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 THE CENTER FOR HIV LAW AND POLICY AND OTHER LEADING HEALTH POLICY AND REPRODUCTIVE JUSTICE ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

S. MANDISA MOORE-O'NEAL
KAE GREENBERG
CENTER FOR HIV LAW AND POLICY
147 Prince Street
Brooklyn, NY 11201

JULIUS J. MITCHELL
JENNER & BLOCK LLP
1155 Avenue of the Americas
New York, NY 10036
(212) 891-1600

DAVID W. DEBRUIN
Counsel of Record
EMANUEL POWELL III
ILLYANA A. GREEN
JENNER & BLOCK LLP
1099 New York Avenue NW
Suite 900
Washington, DC 20001
(202) 639-6000
ddebruin@jenner.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

INTEREST OF *AMICI CURIAE* 1

STATEMENT 5

SUMMARY OF ARGUMENT 9

ARGUMENT 11

I. Members of the U.S. Preventive Services Task Force Are Inferior Officers Who Are Subordinate To The HHS Secretary. 11

A. The Task Force Members are Removable at Will and Subject to the HHS Secretary's Direct Supervision. 13

B. The Other Three Factors Are Also Met. 15

1. Narrow Jurisdiction. 16

2. Certain, Limited Duties. 20

3. Limited Tenure. 22

II. The Task Force Makes Critical, Evidence-Based Recommendations to Improve Health Outcomes Nationwide. 25

A. The Task Force's Mandate Is Narrow, But Critical to Developing Objective and Evidence-Based Preventive Care Services Recommendations. 25

B. The Task Force's Recommendations Have Had an Immeasurable Impact on the Southern Black and Brown LGBTQ+ Communities Amici Serve 27

CONCLUSION 35

TABLE OF AUTHORITIES

CASES

Buckley v. Valeo, 424 U.S. 1 (1976) (per curiam), *superseded by statute as stated in McConnell v. Federal Election Commission*, 540 U.S. 93 (2003) 11

Collins v. Yellen, 594 U.S. 220 (2021) 14

Edmond v. United States, 520 U.S. 651 (1997) 12, 13, 14, 15, 16, 21, 23

Free Enterprise Fund v. Public Co. Accounting Oversight Board, 537 F.3d 667 (D.C. Cir. 2008), *aff'd in part, rev'd in part, and remanded* 561 U.S. 477 (2010) 13

Free Enterprise Fund v. Public Co. Accounting Oversight Board, 561 U.S. 477 (2010) 13, 14

Karsner v. Lothian, 532 F.3d 876 (D.C. Cir. 2008) 18

Mistretta v. United States, 488 U.S. 361 (1989) 26

Morrison v. Olson, 487 U.S. 654 (1988) 11, 12, 14, 16, 17, 21, 22, 23, 27

Pennsylvania v. United States Department of Health & Human Services, 80 F.3d 796 (3d Cir. 1996) 24

Stanley v. Gonzales, 476 F.3d 653 (9th Cir. 2007) 24

Utility Audit, Inc. v. Horace Mann Service Corp., 383 F.3d 683 (7th Cir. 2004) 19

CONSTITUTIONAL PROVISIONS AND STATUTES

U.S. Const. art. II, § 2, cl. 2 11

42 U.S.C. § 299b-4(a) 19

42 U.S.C. § 299b-4(a)(1) 6, 9, 17, 18, 21

42 U.S.C. § 299b-4(a)(2)(A) 21

42 U.S.C. § 299b-4(a)(2)(C) 22

42 U.S.C. § 299b-4(a)(2)(F) 22

42 U.S.C. § 299b-4(a)(4) 22

42 U.S.C. § 299b-4(a)(6) 18

42 U.S.C. § 299b-4(c) 19, 20

42 U.S.C. § 300gg-13 20

42 U.S.C. § 300gg-13(a)(1) 9

42 U.S.C. § 300gg-22(a) 20

42 U.S.C. § 300gg-22(b) 20

42 U.S.C. § 300gg-22(b)(1) 20

Healthcare Research and Quality Act of 1999, Pub. L. No. 106–129, 113 Stat 1653 6

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) 8

LEGISLATIVE MATERIALS

Agency for Health Care Policy and Research Role in Health Care Quality Improvement: *Hearing Before the Subcomm. on Public Health and Safety of the S. Comm. on Labor and Human Resources*, 105th Cong. (1998) 25, 26

Examining the United States Preventive Services Task Force: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce, 114th Cong. (2016) 5, 9, 34

Prevention and Public Health: The Key to Transforming Our Sickcare System: Hearing Before the S. Comm. on Health, Education, Labor, and Pensions, 110th Cong. (2008) 27-28

