No. 24-316

In the Supreme Court of the United States

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

v.

BRAIDWOOD MANAGEMENT, INC., ET AL.
Respondents.

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

BRIEF OF ILLINOIS, ARIZONA, CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, DISTRICT OF COLUMBIA, HAWAII, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, WASHINGTON, AND WISCONSIN AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether the court of appeals erred in holding that the structure of the U.S. Preventive Services Task Force (Task Force), which sits within the Public Health Service of the Department of Health and Human Services (HHS), violates the Appointments Clause, U.S. Const. Art. II, § 2. Cl. 2, and in declining to sever the statutory provision that it found to unduly insulate the Task Force from the HHS Secretary's supervision.

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INTERESTS OF AMICI CURIAE

Amici States of Illinois, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Vermont, Washington, and Wisconsin (collectively, "amici States") submit this brief in support of petitioners.

Amici States have a substantial interest in safeguarding the health and welfare of their residents. The preventive services provision of the Patient Protection and Affordable Care Act (ACA), 42 U.S.C. §§ 300gg-13(a)(1)-(4), advances this interest by expanding state residents' access to important and often lifesaving care. Specifically, the provision requires health insurance issuers and group health plans to cover certain preventive services without imposing cost sharing on patients. *Ibid.*

The Fifth Circuit's conclusion that the structure of the U.S. Preventive Services Task Force violates the Appointments Clause of the United States Constitution interferes with the States' vital interest in ensuring their residents are healthy and safe. Congress instructed the Task Force to issue recommendations for preventive medical services that, under the preventive services provision, health insurance issuers and group health plans must cover without imposing additional out-of-pocket expenses on patients. 42 U.S.C. § 300gg-13(a)(1). But the Fifth Circuit concluded that Congress's statutory design violates the Appointments Clause because the Task Force's members are principal officers of the United

States who must be (but are not) nominated by the President and confirmed by the Senate. Pet. App. 26a. On that basis, it concluded that the federal government could not enforce the preventive services provision's coverage requirements based on the Task Force's recommendations. *Id.* at 47a.

Amici States have a strong interest in defending the healthcare protections that have guaranteed their residents' access to preventive medical services for over a decade. This issue is of particular concern because it is not one that States can address on their own, given federal preemption principles and practical constraints. Amici States thus respectfully request that this Court reverse the Fifth Circuit's decision and hold that the Task Force's structure complies with the Appointments Clause, allowing the preventive services provision to be enforced.

SUMMARY OF ARGUMENT

This case concerns whether the federal government can enforce the preventive services provision, which has significantly improved public health outcomes across the Nation by expanding access to important and often life-saving care. The Fifth Circuit's decision puts these achievements at risk, and this Court should reverse it.

To begin, Task Force members are inferior officers because their work is directed and supervised by the Secretary for the Department of Health and Human Services (HHS), who is a principal officer nominated by the President and confirmed by the Senate. As the Fifth Circuit recognized, the Secretary has the power to remove Task Force members at will. That fact alone suggests that Task Force members are inferior

officers, not principal officers. And multiple provisions of federal law—ranging from HHS authorizing statutes, *e.g.*, 42 U.S.C. §§ 202, 299(a), to provisions specifically addressing the Task Force, *e.g.*, *id.* §§ 300gg-13(b)(1), 299b-4(a)(1)—empower the Secretary to exercise meaningful control over the Task Force and its preventive services recommendations, control the Secretary (acting through a subordinate entity) has consistently used.

The Fifth Circuit's contrary conclusion is flawed and should be reversed. The Fifth Circuit interpreted a single statutory provision to insulate the Task Force from supervision, but its understanding of that provision—42 U.S.C. § 299b-4(a)(6)—is incorrect. Properly read, subsection (a)(6) is meant to protect Task Force members from external pressure, not internal oversight. That conclusion is buttressed by the fact that Congress provided for political insulation only to the extent "practicable," rather than commanding it as an absolute matter. And even if subsection (a)(6) were susceptible to the Fifth Circuit's construction, the canon of constitutional avoidance would require the Court to read it to permit the same degree of oversight that the Fifth Circuit agreed the Secretary exercises over the Task Force's sister entities.

If this Court were to disagree about the best interpretation of subsection (a)(6), the proper course would be to sever that provision, not to hold that the Task Force's recommendations cannot be enforced. That is what the Court did in cases like *United States v. Arthrex, Inc.*, 594 U.S. 1 (2021), and *Seila Law LLC v. CFPB*, 591 U.S. 197 (2020), and the same result is warranted here. That measured approach is

particularly appropriate because millions of Americans rely on the preventive services provision to access essential care that they might otherwise forego because of its substantial costs. If the preventive services provision is unenforceable, insurers would be free to reinstate out-of-pocket fees for preventive care or eliminate coverage of such services altogether. For these reasons, this Court should reverse the decision below.

ARGUMENT

The Appointments Clause of the United States Constitution governs the manner in which "Officers of the United States" must be selected. Art. II, § 2, cl. 2. The parties agree that Task Force members are "Officers of the United States" because they "exercis[e] significant authority pursuant to the laws of the United States." *Buckley v. Valeo*, 424 U.S. 1, 126 (1976) (per curiam). But the Fifth Circuit held that Task Force members are principal officers, who must be nominated by the President and confirmed by the Senate, rather than inferior officers, whose appointment Congress "may by Law vest . . . in the President alone, in the Courts of Law, or in the Heads of Departments." Art. II, § 2, cl. 2.

