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 AMERICAN HOSPITAL ASSOCIATION, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, FEDERATION OF AMERICAN HOSPITALS, AMERICA'S ESSENTIAL HOSPITALS, AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS *AMICI CURIAE* SUPPORTING PETITIONERS

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INTEREST OF *AMICI CURIAE*[1]

The American Hospital Association, the Catholic Health Association of the United States, the Federation of American Hospitals, America's Essential Hospitals, and the Association of American Medical Colleges respectfully submit this brief as *amici curiae*.

The American Hospital Association represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. AHA members are committed to improving the health of the communities they serve and to helping ensure that care is available to and affordable for all Americans. AHA educates its members on healthcare issues and advocates on their behalf so that their perspectives are considered in formulating health policy.

The Catholic Health Association is the national leadership organization for the Catholic health ministry. Comprised of more than 650 hospitals and 1,600 long-term care and other health facilities in all fifty States, CHA works to advance the ministry's commitment to a just, compassionate healthcare system that protects life and advocates for a healthcare system that is available and accessible to everyone, paying special attention to underserved populations.

The Federation of American Hospitals is the national representative of more than 1,000 tax-paying community

1. No counsel for any party authored this brief in whole or in part and no entity or person, aside from *amici curiae*, their members, or their counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

America's Essential Hospitals is dedicated to equitable, high-quality care for all people, including those who face social and financial barriers to care. Consistent with this safety net mission, the association's more than 335 members provide a disproportionate share of the nation's uncompensated care, with three-quarters of their patients uninsured or covered by Medicare or Medicaid. Essential Hospitals reach outside their walls to help communities overcome social drivers of poor health, including poverty, homelessness, and food insecurity.

The Association of American Medical Colleges is a nonprofit association dedicated to improving the health of people everywhere through medical education, healthcare, medical research, and community collaborations. Its members include all 159 U.S. medical schools accredited by the Liaison Committee on Medical Education; approximately 400 teaching hospitals and health systems; and more than 70 academic societies.

Amici and their member-hospitals know better than anyone that preventive healthcare services are essential for the early diagnosis and treatment of life-threatening illnesses for millions of Americans. *Amici* write to offer

guidance, from hospitals' perspectives, on the harmful impact that upholding the Fifth Circuit's decision would have on the American healthcare system and all who depend on it.

INTRODUCTION AND SUMMARY OF ARGUMENT

For more than a decade, federal law has guaranteed that patients have access to certain preventive-care services without out-of-pocket costs like co-insurance, deductibles, and co-payments. By requiring insurers to provide cost-free access to these preventive-care services, the Affordable Care Act enables the timely diagnosis and treatment of many physical and mental health conditions. These early interventions have improved the quality and longevity of life for millions of Americans.

The Fifth Circuit's decision puts access to these preventive services in danger. In holding that the United States Preventive Services Task Force's structure violates the Appointments Clause, the court of appeals threatened the Task Force's ability to provide evidence-based recommendations and opened the door for patients to again bear the costs of certain types of preventive-care services. Patients who relied on the promise of preventive care without out-of-pocket costs for a variety of lifesaving interventions and screenings may now need to bear those costs themselves.

Realistically, this means that patients will not seek out essential preventive care or adhere to preventive medications after they are prescribed. Cost often drives whether a person will obtain health care. Many studies

have shown that cost-sharing, even at modest amounts, deters patients from receiving the preventive services. *E.g.*, Shameek Rakshit et al., *How Does Cost Affect Access to Healthcare?* (Jan. 30, 2023), *at* https://tinyurl.com/2jwtafb8 ("[F]our in ten adults (43%) report that they or a family member in their household put off or postponed needed healthcare due to cost. . . . While most adults in the U.S. have health insurance, cost-sharing can place financial burdens on enrollees, contribute to debt, and render care unaffordable."); Laura Skopec & Jessica Banthin, *Free Preventive Services Improve Access to Care* 2 (July 2022) ("Because preventive care services do not address acute health problems, some people may skip such care if cost sharing is required."). If forced to pay, many patients will forgo these preventive services, even if it will worsen their health and ultimately increase the costs of treatment down the line. Access to preventive care without cost-sharing removed these barriers and thus expanded access to a range of care.