S. Rep. No. 106-82 (1999) 25, 26

OTHER AUTHORITIES

A & B Recommendations, U.S. Preventive Services Task Force, https://bit.ly/3JnxC7m (last visited Feb. 25, 2025) 29

Cagdas Agirdas & Jordan G. Holding, *Effects of the ACA on Preventive Care Disparities*, 16 Applied Health Econ. & Health Pol'y 859 (2018) 33

Nick Armstrong & Rachel Klein, *Pre-Exposure Prophylaxis: Coverage, Compliance, and Ending the HIV Epidemic*, The Aids Inst. (2024), https://bit.ly/3D6HC54 ..... 29, 32

Samantha Artiga & Anthony Damico, *Health and Health Coverage in the South: A Data Update*, Kaiser Family Foundation (Feb. 10, 2016), https://bit.ly/4gQkfdQ 28

Samantha Artiga *et al.*, *Survey on Racism, Discrimination and Health: Experiences and Impacts Across Racial and Ethnic Groups*, KFF (Dec. 5, 2023), https://bit.ly/4hIegJx 31

Gabriel A. Benavidez *et al.*, *Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area*, 21 Prev. Chronic Disease 1 (Feb. 2024) 28

Cancer Facts & Figures for African American/Black People 2022-2024, Am. Cancer Soc'y, Inc. (2022) 33

Cancer Facts & Figures for Hispanic/Latino People 2024-2026 Am. Cancer Soc'y, Inc. (2024) 28-29

Lorraine T. Dean et. al., *Estimating the Impact of Out-of-Pocket Cost Changes On Abandonment of HIV Pre-Exposure Prophylaxis*, 43 Health Affairs 36 (2024), https://bit.ly/4kg5BzG.....32

Maria Godoy, *Black Americans Expect to Face Racism in the Doctor's Office, Survey Finds*, NPR (Dec. 5, 2023), https://bit.ly/4hHMoVQ.....31

Sayward E. Harrison *et al.*, *"Do I want PrEP or do I want a roof?": Social Determinants of Health and HIV Prevention in the Southern United States*, 34 AIDS Care 1435 (2022).....32

The Impact of HIV on Black People in the United States, KFF (Sep. 9, 2024), https://bit.ly/4b2l2qV.....28

The Impact of HIV on Hispanic/Latino People in the United States, KFF (Oct. 15, 2024), https://bit.ly/41k3a7z.....28

Whitney C. Irie et al., *Where do we go from here? Reconciling implementation failure of PrEP for Black women in the South. Leveraging critical realism to identify unaddressed barriers as we move forward.*, Frontiers Reprod. Health (2024), https://bit.ly/41u8wx9.....29, 30

Marquisha Jones & Jill Rosenthal, *How the Affordable Care Act Improved Access to Preventive Health Services*, Ctr. for Am. Progress (July 10, 2024), https://bit.ly/43h94ro 27, 33

Leading Causes of Death, CDC, https://bit.ly/4k7m1dI (last reviewed Oct. 25, 2024).....28

National Center for Health Statistics, *Health, United States, 2020-2021: Annual Perspective* (2023), https://bit.ly/3CW0bZT.....30

OLC Opinion, *Officers of the United States Within the Meaning of the Appointments Clause* (Apr. 16, 2007) 11

Our Members, U.S. Preventive Services Task Force, https://bit.ly/3Qoevxd (last visited Feb. 25, 2024).....6

A. David Paltiel *et al.*, *Increased HIV Transmissions With Reduced Insurance Coverage for HIV Preexposure Prophylaxis: Potential Consequences of* Braidwood Management v. Becerra, Open Forum Infectious Diseases, Vol. 10, Issue 3, (Mar. 2023), https://bit.ly/3EMiyRt.....10

Pre-Exposure Prophylaxis, HIV.gov (last updated Feb. 7, 2025), https://bit.ly/4h2VifD 29

Laura Skopec & Jessica Banthin, *Free Preventive Services Improve Access to Care*, Urban Inst. (2022) 32

Solicitation for Nominations for Members of the U.S. Preventive Services Task Force (USPSTF), 87 Fed. Reg. 2436 (Jan. 14, 2022) 7

Steven W. Thrasher, *The Viral Underclass: The Human Toll When Inequality and Disease Collide* (2022) 31

U.S. Preventive Services Task Force, *Procedure Manual* (2021) 6, 7, 8

U.S. Preventive Services Task Force, *USPSTF: Who We Are & How We Work* (2022) 8

Sam Whitehead, *PrEP Prevents HIV Infections, but it's Not Reaching Black Women*, NPR (Oct. 3, 2023), https://bit.ly/41hheid 30