The amici States agree with petitioners that Task Force members are inferior officers. The Task Force members are appointed and removable at will by the Secretary of Health and Human Services, and multiple other statutory provisions establish the Secretary's power to direct and supervise the Task Force's work, including its recommendations. The Fifth Circuit's contrary view rests on a misreading of subsection (a)(6), which does not insulate Task Force

members from oversight in the way the Fifth Circuit believed. However, if the Court disagrees, the proper course would be to sever subsection (a)(6) rather than to hold the Task Force and its recommendations invalid. Any other result would have devastating consequences, given the many positive effects that the preventive services provision has had on public health, including for those who need healthcare most.

I. The Structure Of The Task Force Does Not Violate The Appointments Clause Because Task Force Members Serve As Inferior Officers Subordinate To The Secretary.

A. "'[W]hether one is an "inferior" officer depends on whether he has a superior' other than the President." *Arthrex*, 594 U.S. at 13 (quoting *Edmond v. United States,* 520 U.S. 651, 662 (1997)). In determining whether an officer has a "superior," the core inquiry is whether an officer's "work is directed and supervised at some level by other officers appointed by the President with the Senate's consent." *Free Enter. Fund v. Pub. Co. Acct. Oversight Bd.*, 561 U.S. 477, 510 (2010) (internal citation and quotation marks omitted).

"In particular," this Court has repeatedly emphasized, "'[t]he power to remove officers' at will and without cause 'is a powerful tool for control' of an inferior." *Ibid.* (quoting *Edmond*, 520 U.S. at 664); see also *Seila Law*, 591 U.S. at 224-225 (principal officers are "meaningfully controlled" by "the threat of removal" by the President). As a result, courts have generally categorized officers as inferior when they are removable at will by a principal officer.

In *Edmond*, for example, this Court held that judges sitting on the Coast Guard Court of Criminal Appeals were inferior officers in part because they could be removed "from [a] judicial assignment without cause." 520 U.S. at 664. Similarly, in *Free Enterprise Fund*, the Court had "no hesitation in concluding that" members of the Public Company Accounting Oversight Board were inferior officers after it concluded that the Security and Exchange Commission had "the power to remove Board members at will" because the "statutory restrictions on the Commission's power to remove Board members [were] unconstitutional and void." 561 U.S. at 510; see also *Free Enter. Fund v. Pub. Co. Acct. Oversight Bd.*, 537 F.3d 667, 707 (D.C. Cir. 2008) (Kavanaugh, J., dissenting) ("[I]f an executive officer is removable at will and is not the head of a department, the officer ordinarily may be considered inferior for purposes of the Appointments Clause.").

Indeed, following these precedents, the D.C. Circuit "confident[ly]" held that Copyright Royalty Judges were inferior officers, despite the fact that their decisions were not "directly reversible" by a principal officer. *Intercollegiate Broad. Sys., Inc. v. Copyright Royalty Bd.*, 684 F.3d 1332, 1340-1341 (D.C. Cir. 2012). The court emphasized that, the Librarian of Congress, a principal officer, had "unfettered removal power" and thus had "the direct ability to 'direct,' 'supervise,' and exert some 'control' over the Judges' decisions." *Ibid.* (quoting *Edmond*, 520 U.S. at 662-664)).

Here, Task Force members are removable at will by the HHS Secretary, as both the Fifth Circuit and the district court agreed. See Pet. App. 18a, 119a.

"Under the traditional default rule, removal is incident to the power of appointment." *Free Enter. Fund*, 561 U.S. at 509. Congress authorized the Secretary to appoint Task Force members by "acting through the Director" of the Agency for Healthcare Research and Quality (AHRQ), 42 U.S.C. 299(a), who convenes the Task Force. See also Reorganization Plan No. 3 of 1966, 80 Stat. 1610, § 1 (authorizing the Secretary to perform "all functions of all agencies of or in the Public Health Service," which includes the AHRQ). Applying the default rule, then, because the Secretary holds the power to appoint Task Force members, the Secretary also holds the corresponding power to remove them.

To be sure, Congress sometimes may limit a principal officer's removal power, such as by requiring "good cause" for an inferior officer's removal. See *Free Enter. Fund*, 561 U.S. at 483. But as both the Fifth Circuit and the district court recognized, Congress imposed no such restrictions on the Secretary's removal authority here. The statutory text is devoid of any protection for Task Force members; it neither specifies a term of years nor stipulates that members may be removed only for cause. The Secretary therefore may remove Task Force members at will. Cf. *Collins v. Yellen*, 594 U.S. 220, 250 (2021) ("[W]e generally presume that the President holds the power to remove at will executive officers and that a statute must contain 'plain language to take [that power] away.'" (quoting *Shurtleff v. United States*, 189 U.S. 311, 316 (1903))). The Secretary's unrestricted removal power provides powerful support for the view

that Task Force members are inferior officers, not principal officers.[1]