For example, the Task Force recommended colorectal cancer screenings starting at age 45. These screenings greatly reduce the mortality rates associated with colorectal cancer, so reimposing financial barriers will likely have a severe impact on those who are at risk of developing intestinal or rectal cancer. Similarly, the Fifth Circuit's decision could put life-saving cardiovascular medications out of reach for many Americans. Knowing that cardiovascular disease is the leading cause of death in the United States, the Task Force reviewed more than twenty evidence-based studies on the effectiveness of statins. Based on that systematic analysis, the Task Force recommended statins for at-risk adults 40-75 years old, enabling cost-free access to these drugs. Reinstating

financial barriers will increase the chance that at-risk patients will not receive this necessary preventive care, leading to more heart attacks and strokes. The list of endangered cost-free preventive services for adults and children could go on and on.

This Court should reverse the Fifth Circuit's Appointments Clause finding and hold that Congress may validly promote independent Task Force recommendations. This disinterested role is critical for ensuring that patients receive care based on medical evidence, rather than political pressure. If, however, the Court agrees with the court of appeals' Appointments Clause holding, it should sever the unconstitutional statutory language. As explained below in Section III, the Court may perform this excision in one of two ways: 1) it can sever 42 U.S.C. § 299b-4(a)(6) in its entirety; or 2) it can simply cut two words ("independent and") from that provision. *Amici* respectfully submit that the two-word excision is more consistent with legislative intent because it preserves Congress' desire for evidence-based preventive service recommendations unless countervailing political considerations require the Secretary to reject them through his "supervision and direction" of the Task Force. 42 U.S.C. § 202. Regardless of the chosen route, however, this Court should follow its normal and required practice of severing the offending provisions so that the Task Force can continue to make high-quality, evidence-based preventive care recommendations.

ARGUMENT

I. Preventive-Care Services Save Lives, Improve Health, and Reduce Healthcare Costs.

Preventive medical services are vital to the health and well-being of patients and communities. These services "can help people avoid acute illness, identify and treat chronic conditions, prevent cancer or lead to earlier detection, and improve health." Office of the Assistant Secretary for Planning and Evaluation, *Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act* (Washington: U.S. Department of Health and Human Services, 2022), *at* https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf. To expand access to these services, Congress required private insurance plans to cover certain preventive services without imposing co-payments, co-insurance, deductibles, or other cost-sharing obligations. *See* 42 U.S.C. § 300gg-13. Less well known than the ACA's other "interlocking reforms," *King v. Burwell*, 576 U.S. 473, 478 (2015), the expansion of preventive care services was nonetheless important to Congress's goal of "increase[ing] the number of Americans covered by health insurance and decreas[ing] the cost of health care," *National Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 519 (2012).

These preventive service reforms have been successful. According to the most recent data, more than 150 million people—and more than 37 million children—now have access to preventive services without cost barriers. *See Access to Preventive Services without Cost-Sharing*, *supra*, at 1. But it is not just *access to* these services.

Patients are *actually using* these services at a greater rate. Since the preventive services provisions took effect in 2010, studies have shown increases in the use of a range of services, including colorectal cancer screenings, blood pressure screenings, and cholesterol screenings. *See* Laura Skopec & Jessica Banthin, *Free Preventive Services Improve Access to Care* 2 (July 2022). Most important, estimates show that an increased uptake of recommended preventive services could save over 100,000 additional lives every year. Jared B. Fox & Frederic E. Shaw, *Clinical Preventive Services Coverage and the Affordable Care Act*, 105 Am. J. Pub. Health 7 (Jan. 2015), *at* https://tinyurl.com/35cd7pry; *see also* Farley TA, Dalal MA, Mostashari F, Frieden TR. Deaths Preventable in the U.S. by Improvements in Use of Clinical Preventive Services., 38 Am. J. Prev. 600 (2010).

The ACA's preventive services provisions also benefit the public as a whole by lowering healthcare costs for patients, providers, and insurers, leading to a more affordable healthcare system for all. "Research has shown that evidence-based preventive services . . . are cost-effective," because they allow treatment "before [illnesses] develop into more complicated, debilitating conditions." *See Kaiser Family Foundation, Preventive Services Covered by Private Health Plans Under the ACA* 1 (Feb. 2023). This should come as no surprise. After all, as one Founding Father famously put it: "an ounce of prevention is worth a pound of cure." Benjamin Franklin, *On Protection of Towns From Fire* (Feb. 4, 1735), *at* https://founders.archives.gov/documents/Franklin/01-02-02-0002.