Tiara C. Willie et al., *Where's the "Everyday Black Woman"? An Intersectional Qualitative Analysis of Black Women's Decision-making Regarding HIV Pre-exposure Prophylaxis (PrEP) in Mississippi*, 22 BMC Pub. Health 1604 (2022), https://bit.ly/4ieMXWP 30-31

Alexis Wojtowicz *et al.*, *Closing Evidence Gaps in Clinical Prevention* (2022) 5, 6, 7

INTEREST OF *AMICI CURIAE*[1]

Amici are leading health policy and reproductive justice organizations committed to serving lesbian, gay, bisexual, transgender, and queer ("LGBTQ+") and Black, Indigenous, and People of Color ("BIPOC") in the Southern United States who are disproportionately vulnerable to preventable health conditions. For these conditions, early detection and preventive services, including those recommended by the U.S. Preventive Services Task Force ("USPSTF" or "Task Force"), are critical. Further, removal of financial barriers for such preventive services pursuant to the preventive care mandate of the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 300gg-13, is one of the most effective tools *amici* have to ensure the health and well-being of their communities. *Amici* write to explain the legal errors of the lower court's decision and to provide unique insights, based on their direct experience working with disproportionately vulnerable communities, how the outcome of this case will impact access to critical preventive services such as diabetes screening, cancer prevention measures, and numerous other preventive interventions recommended by the USPSTF.

The Center for HIV Law and Policy ("CHLP") is a national, abolitionist legal and policy organization fighting to end stigma, discrimination, and violence

---

[1] Pursuant to Rule 37.6, counsel for *amici curiae* state that no counsel for a party authored this brief in whole or in part, and no person or entity other than *amici* or their counsel has made a monetary contribution to the preparation or submission of this brief.

against people living with and vulnerable to human immunodeficiency virus ("HIV") and other stigmatized health conditions. CHLP utilizes legal advocacy, high-impact policy and research initiatives, and the creation of multi-issue partnerships, networks, and resources to support its communities. CHLP operates within and around criminal, legal, and public health systems at the state and federal levels to craft policies that amplify the power of mobilizations for systemic change guided by racial, gender, and economic justice. CHLP collaborates with people living with HIV, organizers and base builders, direct service providers, and national organizations to identify, create, and share expertly crafted, intersectional legal and policy resources and advocacy strategies.

The Afiya Center is a reproductive justice organization centered on transforming the lives of Black women and girls in Texas. This case directly impacts Afiya Center's mission to advocate for comprehensive healthcare access for Black communities in Texas, particularly those affected by HIV. The Afiya Center serves as a crucial support system for Black Texans living with HIV, many of whom rely on preventive care services mandated by the ACA. The potential elimination of the requirement that health plans cover pre-exposure prophylaxis ("PrEP") medications without cost-sharing would have devastating consequences for the community the Afiya Center serves. Texas already faces significant disparities in HIV prevention and treatment, with Black individuals accounting for a disproportionate number of new HIV diagnoses in the state.

Women With A Vision ("WWAV") is a Louisiana-based organization working to improve the lives of marginalized women, their families, and communities by addressing the social conditions that hinder their health and well-being. WWAV accomplishes this through relentless advocacy, health education, supportive services, and community-based participatory research. WWAV was founded in direct response to the HIV/AIDS epidemic, to ensure that its communities received the resources necessary to prevent the transmission of HIV. Thirty-five years later, WWAV continues to lead this work through the implementation of Louisiana's Ending the HIV Epidemic Initiative, alongside community-based organizations, healthcare and direct service providers, and health departments.

Equality Federation is a national advocacy organization dedicated to advancing equality for lesbian, gay, bisexual, transgender, and queer people across the United States, that has a substantial interest in ensuring LGBTQ+ individuals can lead fulfilling lives free from discrimination, with unimpeded access to essential healthcare services. As an organization at the forefront of LGBTQ+ advocacy, Equality Federation seeks to provide this Court with crucial insights into the real-world implications of the Fifth Circuit's decision.

PrEP In Black America ("the Coalition") is a coalition of Black HIV prevention advocates from across the country that mobilizes communities around various policy issues that impact access to PrEP, for the prevention of HIV. The Coalition convenes community members through in-person summits, virtual webinars, and workshops at leading HIV and sexual health

conferences. Through community engagement, the Coalition generates reports and statements to engage key stakeholders such as legislators, as well as local, state, and federal public health officials.

SisterLove, Inc., founded in 1989, is the first women's HIV, Sexual and Reproductive Justice organization in the southeastern United States dedicated to eradicating the adverse impact of HIV, and sexual and reproductive health rights and justice challenges impacting women and their families, gender expansive and LGBTQ+ individuals, and others from marginalized communities. SisterLove operates at the intersection of human rights and social justice, focusing on education, prevention, support, research, and legal and political advocacy both in the United States and internationally.