B. Multiple other statutory provisions also establish the Task Force members' inferior status. To begin, the statutory structure of the Department of Health and Human Services compels the conclusion that Task Force members' "work is directed and supervised at some level" by the Secretary. *Free Enter. Fund*, 561 U.S. at 510 (internal citation and quotation marks omitted). The Task Force is convened by the AHRQ, 42 U.S.C. § 299b-4(a), which is an agency within the Public Health Service, *id.* § 299(a). And the Public Health Service is an agency within the Department of Health of Human Services. *Id.* § 202. In establishing this structure, Congress instituted a clear statutory chain of command: "The Public Health Service in the Department of Health and Human Services shall be administered by the Assistant Secretary for Health under the supervision and direction of the Secretary." *Id.* § 202; see also Reorganization Plan No. 3 of 1966, 80 Stat. 1610 (authorizing the Secretary to perform "all functions of the Public Health Service . . . and of all other officers

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[1] The basic principle that the removal power is generally an effective means of controlling an executive officer likewise underpins decisions in related areas of this Court's caselaw. See, *e.g.*, *Seila Law*, 591 U.S. at 234 (restoring the President's at-will removal power over the director of an otherwise largely independent regulatory agency was sufficient to cure "[t]he only constitutional defect" in the agency's structure); *Bowsher v. Synar*, 478 U.S. 714, 726 (1986) ("Congress cannot reserve for itself the power of removal of an [executive] officer" because such removal power would "in practical terms, reserve in Congress control over the execution of the laws" in violation of separation of powers principles).

and employees of the Public Health Service, and all functions of all agencies of or in the Public Health Service"). Because the Task Force is convened by the AHRQ, and the AHRQ is an agency within the Public Health Service, the Task Force is "under the supervision and direction" of the Secretary. 42 U.S.C. § 202; see also *id.* § 299(a) (HHS Secretary "shall carry out" the "[m]ission and duties" of the AHRQ "acting through the Director").

The Fifth Circuit recognized that these statutory provisions were sufficient to vest the Secretary with authority to "exercise control" over the Health Resources and Services Administration (HRSA), including control over HRSA's guidelines (which are likewise binding on health insurers and plans). See Pet. App. 44a (agreeing that the Secretary can "exercise control over the guidelines [HRSA] publishes by virtue of the transfer of power in HHS's Reorganization Plan No. 3 of 1966"). And the Fifth Circuit did not doubt that the AHRQ is subject to the Secretary's control. But the Fifth Circuit nevertheless concluded that the Secretary lacks statutory authority to exercise control over the Task Force and its recommendations. Pet. App. 31a-32a. This was error.

The Fifth Circuit held that an exception in the Reorganization Plan for "functions vested by law in any advisory council, board, or committee of or in the Public Health Service," 80 Stat. 1610, § 1, applied to the Task Force. Pet. App. 31a-32a. But the Task Force is not an "advisory council, board, or committee" within that exception. Congress made this clear by specifically providing that "the Task Force is not subject to the provisions of" the Federal Advisory

Committee Act (FACA), which governs "committees, boards, commissions, councils, and similar groups which have been established to advise officers and agencies in the executive branch." 42 U.S.C. § 299b-4(a)(5) (Task Force); 5 U.S.C. § 1002(a) (FACA).

Other statutory provisions confirm that the Secretary exercises control over the work of the Task Force, including its recommendations. For example, the Secretary, acting through the AHRQ, can require the Task Force to consider certain recommendations. See 42 U.S.C. § 299b-4(a)(1) (stating that the Task Force's recommendations "*shall* consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality" and other entities controlled by the Secretary (emphasis added)). The Secretary also determines when new recommendations will become "effective" such that private insurers are required to cover them. *Id.* § 300gg-13(b)(1). That power means that, in the end, it is the Secretary's action, not the Task Force's, that binds insurers. These multiple overlapping statutory provisions together give the Secretary enough power over the Task Force to make its members inferior (and not principal) officers. See *Edmond*, 520 U.S. at 661 (noting that there is no "exclusive criterion for distinguishing between principal and inferior officers for Appointments Clause purposes").

As a practical matter, moreover, the Secretary, acting through the AHRQ, has used his statutory authority to exercise control over the Task Force and its recommendations. The AHRQ assigns a federal official to "oversee" every "topic team" organized within the Task Force; funds and administers contracts for the "evidence reviews [that] serve as the

scientific basis for USPSTF recommendations"; "review[s] and approve[s]" all "key questions . . . in the process of assessing and refining" each topic; "amend[s] and approve[s]" proposed lists of "peer reviewers"; helps "draft the recommendation statement"; "review[s] and approve[s]" the final evidence review prior to publication; and "propose[s] revisions" to the final recommendation statement. U.S. Preventive Services Task Force Procedure Manual 8-12, 19 (2021).

The Fifth Circuit dismissed these powers as inconsequential, Pet. App. 20a, but they are potent supervisory tools. For instance, the Secretary could postpone the effective date of no-cost coverage of a new recommendation while simultaneously requiring the Task Force to reevaluate that recommendation, presuming he otherwise acts in accordance with law in doing so. See 45 C.F.R. § 147.130(b)(1) (establishing effective date interval of one year); see also 5 U.S.C. § 706(2).[2] Likewise, the Secretary may remove Task Force members and replace them with new members with "appropriate expertise." 42 U.S.C. § 299b-4(a)(1). It is hard to see how the Secretary can be said to lack "supervision and direction" over the Task Force if he can appoint and remove its members at will, set its agenda, oversee its substantive research at nearly every step, and, at least under certain circumstances, suspend its recommendations from taking effect.