The Fifth Circuit's decision impedes access to these vital preventive services. If upheld, millions of patients

may have to pay out-of-pocket or be subject to cost-sharing for many of these treatments, including screenings for lung cancer, screenings for adolescent drug use, medications to lower the risk of breast cancer, and Hepatitis B and C screenings. *See* KFF, *Preventive Services Tracker* (June 22, 2023), *at* https://tinyurl.com/msz9rdky; Larry Levitt et al., *Q&A: Implications of the Ruling on the ACA's Preventive Services Requirement* (Apr. 4, 2023), *available at* https://tinyurl.com/28b2rahx. The cumulative societal impact of reimposing cost barriers to these services will be monumental, leading to undiagnosed diseases, shorter lifespans, and higher healthcare spending for everyone.

This Court should preserve the Task Force's role in providing evidence-based recommendations for preventive services. As the four examples discussed below demonstrate, these services are essential to detecting and treating life-threatening conditions for every segment of the population.

1. The Task Force recommends screening for colorectal cancer in adults ages 45-75. Colorectal cancer screenings decrease the mortality rate associated with colorectal cancer, which is the third leading cause of cancer death for men and women. *See* US Preventive Servs. Task Force, *Screening for Colorectal Cancer*, 325 J. Am. Med. Ass'n 1965, 1966 (May 11, 2021); *see also* CDC, *Colorectal Cancer Screening Tests* (Feb. 23, 2023), *at* https://tinyurl.com/fp24tjn5. According to estimates, every 1,000 screenings of adults aged 45 to 75 years will save 286 to 337 life-years, avert 42 to 61 colorectal cancer cases, and prevent 24 to 28 colorectal cancer deaths each year. *Screening for Colorectal Cancer*, *supra*, at 1972. The Task Force in May 2021 recommended that colorectal

cancer screening start at age 45 instead of 50, making approximately an additional 15 million Americans eligible to benefit from the preventive-care requirement. Off. of Assistant Sec'y for Plan. & Evaluation, Dep't of Health & Hum. Servs., *Access to Preventive Services Without Cost-Sharing: Evidence from the Affordable Care Act* 8 (Jan. 2022), *at* https://tinyurl.com/43pcrwnd. If all 15 million received their recommended screenings, at least *360,000* unnecessary deaths would be avoided. The elimination of cost-free coverage of colorectal screenings for adults aged 45 to 49 will therefore have a substantial impact on patient health, as 45-to-49-year-olds have seen a 15% increase in colorectal cancer rates over the past 20 years. *Screening for Colorectal Cancer*, *supra*, at 1972.

2. In addition to providing screenings like those discussed above, the ACA's preventive-care coverage requirement ensures access to life-saving medications. Cardiovascular disease is the leading cause of death in the United States, responsible for 1 in 4 deaths. *See* U.S. Preventive Servs. Taskforce, *Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: US Preventive Services Task Force Recommendation Statement*, 328 J. Am. Med. Ass'n 746 (2022). In light of these terrible statistics, the Task Force commissioned a systematic review of the evidence on the benefits and harms of statins in reducing mortality, including a review of 22 trials that reported on the benefits of statin use for primary prevention. Based on this review, the Task Force concluded that, for those at increased risk of cardiovascular disease, statins effectively reduce heart attacks and strokes—including death from these events. The Task Force therefore recommended statins for at-risk adults 40-75 years old, enabling cost-free access to

these drugs. *Id.* This expert recommendation is especially important because greater out-of-pocket costs for statin medications have been associated with fewer prescriptions filled by patients and reductions in statin adherence. *See*, *e.g.*, Watanabe JH, Kazerooni R, Bounthavong M. *Association of copayment with likelihood and level of adherence in new users of statins: a retrospective cohort study*, 20 J. Manag Care Pharm. 43 (2014).

3. The Task Force also recommends certain interventions and screenings for pregnant women, many of whom face unique health risks during pregnancy. These preventive-care services promote positive maternal and infant health outcomes by identifying potential problems during the early stages of pregnancy and providing support and guidance until and after childbirth.

For instance, early interventions can help to prevent or mitigate perinatal depression. This condition—which has become increasingly common in recent years—affects *one in seven* women in the United States, with some estimates showing rates as high as 37% during the first year postpartum. *See* US Preventive Servs. Task Force, *Interventions to Prevent Perinatal Depression*, 321 (6) J. Am. Med. Ass'n 580, 584 (Feb. 12, 2019). If left untreated, perinatal depression can have lifelong, adverse effects on the health of the mother *and* her child. *See id.* at 580. For example, perinatal depression is linked to an increased risk of preterm birth, small-for-gestational-age newborns, and low birth weight. *Id.* What's more, children of mothers who had perinatal depression demonstrate more behavioral problems, lower cognitive functioning, and increased risk of developing psychiatric disorders. *Id.*

In 2019, the Task Force recommended that clinicians identify at-risk pregnant and postpartum women and refer them to counseling interventions. *Id.* The Task Force defined the at-risk population as women who (1) are less than one year postpartum, (2) do not have a current diagnosis of depression, and (3) face an increased risk of developing depression. *Id.* at 582. Based on its review of clinical trials and peer-reviewed studies and publications, the Task Force found "convincing evidence" that counseling interventions were effective in preventing perinatal depression. *Id.* at 580.