BlaqOut is a Black-led organization dedicated to advancing the health and well-being of Black LGBTQ+ communities through culturally responsive care, advocacy, and public health innovation. Central to its work is ensuring access to lifesaving HIV prevention tools, particularly PrEP. The USPSTF awarded PrEP an "A" rating based on its proven efficacy in preventing HIV transmission. BlaqOut's proprietary public health interventions have achieved a 96% adherence rate among members—a rate among the highest documented nationally. Given the Center for Disease Control's ("CDC") 2016 projection that one in two Black men who have sex with men will contract HIV in their lifetime without substantial reductions in transmission rates, continued cost-free access to PrEP is essential. Restricting access would reverse critical progress,

endangering the lives of those already disproportionately impacted by HIV.

STATEMENT

Established in 1984, under the Reagan Administration, the United States Preventive Services Task Force ("Task Force") was originally convened by Edward N. Brandt, assistant secretary of the Department of Health and Human Services ("HHS"), building upon "the innovative work of the Canadian Task Force on the Periodic Health Examination" that "began issuing preventive service recommendations in the late 1970s."[2] The Task Force was formed as "an independent nonpartisan expert panel" to provide evidence-based recommendations that "inform care" and serve as "useful guides for all stakeholders about what the evidence tells us about which preventive services work."[3] From its inception, the Task Force's role was focused on "evaluat[ing] the science on the benefits and harms of a given preventive service and to inform the public so they can make informed decisions about their healthcare."[4]

---

[2] Alexis Wojtowicz et al., *Closing Evidence Gaps in Clinical Prevention* 28 (2022).

[3] *Examining the United States Preventive Servs. Task Force: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Comm.*, 114th Cong. 6, 14 (2016) [hereinafter *Examining the United States Preventive Task Force*] (statement of Kirsten Bibbins-Domingo, M.D., Chairperson, U.S. Preventive Services Task Force).

[4] *Id.* at 14.

Over its more than 40-year history, the Task Force's primary contribution has been the creation of reports identifying effective clinical preventive services following a rigorous review of peer-reviewed evidence.[5] Congress codified the Task Force's role by legislation in 1999, authorizing the Director of the Agency for Healthcare Research and Quality ("AHRQ")—an agency "established within the Public Health Service"—to "periodically convene" the Task Force.[6] The Task Force's initial reports, the *Guide to Clinical Preventive Services*, were published in 1989, 1996, and 2002.[7] The Task Force has continued to issue its recommendations periodically "as well as 'pocket guides' with abridged recommendations the task force had issued individually in the preceding years."[8]

Today, the Task Force is composed of 16 volunteers "with appropriate expertise," 42 U.S.C. § 299b-4(a)(1), in preventive medicine and primary care, including "nationally recognized experts" in "behavioral health, family medicine, geriatrics, internal medicine, pediatrics, obstetrics and gynecology, and nursing."[9]

---

[5] Alexis Wojtowicz et al., *supra* note 2, at 28-30.

[6] Healthcare Research and Quality Act of 1999, Pub. L. No. 106-129, 113 Stat 1653.

[7] Alexis Wojtowicz et al., *supra* note 2, at 28-29; *see also* U.S. Preventive Services Task Force, *Procedure Manual* 1 (2021) [hereinafter *Procedure Manual*].

[8] Alexis Wojtowicz et al., *supra* note 2, at 29-30.

[9] *Our Members*, U.S. Preventive Services Task Force, https://bit.ly/3Qoevxd (last visited Feb. 25, 2025).

Members of the Task Force can be removed at any time by the AHRQ Director. *See* Pet. App. 18a-19a. Task Force members serve limited, four-year terms, *see Solicitation for Nominations for Members of the U.S. Preventive Services Task Force (USPSTF)*, 87 Fed. Reg. 2436, 2436-37 (Jan. 14, 2022), allowing the Task Force's work to benefit from new expertise on an ongoing basis. New volunteers are selected following a rigorous selection process focused on ensuring each member can support the Task Force's mandate to create "balanced, independent, objective, and scientifically rigorous product," including the Task Force's "recommendation statements."[10]

On average, each recommendation statement by the Task Force takes three years to complete,[11] and is "based on a body of scientific evidence that is derived from systematic evidence reviews."[12] During that time, the Task Force selects topics through an open nomination process, develops a rigorous research plan with public comment, reviews peer-reviewed evidence as part of the research process, and drafts preliminary and final recommendations after public comment.[13]

Recommendations resulting from this process receive a grade: A, B, C, D, or I.[14] The Task Force

---

[10] *Procedure Manual*, *supra* note 7, at 2-3.

[11] Alexis Wojtowicz et al., *supra* note 2, at 30.