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[2] Amici States take no position on the procedures the Secretary may be required to use when approving or rejecting Task Force recommendations. See Pet. App. 45a-56a; U.S. Br. 9-10 & n.2.

C. The Fifth Circuit's contrary conclusion stems primarily from its view that a single provision, 42 U.S.C. § 299b-4(a)(6), fully insulates Task Force members from the Secretary's supervision, thus making them principal officers. Pet. App. 20a-26a. That subsection states:

> All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

The Fifth Circuit read this provision to grant the Task Force "complete autonomy." Pet. App. 20a. In its view, "the Task Force cannot be 'independent' and free from 'political pressure' on the one hand, and at the same time be supervised by the HHS Secretary, a political appointee, on the other." *Ibid.* That understanding of subsection (a)(6) is wrong for multiple reasons.

First, as discussed, multiple other provisions establish the Secretary's oversight of the Task Force. *Supra* pp. 8-11. Subsection (a)(6) must be read alongside these provisions, rather than as implicitly repealing them. See *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) ("It is a fundamental canon of statutory construction" that courts should interpret a statutory scheme to "fit, if possible, all parts into an harmonious whole." (internal quotation marks and citations omitted)). And where a statutory provision can reasonably be interpreted in a way that is "harmonious" with both the larger statutory design *and* the Constitution, this Court's precedent doubly supports that

interpretation. See *United States ex rel. Att'y Gen. v. Del. & Hudson Co.*, 213 U.S. 366, 408 (1909) ("[W]here a statute is susceptible to two constructions, by one of which grave and doubtful constitutional questions arise and by the other of which such questions are avoided, our duty is to adopt the latter.").

Given these principles, subsection (a)(6) is best read to direct Task Force members to use their objective, unbiased judgment to evaluate scientific evidence when developing their recommendations, and not to limit the Secretary's authority to supervise them. To begin, this reading of subsection (a)(6) accords with context: Task Force members are physicians, scientists, and public-health experts who have other professional and organizational ties, and subsection (a)(6) ensures they are exercising their own judgment rather than operating at the behest of external entities. The Task Force has carried out this directive by implementing extensive protocols regarding conflicts of interest. See U.S. Preventive Services Task Force Procedure Manual 2 (2021) (Task Force members "must have no substantial conflicts of interest, whether financial, professional, or intellectual, that would impair the scientific integrity of the work of the USPSTF and must be willing to complete regular conflict of interest disclosures.").

Moreover, nothing in the statutory text suggests that subsection (a)(6) was meant to shield the Task Force from internal supervision rather than from external pressure from outside interests. When Congress seeks to form entities that are truly "independent" in the sense that they are exempted from traditional principles of executive control, it does so expressly. For example, the statute establishing

the Consumer Financial Protection Bureau not only deems it "an independent bureau" within "the Federal Reserve System," 12 U.S.C. § 5491, but goes farther, setting out provisions establishing the "Autonomy of the Bureau." See, *e.g.*, 12 U.S.C. § 5492(c) (providing that, among other things, the Federal Reserve Board of Governors "may not . . . intervene in any matter or proceeding before the [CFPB Director]," and "may not . . . appoint, direct, or remove any officer or employee of the Bureau" or "approv[e] or review" any "rule or order of the Bureau"). Similarly, when creating the Office of the Comptroller of the Currency, an independent bureau located within the Department of the Treasury, Congress specifically set out provisions ensuring its independence, including prohibiting the Treasury Secretary from "delay[ing] or prevent[ing] the issuance of any rule or the promulgation of any regulation by the Comptroller." 12 U.S.C. § 1(b). Subsection (a)(6) imposes no such limitations on the Secretary.

The fact that Congress has labeled an entity or individual as "independent" does not automatically confer principal officer status. Cf. *Collins*, 594 U.S. at 249 ("[T]he term 'independent' does not necessarily connote independence from Presidential control, and we refuse to read that connotation into the Recovery Act."). Indeed, this Court "ha[d] no hesitation in concluding" that the Public Company Accounting Oversight Board members were inferior officers, despite the fact that they were "empowered to take significant enforcement actions . . . largely independently of the [Securities and Exchange] Commission." *Free Enter. Fund*, 561 U.S. at 504. And *Edmond* held that judges of the Coast Guard Court of

Criminal Appeals were inferior officers despite the fact that they had the authority to make independent decisions subject only to limited, deferential review by a higher court. 520 U.S. at 665 ("This limitation upon review . . . does not in our opinion render the judges of the Court of Criminal Appeals principal officers.").