Reducing cost barriers is particularly important for preventing and treating perinatal depression. Without early interventions and counseling, many mothers may not know that they are at risk of perinatal depression or even know the symptoms of the condition. Janice H. Goodman, *Women's Attitudes, Preferences, and Perceived Barriers to Treatment for Perinatal Depression*, 36 (1) Birth 60, 61, 67 (Mar. 2009); Donna Moore et al., *A Thematic Analysis of Stigma and Disclosure for Perinatal Depression on an Online Forum*, 3 J. Med. Internet Rsch. Mental Health 18 (2016). Removing financial barriers increases access to these services, especially for low-income patients who face a higher risk of developing perinatal depression and who are less likely to seek out preventive services due to cost. *See infra* at 3-4. The Fifth Circuit's decision puts all of this at risk, subjecting pregnant women and new mothers to cost-sharing for healthcare services that are critical to them *and* their growing families.

4. The Fifth Circuit's decision also will remove the guarantee of cost-free preventive services for children.

These services include cost-free vision screening for 3-to-5 year-olds. The Task Force found that "[o]ne of the most important causes of vision abnormalities in children is amblyopia (also known as "lazy eye"), *i.e.*, an alteration in the visual neural pathway in a child's developing brain that can lead to permanent vision loss in the affected eye." US Preventive Servs. Task Force, *Interventions to Prevent Perinatal Depression*, 318 J. Am. Med. Ass'n 836, 836 (2019). The medical evidence shows that untreated amblyopia results in uncorrectable vision loss, and the benefits of screening and treatment potentially can be experienced over a child's lifetime. *See id.* For example, early detection and screening reduces short- and long-term physical and psychological harms, including accidents and injuries, poor visual motor skills, adult depression and anxiety, and problems at school and work. *See id.* The Task Force further found that vision screening tools are accurate in detecting vision abnormalities. *See id.* Accordingly, the Task Force recommended that 3-to-5 year-old children receive cost-free vision testing. While not as momentous as cancer screening or statin medications, this example nevertheless reveals the ways in which the Task Force's focus on hard medical evidence improves the lives of all patients—including our youngest ones.

As these examples demonstrate, the Task Force's recommendations and the ACA's preventive-care coverage provisions protect the lives and improve the health of men, women, and children. To preserve access to these services and the Task Force's role in making evidence-based recommendations about them, this Court should reverse the court of appeals.

II. Preventive-Care Recommendations Should Be Based on Medical Evidence, Not Political Pressure.

The Fifth Circuit's decision will harm patients and communities because it thwarts Congress' goal that Task Force recommendations be evidence-based and not subject to undue political pressure.

1. "The Task Force was established in 1984, under the Reagan administration, as an independent, nonpartisan, expert panel that seeks to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications." Kirsten Bibbins-Domingo, Testimony for the House Energy and Commerce Health Subcommittee Hearing "Examining the US Preventive Services Task Force" (Nov. 30, 2016), *at* https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/reports-congress. Later formally codified into law, *see* Healthcare Research and Quality Act of 1999, Pub. L. No. 106-129, sec. 2(a), § 915(a)(1), 113 Stat. 1659, the Task Force is composed of 16 independent clinicians who serve four-year terms, *see* U.S. Preventive Service Task Force, Celebrating 40 Years of Prevention Guidance, *at* https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/40th-anniversary-timeline. The Task Force's member-clinicians are experts in prevention and evidence-based medicine. *See* Barron H. Lerner & Graham Curtiss-Rowlands, *Evidence over Politics—The U.S. Preventive Services Task Force*, 388 N.E. J. Med. 1, 3 (Jan. 5, 2023).

"The defining characteristic of the U.S. Preventive Services Task Force is its process for developing rigorously evidence-based prevention guidelines."