[12] *Procedure Manual*, *supra* note 7, at 47.

[13] Alexis Wojtowicz et al., *supra* note 2, at 30-31.

[14] *Procedure Manual*, *supra* note 7, at 48.

recommends a preventive service for those receiving an A or B, recognizing the Task Force's certainty that the preventive service will have a moderate to substantial net benefit on health outcomes.[15] The Task Force assigns a C grade when there is a "moderate certainty that the net benefit is small" and therefore recommends healthcare providers offer the service "based on professional judgment and patient preferences."[16] The Task Force issues a D grade when the evidence shows the service has no benefit or the "harms outweigh the benefits," and an I grade when "the current evidence is insufficient to assess the balance of benefits and harms of the service."[17]

The Task Force has developed recommendations for over 80 different preventive services topics, ranging "from vision screening in young children, to heart disease prevention in adults, to colorectal cancer screening in older adults."[18] When passing the ACA, Congress decided that private insurers should not impose cost-sharing requirements to cover preventive services that have "a rating of 'A' or 'B' in the current recommendations of the [USPSTF]."[19]

---

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] U.S. Preventive Services Task Force, *USPSTF: Who We Are & How We Work* 1 (2022).

[19] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat 119 (2010) (codified at 42 U.S.C. § 300gg-13(a)(1)).

While Congress expanded the *use* of the Task Force's recommendations in the ACA, the volunteer body's *mandate* has remained limited and consistent over its 40-year history, namely "to evaluate the science on the benefits and harms of a given preventive service and to inform the public so they can make informed decisions about their healthcare."[20]

SUMMARY OF ARGUMENT

The Task Force works to improve the lives of Americans nationwide by recommending preventive medical services, such as screenings and medications, to avoid serious health conditions. Under the ACA, Congress requires health insurance issuers and health plans to cover certain preventive services recommended by the Task Force without imposing any cost-sharing requirements on patients. 42 U.S.C. § 300gg-13(a)(1). The Fifth Circuit's decision would jeopardize the ACA's guarantee of cost-free coverage for the Task Force's recommended services—a measure that ensures more than 150 million Americans' access to life-saving healthcare.

Amici submit that Congress's choice to empower the Task Force should be upheld. The Task Force sits within the Public Health Service, over which the HHS Secretary exercises supervisory authority. Moreover, the HHS Secretary may remove Task Force members at will, and these members have a limited mandate: issue

---

[20] *Examining the United States Preventive Task Force*, *supra* note 3, at 14; *see also* 42 U.S.C. § 299b-4(a)(1).

evidence-based recommendations concerning preventive health services.

Contrary to the Fifth Circuit's decision, the Task Force's structure does not violate the Appointments Clause of the Constitution, art. II, § 2, cl. 2. Task Force members are removable at will, are supervised by superiors, and have narrow jurisdiction, limited duties, and limited tenure. Under this Court's precedents, Task Force members are inferior officers who are subordinate to the HHS Secretary. Upending the scheme that Congress crafted would have severe practical consequences for millions of Americans who benefit from no-cost preventive services based on the Task Force's recommendations.

Further, *amici* write to emphasize the importance of Task Force recommendations and no-cost preventive care on public health in America. No-cost preventive care reduces the incidence of many diseases and other health conditions—from cardiovascular disease to diabetes to HIV—thereby improving quality of life and reducing premature death. For example, one study estimates that if allowed to stand, the Fifth Circuit's ruling in the first year alone "will result in more than 2000 entirely preventable primary HIV infections … and many more infections in other populations at high risk of HIV transmission."[21] For the communities that *amici*

---

[21] A. David Paltiel *et al.*, *Increased HIV Transmissions With Reduced Insurance Coverage for HIV Preexposure Prophylaxis: Potential Consequences of* Braidwood Management v. Becerra, Open Forum Infectious Diseases, Vol. 10, Issue 3, at 3 (Mar. 2023), https://bit.ly/3EMiyRt.

serve, the Task Force's recommendations improve access to critical, life-saving health care.

Amici therefore respectfully request that this Court reverse the Fifth Circuit's decision.

ARGUMENT

I. Members of the U.S. Preventive Services Task Force Are Inferior Officers Who Are Subordinate to The HHS Secretary.

The Appointments Clause of the Constitution empowers the President to:

> nominate, and by and with the Advice and Consent of the Senate, … appoint ... all other Officers of the United States, whose Appointments are not herein otherwise provided for, and which shall be established by Law: but the Congress may by Law vest the Appointment of such inferior Officers, as they think proper, in the President alone, in the Courts of Law, or in the Heads of Departments.