Finally, although Congress provided that the Task Force's members and recommendations be "free from political pressure," it qualified that directive, explaining that the members and recommendations should be free from such pressure "to the extent practicable." 42 U.S.C. § 299b-4(a)(6). Congress's apparent view that some form of political pressure may be unavoidable is fully consistent with the structure established by the relevant statutes: one in which Task Force members are selected, overseen, and can be removed at will by the Secretary. *Supra* pp. 6-11. And Congress's inclusion of this qualifier provides yet another reason to decline to read subsection (a)(6) as precluding supervision by the Secretary: If such supervision is constitutionally necessary, as the Fifth Circuit believed, then the phrase "to the extent practicable" can be interpreted to allow it. This Court construes statutes to "avoid" rendering them "unconstitutional" if "there is another reasonable interpretation available." *Edmond*, 520 U.S. at 658. Here, it is easy to read subsection (a)(6), as explained, *supra* pp. 13-14, to reflect Congress's view that the Task Force's members and recommendations should be insulated from external pressure, not from internal oversight, especially given the qualifier that Congress placed on this provision.

* * *

In sum, Task Force members are inferior officers because they may be appointed and removed at will by the Secretary and because multiple statutory provisions establish the Secretary's supervision and direction of the Task Force and its recommendations. Subsection (a)(6) does not compel a contrary conclusion because that provision is best interpreted as addressing external pressure, not internal supervision. The Fifth Circuit's decision should be reversed.

II. If Subsection (a)(6) Renders Task Force Members Principal Officers, It Should Be Severed.

A. Even if this Court were to conclude that Task Force members are principal officers, nothing requires the Court to cast aside the no-cost insurance coverage requirements that millions of Americans rely upon. If the Task Force is unconstitutionally insulated from the Secretary's supervision, the Court's longstanding "remedial preference" is to hold unconstitutional and sever the sole provision that blocks that supervision—not to scrap the otherwise valid statutory design. *Barr v. Am. Ass'n of Pol. Consultants, Inc.*, 591 U.S. 610, 626 (2020) (opinion of Kavanaugh, J.).

This Court has repeatedly emphasized that "'when confronting a constitutional flaw in a statute, we try to limit the solution to the problem' by disregarding the 'problematic portions while leaving the remainder intact.'" *Arthrex*, 594 U.S. at 23 (plurality opinion of Roberts, C.J.) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328-329 (2006)). Whether this fundamental principle of judicial

restraint is viewed as a "strong presumption of severability," *Am. Ass'n of Pol. Consultants*, 591 U.S. at 625, or as a preference for a "tailored declaration of unconstitutionality," the guiding question is whether the remainder of the statutory scheme would be "incomplete or unworkable" absent the constitutionally flawed provision, *Arthrex*, 594 U.S. at 24-25. This Court has often invoked principles of severability in cases concerning constitutional challenges to the appointment and removal of executive branch officials. See*, e.g.*, *id.* at 25 (severing the statutory provision that prevented the Patent and Trademark Office from reviewing decisions of Administrative Patent Judges and concluding that the APJs were thus inferior officers); *Free Enter. Fund*, 561 U.S. at 508 (severing the for-cause removal protections of the Public Company Accounting Oversight Board and concluding that Board members were thus inferior officers); *Seila Law*, 591 U.S. at 234 (severing the for-cause removal protections of the CFPB director and concluding this was sufficient to cure "[t]he only constitutional defect" in the agency's structure).

Here, the sole "problematic" provision would be subsection (a)(6), which, as discussed, *supra* pp. 11-15, states that the Task Force's members and recommendations "shall be independent and, to the extent practicable, not subject to political pressure." 42 U.S.C. § 299b-4(a)(6). Severing this provision would "not result in an incomplete or unworkable statutory scheme." *Arthrex*, 594 U.S. at 25. To the contrary, it would merely subject the Task Force to the same degree of supervision and direction that the Secretary exercises over its sister entities, the

Advisory Committee on Immunization Practices (ACIP) and HRSA, which also issue recommendations and guidelines that private plans must cover. See Pet. App. 44a-45a (concluding that the Secretary "exercise[s] supervisory authority over ACIP and HRSA . . . that encompasses the prerogative to ratify their preventive-care recommendations and guidelines made pursuant to § 300gg-13(a)"). Further, nothing in the statutory scheme suggests that Congress "would have preferred no [Task Force] at all to a [Task Force] whose members" were subject to the Secretary's supervision and direction. *Free Enter. Fund*, 561 U.S. at 477. Indeed, Congress's inclusion of the qualifying phrase "to the extent practicable" underscores that Congress acknowledged that *some* form of "political pressure" may be permitted if it were impracticable to avoid it. The qualifying phrase removes any doubt over Congress's intentions to protect the Task Force rather than have it cast aside.

B. The Fifth Circuit did not disagree with these well-established principles. Rather, it declined to apply them because it questioned where the "Secretary's power to review the recommendations would derive once we decide to disregard the command of" subsection (a)(6). Pet. App. 31a. Specifically, the Fifth Circuit assumed that the Task Force fell under an exception to the Secretary's supervisory authority for "advisory" groups. *Ibid.* (citing Reorganization Plan No. 3 of 1996). As explained, however, that exception does not apply to the Task Force, and multiple statutory provisions authorize the Secretary to oversee its work. See *supra* pp. 8-11. The Fifth Circuit thus erred in reasoning

that severing subsection (a)(6) would not "*empower* the Secretary to" supervise the Task Force's recommendations, Pet. App. 31a (emphasis in original); rather, other statutory provisions already permit him to exercise such authority.