Alex H. Krist, et al., *Evolution of the U.S. Preventive Services Task Force's Methods*, 58 Am. J Prev. Med. 332, 332 (2019). This evidence-based approach is built into the law itself. To ensure that patients receive evidence-based care, 42 U.S.C. § 299b-4(a)(1) provides that the Task Force "review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations." And consistent with this goal of evidence-based recommendations, the law further provides that the Task Force should be "independent and, to the extent practicable, not subject to political pressure." *Id.* § 299b-4(a)(6). Precisely because the Task Force's "recommendations reflect the state of the science for clinical preventive services[,] . . . [c]linicians, patients, and policymakers trust the USPSTF's recommendations." *Evolution of the U.S. Preventive Services Task Force's Methods*, *supra*, at 332.

The Task Force's insulation from outside pressures allows it to make recommendations based purely on the data, rather than non-medical factors—such as partisan ideology, interest-group lobbying, or drug- or-insurance-company influence—that are not necessarily in the best interest of the patient. The Task Force members must abide by strict conflict-of-interest rules to ensure that recommendations are not influenced by a member's commercial or institutional considerations. *See* US Preventive Servs. Task Force, *Standards for Guideline Development* (May 2021), *at* https://tinyurl.com/5n77buap. Before making a recommendation, moreover, the Task Force undertakes a rigorous assessment process that

includes analyzing "high-quality evidence (such as data from meta-analyses and randomized, controlled trials)," as well as "studies that may be more prone to bias." *Id.* at 4. In addition, the Task Force consults external stakeholders, including "scientific and clinical experts, health care and specialty organizations, and federal health agencies" when developing its recommendations. US Preventive Servs. Task Force, *Standards for Guideline Development* (May 2021), *at* https://tinyurl.com/5n77buap. "This approach systematically considers the evidence as a whole, limits the risk of bias when considering the evidence, does not rely on professional opinion when evidence is lacking, is not influenced by financial interests or conflict of interest, and seeks external review from other experts and the public—all best practices advocated for by the National Academy of Medicine in their report on trustworthy guidelines." *Evolution of the U.S. Preventive Services Task Force's Methods*, *supra*, at 332.

Alongside its focus on the evidence, the Task Force prioritizes public engagement and transparency. Shortly after the ACA was enacted, the Task Force started publishing consumer fact sheets for the public that described the Task Force's draft and final recommendations of newly recommended preventive services. US Preventive Servs. Task Force, *Policy Manual § 9, Engagement With the Public, Stakeholders, and Partners* (July 2017). The Task Force also submits annual reports to Congress. *See* U.S. Preventive Services Task Force, Reports to Congress, *at* https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/reports-congress. And it solicits input from the public. Through the Task Force's website, any member of the public can nominate new members to serve on the Task Force, suggest new services for the Task

Force to consider in future recommendations, and provide comments on draft research plans, evidence reviews, and recommendation statements. *Id.* Thus, while the Task Force may be data-driven and evidence-based, it is by no means isolated or free from public accountability.

Ultimately, the Task Force's evidence-based approach benefits the public in two important ways. *First*, it increases public trust in preventive medicine. Patients, providers, and communities will pursue preventive services like colorectal cancer screenings and statin medications—that is, treatments *before* someone is actually sick—only when they believe these treatments will actually help prevent illness down the road. A trustworthy, evidence-based approach increases public uptake in important preventive services. *See Evolution of the U.S. Preventive Services Task Force's Methods*, *supra*, at 332 ("Consumers of preventive service guidelines need to know concretely what is known and unknown, and they need confidence that what is being recommended is not influenced by economic or political pressures or by professional opinion with a limited evidence basis.").

Second, and more fundamentally, an evidence-based approach to preventive medicine actually improves health and reduces healthcare costs. The Task Force's "A, B, and C grades all indicate that *the science* gives [the Task Force] moderate to high certainty that this preventive service is likely to yield *net health benefits*. Kirsten Bibbins-Domingo, Testimony for the House Energy and Commerce Health Subcommittee Hearing "Examining the US Preventive Services Task Force" (Nov. 30, 2016) (emphasis added), *at* https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/

reports-congress. At the same time, the Task Force's D grades indicate that "on balance, when one considers both the benefits and the harms, *the evidence* tells us that a patient is not likely to benefit overall from the service or may even be harmed." *Id.* (emphasis added). Finally, the Task Force offers an I grade where there is "insufficient evidence," and then it makes "a clear call to the scientific community about the need for more research." *Id.* In this way, the Task Force's reliance on *actual evidence* of health benefits, risks, or lack of sufficient knowledge—rather than economic or political influence—increases the likelihood of positive health outcomes and decreases the use of unnecessary services that increase healthcare costs with no corresponding health improvements.