U.S. Const. art. II, § 2, cl. 2. The clause limits the exercise of certain kinds of governmental power to those persons appointed pursuant to the special procedures provided for officers. *See Buckley v. Valeo*, 424 U.S. 1, 125-26 (1976) (per curiam), *superseded by statute as stated in McConnell v. Fed. Election Comm'n*, 540 U.S. 93 (2003); OLC Opinion, *Officers of the United States Within the Meaning of the Appointments Clause* (Apr. 16, 2007).

For purposes of appointment, the Constitution "divides all its officers into two classes." *Morrison v. Olson*, 487 U.S. 654, 670 (1988) (quoting *United States v.*

Germaine, 99 U.S. 508, 509 (1878)). "[P]rincipal officers are selected by the President with the advice and consent of the Senate." *Id.* While "[g]enerally speaking, the term 'inferior officer' connotes a relationship with some higher ranking officer or officers below the President," "[w]hether one is an 'inferior' officer depends on whether he has a superior." *Edmond v. United States*, 520 U.S. 651, 662 (1997). Thus, "inferior officers" are "officers whose work is directed and supervised at some level by others who were appointed by Presidential nomination with the advice and consent of the Senate." *Id.* at 663.

The Clause therefore establishes two tiers of officers—principal and inferior—and provides different appointment processes for each. As this Court has repeatedly held, the Clause's delineation of principal and inferior officers is "among the significant structural safeguards of the constitutional scheme" and is "designed to preserve political accountability relative to important Government assignments." *Id.* at 659, 663.

Though this Court has not "set forth an exclusive criterion for distinguishing between principal and inferior officers," *id.* at 661, its precedents set forth "several factors" that guide its analysis, including whether the officer: (1) "was subject to removal by a higher officer," (2) only performed "limited duties," (3) has limited jurisdiction, and (4) limited tenure. *Id.* Indeed, looking to these factors, this Court has held that the independent counsel created by provisions of the Ethics in Government Act of 1978, 28 U.S.C. §§ 591-599, was an inferior officer, *Morrison*, 487 U.S. at 695-97; that judges of the Coast Guard Court of Criminal Appeals

were inferior officers, *Edmond*, 520 U.S. at 661; and that members of the Public Company Accounting Oversight Board were inferior officers, *Free Enterprise Fund v. Public Co. Accounting Oversight Board*, 561 U.S. 477, 510 (2010).

Here, all four factors are met, confirming that the Task Force members are inferior officers for purposes of the Appointments Clause.

A. The Task Force Members are Removable at Will and Subject to the HHS Secretary's Direct Supervision.

This Court's cases have recognized that the key threshold question in determining whether an officer is inferior is whether the officer is removable at will. In *Edmond*, this Court held that judges of the Coast Guard Court of Criminal Appeals were inferior officers in part because they could be removed by the Judge Advocate General "without cause." 520 U.S. at 664. This Court noted that "[t]he power to remove officers" at will and without cause "is a powerful tool for control" of an inferior. *Id.*; *see also Free Enter. Fund v. Pub. Co. Acct. Oversight Bd.*, 537 F.3d 667, 707 (D.C. Cir. 2008) (Kavanaugh, J., dissenting) (noting that "*Edmond* was a relatively easy case" because "[t]he officers were removable at will"), *aff'd in part, rev'd in part, and remanded* 561 U.S. 477 (2010).

In *Free Enterprise Fund*, then-Judge Kavanaugh reasoned that "[r]emovability at will carries with it the inherent power to direct and supervise," which connotes an officer's inferiority for purposes of the Appointments Clause. 537 F.3d at 707. In holding that members of the

Public Company Accounting Oversight Board were inferior officers, this Court relied heavily on the fact that the "statutory restrictions on the Commission's power to remove Board members" was "unconstitutional and void," without which the Commission could "remove Board members at will." *Free Enterprise Fund*, 561 U.S. at 510. Likewise, Justice Scalia's dissent in *Morrison* reasoned that if the independent counsel there had been "removable at will by the Attorney General, then she would [have been] subordinate to him and thus properly designated as inferior." 487 U.S. at 716 (Scalia, J., dissenting).

The rule that emerges from this Court's precedents dictates that "the term 'inferior officer' connotes a relationship with some higher-ranking officer or officers below the President." *Edmond*, 520 U.S. at 662. In other words, "[w]hether one is an 'inferior' officer depends on whether he has a superior." *Id.* Moreover, this Court has repeatedly held that at-will removal is the *sine qua non* of inferior officer status.