Respondents advance an alternative argument against severability, Br. in Support of Cert. 32-33, but it lacks merit. Respondents contend that severing subsection (a)(6) would not remedy the constitutional violation because, although the Secretary would be able to review the Task Force's recommendations, the Task Force would nonetheless retain the authority to "*not* adopt an 'A' or 'B' recommendation" in the first instance. *Id.* at 33. This ignores that the Secretary can remove Task Force members at will and require them to consider (or reconsider) any recommendation. *Supra* pp. 7, 10. Those are powerful tools of control over the Task Force. Regardless, any *inaction* that might be attributable to the Task Force is irrelevant to whether subsection (a)(6) may be severed because if Task Force members declined to adopt a recommendation, then they would not have "exercis[ed] significant authority pursuant to the laws of the United States," *Buckley*, 424 U.S. at 126, because insurers would be free to decide whether or not to cover the relevant preventive service, see 42 U.S.C. 300gg-13(a).

In sum, by severing subsection (a)(6), this Court would clarify that the Secretary's oversight of the Task Force is on equal footing with that of ACIP and HRSA. The Fifth Circuit recognized that the Secretary "can exercise supervisory authority over ACIP and HRSA," including "their preventive-care recommendations and guidelines made pursuant to

§ 300gg-13(a)." Pet. App. 45a. The same conclusion is appropriate here.

III. Enjoining Enforcement Of The Task Force's Recommendations Would Negatively Impact Public Health Outcomes.

The importance of the preventive services provision is further reason why the Court should, at a minimum, use "a scalpel rather than a bulldozer in curing [any] constitutional defect." *Seila Law*, 591 U.S. at 237 (plurality opinion of Roberts, C.J.). The preventive services provision has significantly improved public health outcomes throughout the country by expanding access to important and often life-saving care. An opinion holding the Task Force's recommendations unenforceable would put these advancements at risk, as health insurers and plans would be free to reinstate out-of-pocket fees for essential preventive care. And States will not be able to fill the significant gap in coverage that would result if this Court were to hold that the Task Force's recommendations are unenforceable, because federal law preempts States from regulating the health plans that cover many of their residents. The Court should thus "'limit the solution to the problem'" should it determine that there is a constitutional flaw in the statutory scheme. *Free Enter. Fund*, 561 U.S. at 508 (quoting *Ayotte*, 546 U.S. at 328).

A. The preventive services provision has significantly improved public health outcomes throughout the Nation. When the ACA was enacted, the medical community widely agreed that several leading causes of death in the United States were

largely avoidable.[3] Although the American healthcare system offers robust preventive care, such as cancer screenings and vaccinations, many Americans did not avail themselves of these critical services because the costs were significant and often prohibitive.[4] This was true even for people with insurance because many insurers either did not cover preventive services or they imposed significant out-of-pocket costs, like deductibles, copayments, and coinsurance, for those services.[5] These expenses deterred individuals of all backgrounds from accessing preventive care, but they particularly

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[3] See, *e.g.*, Jared B. Fox & Frederic E. Shaw, *Clinical Preventive Services Coverage and the Affordable Care Act*, 105(1) Am. J. Pub. Health 7, 7-8 (2015) (concluding based on 2010 data that 9 out of 10 leading causes of death were preventable); Mark Mather & Paola Scommegna, *Up to Half of U.S. Premature Deaths are Preventable; Behavioral Factors Key*, Population Reference Bureau (Sept. 14, 2015), https://tinyurl.com/mpmhtbmv (48% of deaths before age 80 were preventable in 2010); *Background: The Affordable Care Act's New Rules on Preventive Care*, Ctrs. for Medicare & Medicaid Servs. (July 14, 2010), https://tinyurl.com/mwhawnjr (many deaths due to chronic illnesses, which cause 70% of deaths in America, were preventable).

[4] Fox & Shaw, *supra* note 3, at 7; *Background: The Affordable Care Act's New Rules on Preventive Care*, *supra* note 4; Hope C. Norris et al., *Utilization Impact of Cost-Sharing Elimination for Preventive Care Services: A Rapid Review*, 79(2) Med. Care Rsch. & Rev. 175, 175 (2022); Laura Skopec & Jessica Banthin, *Free Preventive Services Improve Access to Care*, Urban Inst., 2 (July 2022), https://tinyurl.com/5ejun8ez; U.S. Preventive Servs. Task Force, *A & B Recommendations*, https://tinyurl.com/3hjfanj3.

[5] Sabrina Corlette, *A World Without the ACA's Preventive Services Protections: The Impact of the* Braidwood *Decision*, Georgetown Univ., Health Pol'y Inst. (Apr. 18, 2023), https://tinyurl.com/2p9xr6j2.

impacted marginalized and vulnerable communities, such as people of color, individuals living in poverty, and single parents.[6] By one estimate, more than 100,000 individuals lost their lives each year to conditions that could have been remediated by preventive care.[7]

Congress passed the preventive services provision to ensure that no other Americans would lose their lives for inability to access preventive services.[8] Within 4 years of the ACA's passage, approximately 76 million Americans gained expanded coverage to one or more preventive services.[9] This number has grown steadily: As of 2020, an estimated 151.6 million people are enrolled in private insurance plans that cover preventive services at no cost to patients.[10] And as Congress anticipated, when individuals do not face significant financial barriers to preventive

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[6] Danielle Kilchenstein et al., *Cost Barriers to Health Services in U.S. Adults Before and After the Implementation of the Affordable Care Act*, 14(2) Cureus 1, 12-14 (2022).