III. Section 299b-4(a)(6) Can Be Severed, Either In Whole Or In Part, To Cure Any Purported Constitutional Defect.

The importance of preserving the Task Force's ability to make evidence-based recommendations is crystal clear. Others have explained why the current legal regime does not violate the Constitution. *Amici* focus instead on what this Court should do if it were to find an Appointments Clause violation.

Put simply, this Court should follow the "'normal'" and "'required'" course by severing only the portions of the statute that give rise to the constitutional defect. *United States v. Arthrex*, 594 U.S. 1, 24 (2021) (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)). Here, the Court has two options: it could either sever 42 U.S.C. § 299b-4(a)(6) in its entirety or simply strike two words ("independent and") from that provision: "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." Both options would cure the constitutional defect, fulfill Congress' intent, and satisfy the bedrock principle that courts must "try not to nullify more of a legislature's work than is necessary." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006).

A. This Court Can Sever Section 299B-4(A)(6) In Its Entirety To Correct Any Constitutional Flaws

Striking 42 U.S.C. § 299b-4(a)(6) in its entirety would easily cure any constitutional ills. Notably, the Fifth Circuit itself appeared to reach this conclusion, explaining that excising the entire provision would eliminate any unconstitutional independence. Pet. App. 31a ("If we were to 'sever' § 299b-4(a)(6), we would indeed have no reason to ensure that the Task Force remained 'independent' and not 'subject to political pressure,' as that provision requires."). The Fifth Circuit also explained that eliminating Task Force independence and providing for Secretarial review of Task Force recommendations "would not conflict with any other applicable statutory provision." *Id.* In its view, however, the only thing standing in the way of severance was the absence of a statutory provision that affirmatively "empower[ed] the Secretary to begin reviewing, and possibly rejecting, the Task Force's recommendations." Pet. App. 31a.

The Fifth Circuit was wrong to conclude that Congress failed to affirmatively authorize the Secretary to review Task Force recommendations in the absence of

42 U.S.C. § 299b-4(a)(6). The Acting Solicitor General has persuasively described why this conclusion was incorrect under *Arthrex* and based on factual misunderstandings of HHS's Reorganization Plan No. 3 of 1966, 80 Stat. 1610. *See* Br. for the Petrs.' at 39-44. As in *Arthrex*, the Secretary's background statutory authority to "supervise[] and direct[]" the Public Health Service sufficiently allows the Secretary to review Task Force recommendations once § 299b-4(a)(6) is excised from the statute. *See id.* at 42 (quoting 42 U.S.C. § 202).

Amici need not repeat those arguments. Instead, we wish to add only one point to the Acting Solicitor General's convincing analysis—namely, that the Fifth Circuit failed to apply principles of constitutional avoidance to the *newly-severed* statute. When properly applied, constitutional avoidance principles cinch the conclusion that severance can cure any constitutional infirmity here.

Severability and constitutional avoidance are related. Both are doctrines of judicial modesty and respect for the separation of powers. Just as the question in the severability analysis is: "[w]ould the legislature have preferred what is left of its statute to no statute at all?," *Ayotte*, 546 U.S. at 330, the constitutional-avoidance question *after* an offending statutory provision is severed is: what would Congress have "willed had it been apprised of the constitutional infirmity[?]'" *Sessions v. Morales-Santana*, 582 U.S. 47, 73-74 (2017) (quoting *Levin v. Commerce Energy, Inc.*, 560 U.S. 413, 427 (2010)).

In answering this post-severance constitutional-avoidance question, "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality." *Hooper v. California*, 155 U.S. 648,

657 (1895). Here, it is more than "reasonable"—as it was in *Arthrex*—to conclude that the text and structure of the background provisions governing the Secretary, the Public Health Service, and the Task Force allow the HHS Secretary to review the Task Force's preventive service recommendations. In particular, the Secretary's authority under 42 U.S.C. § 202 to "supervise[] and direct[]" the Public Health Service (and, in turn, the Task Force, which sits within the Public Health Service) can be plausibly read to allow it to "supervise[] and direct[]" any preventive service recommendation that the Task Force makes. After all, what is "supervision and direction" if not the authority to review or reject the sub-component's work product? *See* Webster's Third New International Dictionary 2296 (2002) (defining "supervision" as "the act, process, or occupation of supervising: direction, inspection, and critical evaluation: oversight, superintendence"); *id.* (defining "supervise" as to look over, inspect, oversee"); *id.* at 640 (defining "direction" as "a guidance or supervision of action, conduct, or operation"). Thus, had the Fifth Circuit afforded "proper respect for the representative branches of our Government," *United States v. Davis*, 588 U.S. 445, 494 (2019) (Kavanaugh, J., dissenting), it would have modestly concluded that:

1) Congress would have much preferred a Preventive Services Task Force subject to Secretarial "supervision and direction" than "no [Preventive Services Task Force] at all, *see Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010); *see Edmond v. United States*, 520 U.S. 651, 658 (1997) (construing a statute to avoid an Appointments Clause violation where there was "another reasonable interpretation available"); and

2) the Secretary's background authorities can be reasonably read as "fallback provisions on which [the Secretary] can rely to exercise a supervisory power," Pet. App. 32a.