Applying that framework here, Task Force members are inferior officers. The Fifth Circuit acknowledged that an "officer's removability" is the "most important" "hallmark[] of inferiority." Pet. App. 17a. That factor is met here. As the Fifth Circuit acknowledged, "the HHS Secretary may remove members of the Task Force at will." Pet. App. 18a-19a (reasoning that 42 U.S.C. § 229b-4(a)(6) cannot be construed to "inhibit the HHS Secretary from removing the Task Force members at his will"); *cf. Collins v. Yellen*, 594 U.S. 220, 248 (2021) ("When a statute does not limit the President's power to remove an agency head, we generally presume that the

officer serves at the President's pleasure."). Moreover, as the Government emphasizes in its brief, the HHS Secretary has direct supervisory authority over the Task Force and can deny binding effect to their preventive services recommendations. *See* Pet'r Br. 26-30.

In sum, that the HHS Secretary has the power to "control" Task Force members "by removal" "establishe[d] that the [members] here have the necessary superior." *Edmond*, 520 U.S. at 667 (Souter, J., concurring in part).

B. The Other Three Factors Are Also Met.

This Court considers three other factors when determining whether an officer is inferior under the Appointments Clause. The Fifth Circuit overlooks these factors, which are relevant indicia of inferiority. The Court in *Edmond* recognized that its prior cases did "not set forth an exclusive criterion for distinguishing between principal and inferior officers," but that its decision in *Morrison* was guided by "several factors: that the [officer] was subject to removal by a higher officer . . . that she performed only limited duties, that her jurisdiction was narrow, and that her tenure was limited," 520 U.S. at 661 (citing *Morrison*, 487 U.S. at 671-72).

As discussed *supra*, the Task Force members are removable at-will and supervised by the HHS Secretary. The other three factors—limited duties, narrow jurisdiction, and limited tenure—are also satisfied. We begin with narrow jurisdiction.

1. Narrow Jurisdiction.

The Task Force has narrow jurisdiction. Its members make recommendations regarding specific types of care for a specific subset of the healthcare community subject to review of a specific set of clinical preventive best practice recommendations. Its "recommendations," plainly read, are mere suggestions or proposals for actions authorized to be taken only by the HHS Secretary. Finally, the Task Force has no authority whatsoever to enforce its recommendations. That authority lies instead with the 50 states and the HHS Secretary.

When deciding if an officer is inferior, the Court examines whether an officer is "limited in jurisdiction." *Edmond*, 520 U.S. at 661. In *Edmond*, this Court concluded that the military judges at issue were not "'limited in jurisdiction,' as used in *Morrison* to refer to the fact that an independent counsel may investigate and prosecute only those individuals, and for only those crimes, that are within the scope of jurisdiction granted by the special three judge appointing panel." *Id.* In *Morrison*, the Court concluded that "the Act itself [was] restricted in applicability to certain federal officials suspected of certain serious federal crimes," and "c[ould] only act within the scope of the jurisdiction" granted by "the Special Division [of the U.S. Court of Appeals for the District of Columbia Circuit] pursuant to a request by the Attorney General." 487 U.S. at 672. There, Title VI of the Ethics in Government Act granted the independent counsel, (once requested by the Attorney General and appointed by the Special Division), "full power and independent authority to exercise *all*

investigative and prosecutorial functions and powers of the Department of Justice, the Attorney General, and any other officer or employee of the Department of Justice"—with a minor exception for matters requiring "personal action" by the Attorney General alone. *Id.* at 660-63, 663 n.6 (emphasis added). The scope of such jurisdiction, upon consideration of the Attorney General's request, was specifically defined by the Special Division. *Id.* at 661.

Likewise, the Task Force is limited in jurisdiction. First, Task Force members are limited in that they make "recommendations" for a specific type of care for a specific subset of the healthcare community. Initially "convene[d]" only by the AHRQ Director, the Task Force "shall review" "scientific evidence" and "develop[]" and "updat[e]" "previous clinical preventive recommendations" "for the health care community." 42 U.S.C. § 299b-4(a)(1). Upon being "convene[d]" by the AHRQ Director, the ACA provides that the Task Force is restricted to only "*clinical preventive* recommendations," *id.* (emphasis added)—as opposed to a much broader range of care, which might include diagnostic or therapeutic care for the management and treatment of *existing* medical conditions. Under Section 299b-4(a)(1), the "recommendations" are then "published in the Guide to Clinical Preventive Services" for a specific group—"individuals and organizations delivering clinical services"—rather than a more expansive group that might include pivotal non-clinical roles in the areas of hospital administration, research, and patient data management.