[7] *Background: The Affordable Care Act's New Rules on Preventive Care*, *supra* note 2; see also Michael V. Maciosek et al., *Greater Use of Preventive Services in U.S. Health Care Could Save Lives at Little or No Cost*, 29(9) Health Affs. 1656, 1659 (2010) (explaining that greater use of preventive services could prevent the loss of more than two million life-years annually).

[8] Norris, *supra* note 4, at 175-76.

[9] Amy Burke & Adelle Simmons, Off. of the Assistant Sec'y for Plan. & Evaluation, *Increased Coverage of Preventive Services With Zero Cost Sharing Under the Affordable Care Act* 1 (June 27, 2014), https://tinyurl.com/4h5yynnr.

[10] *Access to Preventive Services Without Cost-Sharing: Evidence from the Affordable Care Act*, Off. of the Assistant Sec'y for Plan. & Evaluation, 3 (Jan. 11, 2022), https://tinyurl.com/5a8bducj.

services, they use those services.[11] Numerous studies confirm that, after the preventive services provision was enacted, the use of preventive care—such as routine examinations, blood pressure checks, and cholesterol screenings—increased across the board.[12]

These services improve public health outcomes by enabling medical professionals to identify and treat illnesses earlier, and, in some cases, prevent them.[13] For instance, colorectal cancer—the second leading cause of cancer fatalities in America—is considered largely preventable with screening, which allows doctors to identify and then remove cancerous pregrowths.[14] At the time the ACA was enacted, however, a colorectal cancer screening could cost patients $1,600 out of pocket, which was often financially prohibitive, and the number of colorectal

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[11] Norris, *supra* note 4, at 192.

[12] Xuesong Han et al., *Has Recommended Preventive Service Use Increased After Elimination of Cost-Sharing as Part of the Affordable Care Act in the United States?*, 78 Preventive Med. 85, 90-91 (2015); Josephine S. Lau et al., *Improvement in Preventive Care of Young Adults After the Affordable Care Act*, 168(12) JAMA Ped. 1101, 1105 (2014) (finding a significant increase in routine examinations, blood pressure and cholesterol screenings, and dental visits by young adults following no-cost coverage).

[13] *Preventive Services Covered by Private Health Plans Under the Affordable Care Act*, Kaiser Fam. Found. (May 15, 2023), https://tinyurl.com/3tka45ff.

[14] *Access to Preventive Services Without Cost-Sharing: Evidence from the Affordable Care Act, supra* note 10, at 7-8; Michelle R. Xu et al., *Impact of the Affordable Care Act on Colorectal Cancer Outcomes: A Systematic Review*, 58(4) Am. J. Prev. Med. 1, 2 (2020) (screening for colorectal cancer can decrease incidence and mortality by 30 to 60%).

screenings was declining.[15] But when this financial barrier was removed following the Task Force's recommendation—and the Secretary's decision to make that recommendation effective one year later, see 26 C.F.R. § 54.9815-2713(b)(1)—colorectal cancer screening rates increased for many populations.[16] As predicted, this increase in screening has been associated with decreased incidence of colorectal cancer, as well as resulting deaths.[17]

The preventive services provision has had a particularly notable impact on populations traditionally underserved by the healthcare system. Studies show that those with socioeconomic disadvantages have benefited the most from this provision, as the coverage has increased the likelihood they will receive preventive care and thereby reduced disparities in access to healthcare.[18] For instance, community health centers, which serve

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[15] Djenaba A. Joseph et al., *Prevalence of Colorectal Cancer Screening Among Adults—Behavioral Risk Factor Surveillance System, United States, 2010*, Ctrs. for Disease Control & Prevention ("CDC") (June 15, 2012), https://tinyurl.com/nv5kt994.

[16] Xu et al., *supra* note 14, at 6.

[17] *Access to Preventive Services Without Cost-Sharing: Evidence from the Affordable Care Act*, *supra* note 10, at 8. The number of lives saved is likely to increase, as the Task Force recently updated its recommendation to require insurers to also cover certain follow-up tests for colorectal cancer. *FAQs About Affordable Care Implementation Part 51*, Dep't of Labor 12 (Jan. 10, 2022), https://tinyurl.com/282nxzk2.

[18] Norris, *supra* note 4, at 192, 194; Gregory S. Cooper et al., *Cancer Preventive Services, Socioeconomic Status, and the Affordable Care Act*, 123(9) Cancer 1585, 1588 (Jan. 9, 2017).

individuals with limited financial means, received increasing visits for a variety of screenings and treatments after the ACA, including the preventive services provision, became effective.[19] Women, too, have benefited from the preventive services coverage requirements. Before the ACA, many insurers charged women higher rates and excluded numerous women's health services from coverage.[20] After the ACA, the Task Force recommended no-cost coverage for services specific to women's health such as mammograms, gestational diabetes tests, and cervical cancer screenings.[21] And no-cost coverage has also reduced racial and ethnic disparities in accessing health care by expanding access to a variety of preventive services.[22] For example, Hispanic and Black women have the highest rates of cervical cancer in the general population, and they increased their use of cervical cancer screenings following the enactment of the preventive services provision.[23]

In addition to improving health outcomes for specific individuals, the preventive services provision promotes the public health more broadly by reducing

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[19] Nathalie Huguet et al., *Cervical and Colorectal Cancer Screening Prevalence Before and After Affordable Care Act Medicaid Expansion*, 124 Prev. Med. J. 91, 96 (2019).