B. This Court Can Sever The Words "Independent And" From Section 299B-4(A)(6) To Leave More Of The Remaining Statute Intact And Preserve Congress' Preference For Evidence-Based Recommendations

The above discussion demonstrates that this Court can sever the entirety of 42 U.S.C. § 299b-4(a)(6)—with or without applying constitutional avoidance—consistent with its duty to disregard only the "problematic portions [of a statute] while leaving the remainder intact." *Ayotte*, 546 U.S. at 328-329. But *Amici*'s preferred course is an even more limited excision.

Severability may be achieved "by striking out or disregarding words that are in the [challenged] section." *United States v. Reese*, 92 U.S. (2 Otto) 214, 221 (1875); *see Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177, 179-80 (1803) (invalidating only a clause of § 13 of the Judiciary Act of 1789 and not the entire section); *Regan v. Time*, 468 U.S. 641, 653-54 (1984) (Op. of White, J.) (supporting severance of selected words, but not an entire statutory provision, because "a court should refrain from invalidating more of the statute than is necessary"); *Alaska Airlines, Inc. v. Donovan*, 766 F.2d 1550, 1560 (D.C. Cir. 1985), *aff'd sub nom. Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987) (severing one portion of subsection 49 U.S.C. § 1552(f)(3) and leaving the remainder of the section—including the

first sentence of the subsection—unaffected); *Helman v. Dep't of Veterans Affairs*, 856 F.3d 920, 936 (Fed. Cir. 2017) (severing selected portions from a statutory provision after finding an Appointments Clause violation). Thus, striking *only* the words "independent and" from § 299b-4(a)(6) is both permissible under longstanding precedent and even more respectful of Congressional intent because it preserves even more of the existing statute.

Severing only those two words from the statute—while leaving intact the phrase "to the extent practicable, not subject to political pressure"—serves an important legislative goal. Through that language, Congress expressed a desire that the Task Force presumptively follow the medical evidence, rather than submitting to political pressures. Preserving that statutory language reinforces this congressional preference and maintains all of the benefits of evidence-based recommendations discussed in Section II above.

At the same time, Congress recognized that it was impossible to *completely* insulate the Task Force from politics. The Task Force sits within a Cabinet agency and makes recommendations on certain topics that have a political valence. Congress was realistic enough to know that *entirely* eliminating political pressure was simply not doable. Thus, when it included the qualifying phrase "to the extent practicable," it explicitly required that the Task Force *minimize* political pressures—not eliminate them altogether. Similarly, the phrase "to the extent practicable" necessarily recognizes that sometimes it may *not* be "practicable," and so in those circumstances political considerations can inform Task Force decision-making.

Striking the words "independent and" (and thereby subjecting the Task Force to greater "supervision and direction" of the Secretary) would, of course, increase the likelihood that political pressure would bear upon the Task Force. That is understandable and to be expected. *See Dep't of Commerce v. New York*, 588 U.S. 752, 781 (2019) ("Agency policymaking is not a 'rarified technocratic process, unaffected by political considerations or the presence of Presidential power.' *Sierra Club v. Costle*, 657 F.2d 298, 408 (D.C. Cir. 1981). Such decisions are routinely informed by unstated considerations of politics, the legislative process, public relations, interest group relations, foreign relations, and national security concerns (among others)."). But nothing about eliminating the Task Force's independence to satisfy the Appointments Clause is inconsistent with Congress' desire to *minimize* political pressure—"to the extent practicable"—on the Task Force's decision-making. And nothing about preserving all but those two words raises separate Appointments Clause concerns. Even the Fifth Circuit seemed to agree with this conclusion. *See* Pet. App. 21a (distinguishing between the statutory terms regarding independence, on the one hand, and political pressure, on the other hand, explaining that "even if we thought that § 299b-4(a)(6) provided some interpretive flexibility with respect to the amount of political pressure that the HHS Secretary could place on the Task Force, the terms of the provision prevent us from using that same flexibility with respect to the Task Force's statutorily required independence.").[2]

