Blekinge	01/2011 - 06/2016		
<b>No NT coverage</b>			0.038	0.035
	Sörmland	01/2011 - 12/2011		
	Kronoberg	01/2011 - 02/2012		
	Kalmar	01/2011 - 02/2012		
	Halland	01/2011 - 04/2017		
	Västmanland	01/2011 - 12/2019		
	Västernorrland	01/2011 - 02/2012		
	Blekinge	07/2016 - 12/2019		
	Norrbotten	01/2011 - 12/2019		

Note: Table shows which region-months (from 2011 through 2019) are in which of the NT coverage regimes listed. It also shows the share of pregnancies in the Medical Birth Records from 2011-2019 in each regime, and the share of pregnancies in the Medical Birth Records from 2019 in each regime.

Appendix Table A2: cfDNA coverage regimes

cfDNA coverage regime	Region	Month introduced	Share of baseline sample
<b>[1/200,1/51]</b>			0.811
	Stockholm	10/2016	
	Sörmland	09/2016	
	Gotland	02/2016	
	Halland	05/2017	
	Västra Götaland	02/2017	
	Västmanland	02/2017	
	Dalarna	11/2017	
	Jämtland	09/2017	
<b>1/200 and above</b>			0.085
	Uppsala	09/2016	
	Värmland	04/2018	
	Gävleborg	02/2017	
	Västernorrland	09/2017	
<b>[1/1000,1/51]</b>			0.046
	Kronoberg	05/2017	
	Skane	05/2017	
<b>1/1000 and above</b>			0.058
	Örebro	10/2018	
<b>[1/300,1/51]</b>			0.000*
	Östergötland	01/2016	
	Jönköping	06/2018	
	Kalmar	09/2017	
<b>Age 32 and older</b>			0.000*
	Blekinge	06/2016	
<b>No cfDNA coverage</b>			0.000
	Västerbotten	NA	
	Norrboten	NA	

Note: This table shows the cfDNA coverage regimes in Sweden. For each regime, we list the health-care regions that adopted the regime, the date of introduction of cfDNA coverage in each of these regions, and the share of our baseline sample that is accounted for by pregnancies in the regions that adopted the regime.

\*No pregnancies in the three regions that adopted cfDNA coverage in the range  $[\frac{1}{51}, \frac{1}{300}]$  are included in the NT database; similarly, no pregnancy in the region that adopted cfDNA coverage for patients aged 32 or older is included in the NT database. (As per the discussion in [Appendix A](#), this stems from the fact that the NT clinics in these regions do not use the dominant algorithm to calculate the NT score.) Consequently, no pregnancies from these regions enter our baseline sample.

Appendix Table A3: The impact of sample restrictions

	All live births (1)	All live births in region-months w/ universal NT coverage (2)	NT screened pregnancies in region- months w/ universal NT coverage (3)
Number of pregnancies	973,673	458,054	234,817
<b>Demographics:</b>			
Married	0.464	0.479	0.423
Foreign-born	0.265	0.276	0.226
Maternal age:			
Average age	30.4	30.9	32.0
<25	0.128	0.109	0.063
25-35	0.652	0.649	0.628
>35	0.220	0.242	0.309
Household income:			
Average income (\$US)	58,654	65,475	75,960
Lowest quartile	0.191	0.167	0.121
Second quartile	0.229	0.223	0.217
Third quartile	0.246	0.241	0.237
Highest quartile	0.310	0.348	0.424
Missing	0.024	0.021	0.001
Education:			
No college	0.458	0.428	0.320
Some college	0.131	0.135	0.130
College graduate	0.390	0.416	0.453
Missing	0.021	0.021	0.098
Any previous children	0.530	0.525	0.517
Any previous pregnancy or birth complications	0.224	0.227	0.240
Miscarriage, stillbirth, pre-term, death w/in 28 days	0.208	0.212	0.226
Congenital deformation or chromosomal abnormalities	0.025	0.024	0.022

Note: Table shows how the sample restrictions affect sample composition. Column (3) presents summary statistics for our full sample, replicating column (1) of Table 1 in the main text. Column (1) and (2) in the above table use the Medical Birth Records to report statistics on all (singleton) live births in Sweden (column (1)) and on then limited to the region-months with universal NT coverage (column (2)). Note that some pregnancies in column (3) will not appear in column (2) since not all pregnancies with an NT screen result in a live birth.

Appendix Table A4: Outcomes under counterfactual information and technology, Full sample

	No post-NT testing (1)	First best (full information) (2)	Free invasive (No cfDNA) (3)	Free invasive & Full cfDNA covg. (4)
<b>Testing (per 100 pregnancies):</b>				
Any testing	0	--	3.32	47.37
cfDNA only	0	--	0	46.3
Invasive only	0	--	3.32	0.32
Both	0	--	0	0.75
<b>Birth outcomes (per 100 pregnancies):</b>				
Live birth	99.86	99.57	99.60	99.58
No chrom. Abnormalities	99.45	99.52	99.50	99.52
Chrom. Abnormalities, a > c	0.35	0.00	0.04	0.01
Chrom. Abnormalities, a < c	0.06	0.06	0.06	0.06
No live birth	0.14	0.43	0.40	0.42
No chrom. Abnormalities	0.07	0.00	0.01	0.00
Chrom. Abnormalities (& a>c)	0.07	0.43	0.39	0.42
<b>Cost and surplus (\$US per pregnancy):</b>				
Total government cost	0	--	42	280
cfDNA cost	0	--	0	267
Invasive testing cost	0	--	42	13
Consumer surplus	normalized to 0	333	286	326

Note: Table reproduces Table 3 of the main text, but using the full sample (instead of the baseline sample), which also includes many low-risk pregnancies (see Table 1).

Appendix Table A5: Outcomes under counterfactual information and technology, Full sample

	No cfDNA	Full cfDNA covg.*	No cfDNA covg.	cfDNA covg. For NT $\geq$ 1/200	cfDNA covg. For NT in [1/200,1/51]
	(1)	(2)	(3)	(4)	(5)
<b>Testing (per 100 pregnancies):</b>					
Any testing	3.32	47.37	3.70	4.27	4.24
cfDNA only	0	46.30	1.88	3.52	2.88
Invasive only	3.32	0.32	1.74	0.46	1.25
Both	0	0.75	0.08	0.29	0.12
<b>Birth outcomes (per 100 pregnancies):</b>					
Live birth	99.60	99.58	99.60	99.60	99.60
No chrom. Abnormalities	99.50	99.52	99.51	99.52	99.51
Chrom. Abnormalities, a > c	0.04	0.01	0.04	0.03	0.03
Chrom. Abnormalities, a < c	0.06	0.06	0.06	0.06	0.06
No live birth	0.40	0.42	0.40	0.40	0.40
No chrom. Abnormalities	0.01	0.00	0.01	0.00	0.00
Chrom. Abnormalities (& a>c)	0.39	0.42	0.39	0.40	0.40
<b>Cost and surplus (\$US per pregnancy):</b>					
Total government cost	42	106	23	29	30
NT saving*	0	-174	0	0	0
cfDNA cost	0	267	0	20	13
Invasive testing cost	42	13	23	9	17
Consumer surplus	286	326	288	305	300

Note: Table reproduces Table 4 of the main text, but using the full sample (instead of the baseline sample), which also includes many low-risk pregnancies (see Table 1).

\*In the case of full cfDNA coverage for the full sample, an NT screening is redundant, so one of the benefits of full coverage that we account for is the saving of the cost (\$174 per pregnancy) of the NT screening.