[20] Munira Z. Gunja et al., *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care*, The Commonwealth Fund (Aug. 10, 2017), https://tinyurl.com/cfazjvw9.

[21] U.S. Preventive Servs. Task Force, *supra* note 4.

[22] *Access to Preventive Services Without Cost-Sharing: Evidence from the Affordable Care Act*, *supra* note 10, at 7.

[23] Huguet, *supra* note 19.

the spread of diseases. As one example, the United States recently faced an increase in cases of active tuberculosis, a highly contagious disease that is spread by coughing and sneezing.[24] The Task Force reaffirmed its recommendation that at-risk individuals receive testing for "latent" tuberculosis, which, if untreated, can develop into an active infection that rapidly spreads to others.[25] By removing cost barriers to such testing, the preventive services provision promoted one of the most effective means of controlling tuberculosis outbreaks. Without no-cost coverage, however, testing rates could drop and infection rates may grow.

In short, the preventive services provision improves healthcare outcomes, reduces healthcare disparities, and saves lives.

B. If the preventative services provision cannot be enforced, States will face significant obstacles in ensuring their residents' access to such services. The States' authority to act on their own to ensure access to no-cost preventive care is constrained by the Employee Retirement Income Security Act of 1974 (ERISA), which limits the ways in which States can regulate employer-sponsored health plans. 29 U.S.C. §§ 1003(a), 1144(a), 1144(b)(2)(A). As a result, a ruling prohibiting the federal government from

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[24] Aria Bendix, *Why Tuberculosis Cases Have Risen In Recent Years After Decades Of Decline*, NBC News (May 2, 2023), https://www.nbcnews.com/health/health-news/why-tuberculosis-cases-rose-after-decades-decline-rcna82288.

[25] *Ibid.*

implementing the preventive services provision would leave significant gaps in coverage.

Employer-sponsored health plans are generally structured in one of two ways. The first is a "fully insured" plan, in which the employer purchases an insurance contract to cover risks associated with its employee health plan.[26] The second is a "self-funded" plan, in which the employer uses its own funds to cover such costs directly.[27] Self-funded plans are increasingly common for a variety of reasons. For instance, many employers choose these plans because they prefer paying for actual bills presented by employees rather than pre-paying large premiums to insurance carriers.[28]

ERISA preempts the States from directly regulating self-funded employer health plans. 29 U.S.C. §§ 1003(a), 1144(a), 1144(b)(2)(A); see *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (States cannot directly regulate "self-funded employee benefit plans" under ERISA). Accordingly, if the preventive services provision cannot be enforced, States would not be able to respond by enacting similar mandates to protect their residents enrolled in self-funded plans. And there are many such residents: In 2023,

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[26] Paul Fronstin, *Trends in Self-Insured Health Plans Since the ACA*, Emp. Benefit Rsh. Inst. (Sept. 30, 2021), https://tinyurl.com/23cz42ph.

[27] *Ibid.*

[28] *What Is Self Funding?*, Health Care Adm'rs Ass'n, https://tinyurl.com/2zfnsbkz.

65% of employees with employer-sponsored coverage were enrolled in self-funded plans.[29]

In the absence of a federal preventive services mandate, then, it would be up to employers with self-funded plans to decide whether to continue to fully cover preventive services. As explained, before the ACA, many employer-sponsored plans did not fully cover preventive care despite the medical consensus regarding the benefits of such care. See *supra* p. 20-21; see also *Skyline Wesleyan Church v. Cal. Dep't of Managed Health Care*, 968 F.3d 738, 750 (9th Cir. 2020) (that insurers offered restricted coverage before California imposed coverage requirements was "strong evidence" that insurers would revert to original plans absent state regulation). Without a mandate, employers with self-funded plans are likely to revert to their prior practice, especially as to the more expensive preventive services. This will result in a patchwork of coverage with many people left without access to preventive care. Experience teaches that these gaps in covered care will be felt most strongly by those least able to afford services,[30] including historically disadvantaged communities and individuals living in poverty, as they took particular advantage of preventive care following the ACA's enactment, see *supra* pp. 22-25.[31]

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[29] *2023 Employer Health Benefits Survey, Sec. 10: Plan Funding*, Kaiser Fam. Found. (Oct. 18, 2023), https://tinyurl.com/538n42zm.

[30] Skopec & Banthin, *supra* note 4, at 3.

[31] *Corlette*, *supra* note 5.

In sum, the preventive services provision has been critically important to improving public health throughout the Nation. Thus, if this Court were to hold that the structure set up by Congress is unconstitutional, the Court should sever the provision that the Fifth Circuit held limits the Secretary's control over the Task Force.

CONCLUSION

The decision below should be reversed.

Respectfully submitted,

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