2. The Fifth Circuit raised "line-drawing" concerns about how much political pressure would be permissible, insisting that "the Government does not offer any textually plausible way to draw the line" for "what the constitutionally optimal amount of 'political pressure' ought to be." Pet. App. 22a. *Amici* respectfully submit

Consider the following hypothetical: much like Congress' desire to promote evidence-based preventive care recommendations, it now wishes to formally encourage Assistant United States Attorneys to bring indictments based on evidence-based considerations. *Cf.* Dept. of Justice, Justice Manual §§ 9-27.220 (Grounds for Commencing or Declining Prosecution); *id.* § 9-27.260 (Initiating and Declining Charges—Impermissible Considerations); *cf. also* Memorandum from the Attorney General to All Department Employees, *Restoring the Integrity and Credibility of the Department of Justice* 2 (Feb. 5, 2025), *at* https://www.justice.gov/ag/media/1388506/dl?inline (contrasting the exercise of criminal enforcement authority where it "appears to have been designed to achieve political objectives or other improper aims rather than pursuing justice or legitimate governmental objectives"); Am. Bar Ass'n, *Criminal Justice, Standards for the Prosecution Function*, Standard 3-1.6 (4th ed. 2017) ("A prosecutor should not use other improper considerations, such as partisan or political or personal considerations, in exercising prosecutorial discretion."). Accordingly, it enacts a similarly worded statute requiring AUSAs to make charging decisions, "to the extent practicable," that are not "subject to political

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that the Court need not answer this question in this case. To the extent any line-drawing issues arise in a future case challenging a particular instance of Secretarial decision-making, this Court can consider them then. That being said, *Amici* respectfully submit that it is consistent with both the Appointments Clause and § 299b-4(a)(6) to read the non-severed language as a strong preference in favor of evidence-based preventive-service recommendations that can be overridden in certain cases, especially if the Secretary is willing to take the electoral risk by introducing politics into scientific decision-making or, conversely, by following the evidence on a politically unpopular recommendation.

pressure." Even with this new provision, however, federal prosecutors would remain subject to the direction and supervision of the Attorney General. All this hypothetical statute would do, much like § 299b-4(a)(6), is set forth a preferred criterion for decision-making—evidence—that still can be overridden by countervailing political concerns when a higher-ranking Cabinet officer sees fit.

It is hard to identify anything about such a statute that would violate the Appointments Clause or any other constitutional provision. *See United States v. Wayte*, 470 U.S. 598, 608 (1985) ("The decision to prosecute may not be deliberately based upon an unjustifiable standard such as race, religion, or other arbitrary classification, including the exercise of protected statutory and constitutional rights." (cleaned up)); *see also Morrison v. Olson*, 487 U.S. 654, 693-696 (1988); 28 U.S.C. § 530B(a). That hypothetical DOJ regime, like *Amici*'s preferred one for the Task Force, would feature "'a clear and effective chain of command' down from the President, on whom all the people vote." *Arthrex*, 594 U.S. at 11 (quoting *Free Enter. Fund*, 561 U.S. at 498). Democratic accountability, therefore, would exist. As with the Task Force, removal could take place. *Compare* Pet. App. 19a ("[W]e agree with the Government that, whatever else § 299b-4(a)(6) means, it does not inhibit the HHS Secretary from removing the Task Force members at his will."), *with* 28 U.S.C. § 542(b) ("Each assistant United States attorney is subject to removal by the Attorney General."). And political factors could be considered, even though they would be disfavored. All the while, evidence-based recommendations would be promoted, all else being equal. For these reasons, this hypothetical helpfully proves that *Amici*'s preferred two-word excision is permissible under the Appointments Clause and more in line with Congressional intent.

All in all, *Amici* appreciate that severability is a "blunt" instrument. *Seila Law LLC v. Consumer Fin. Prot. Bureau*, 591 U.S. 197, 237 (2020). Severance can, however, be exercised more or less bluntly in any given case. *Amici* favor the more surgical, two-word-excision to preserve Congress' preference for evidence-based decision-making, but we favor even more the continued operation of a Task Force rather than no Task Force at all. For all of these reasons, this Court should sever some or all of § 299b-4(a)(6) if it finds the existing statute to be unconstitutional.

CONCLUSION

This Court should reverse the Fifth Circuit's decision. But if it agrees with the court of appeals and finds an Appointments Clause violation, it should sever some or all of 42 U.S.C. § 299b-4(a)(6).

Respectfully submitted,

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