Second, the Act also limits the Task Force's scope of review to a narrow set of "clinical preventive best practice recommendations" from specific groups, including "from the Agency for Healthcare Research and Quality," which retains authority to convene the Task Force. 42 U.S.C. § 299b-4(a)(1). The relevant provision provides that Task Force "recommendations" "*shall* consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies." *Id.* (emphasis added). Task Force recommendations, therefore, must consider best practice recommendations from other federal agencies such as the NIH and the CDC.[22]

Further, the ACA requires the Task Force to make "recommendations," which, plainly read, constrains its authority. A "recommendation" is defined as a suggestion or proposal for a particular course of action. *Karsner v. Lothian*, 532 F.3d 876, 886-87 (D.C. Cir. 2008) ("'Recommend' is defined as to suggest that (a particular action) should be done." (internal quotation marks and

---

[22] We briefly note that this provision also highlights the Fifth Circuit's legally erroneous overreading of "independent and, to the extent practicable, not subject to political pressure." 42 U.S.C. § 299b-4(a)(6). Congress intended the Task Force to be independent only insofar as its recommendations and free from political influence. Mandating that the Task Force consider specific best practice recommendations from other federal agencies such as the NIH and the CDC, in addition to its members' removability at will and the direct supervision by the HHS Secretary, demonstrates that the Task Force's role is quite constrained in scope.

citation omitted)); *Utility Audit, Inc. v. Horace Mann Serv. Corp.*, 383 F.3d 683, 687 (7th Cir. 2004) ("'[R]ecommendation' is defined as a suggestion that something is good or suitable for a *particular* job, while 'recommend' is defined as to suggest that (a *particular* action) should be done." (cleaned up)). As the Government has explained, the HHS Secretary, and *not* the Task Force, retains the sole authority to determine *whether* and *when* certain recommendations become binding on private parties. Pet'r Br. 26-30. The Task Force, therefore, merely makes suggestions or proposals, while the HHS Secretary performs the affirmative action that gives the recommendations legal effect.

The use of "recommendation" elsewhere in the Act is consistent with that interpretation. Part B of Subchapter VII of the ACA, which amends the role of the Task Force, further supports that the meaning of "recommendation" is a mere suggestion or proposal. Part B mandates that the HHS Secretary act "*through the … Task Force*" to "conduct a series of studies designed to identify preventive interventions that can be delivered in the primary care setting and that are most valuable to older Americans." 42 U.S.C. § 299b-4a(a). It also stipulates that the HHS Secretary, once a year, "shall submit to Congress a report on the conclusions of the studies conducted . . . "together with *recommendations* for such legislation and administrative actions as the Secretary considers appropriate." 42 U.S.C. § 299b-4a(c) (emphasis added). In other words, as part of this annual report, the HHS Secretary, through the Task Force, provides its

suggestions or proposals to Congress about a separate course of action—specifically "for such legislation and administrative actions as the Secretary considers appropriate." *Id.* These "recommendations" further reflect Congress's intent that the Task Force's jurisdiction be limited in scope.

Finally, the Task Force has no investigative or prosecutorial authority to enforce its recommendations, which requires group health plans and individual health issuers to provide coverage with no cost-sharing for certain "evidence-based items or services" in the Task Force's "current recommendations." 42 U.S.C. § 300gg-13. Enforcement authority for this provision, including the potential imposition of civil penalties, lies with the states and the HHS Secretary, *not* the Task Force. 42 U.S.C. § 300gg-22(a)-(b) (explaining enforcement authority of each state and the Secretary to enforce provisions of Part A or Part D, including the imposition of penalties). As argued by the Government, the Task Force also lacks the authority to determine *whether* and *when* their recommendations become binding. Pet'r Br. 26-30. Congress expressly placed that authority in the hands of the HHS Secretary. 42 U.S.C. § 300gg-13(b)(1) ("The Secretary shall establish a minimum interval between the date on which a recommendation . . . is issued and the plan year with respect to which the requirement . . . is effective with respect to the service described in such recommendation").

2. Certain, Limited Duties.

As mentioned *supra*, the Task Force is authorized to "review scientific evidence" and "develop[] recommendations" for specific types of care for specific

individuals and groups and, in doing so, must consider specific best practice recommendations. 42 U.S.C. § 299b-4(a)(1). The duties set forth in the ACA that follow from this narrow jurisdiction are limited in scope.

To determine if an officer is inferior, the Court in *Edmond* wrote that it examined whether the officer had "performed only limited duties." 520 U.S. at 661. In *Morrison*, the Court concluded that the independent counsel had limited duties because her role, as compared to other prosecutors, was "restricted primarily to investigation and, if appropriate, prosecution for certain federal crimes." 487 U.S. at 671. Though the statute there delegated "full power and independent authority to exercise all investigative and prosecutorial functions and powers of the Department of Justice," the Court emphasized that such authority "does not include any authority to formulate policy for the Government or the Executive Branch, nor does it give [the independent counsel] any administrative duties outside of those necessary to operate her office." *Id.* at 671-72 (internal quotation marks and citation omitted). It further noted that the statute "specifically provides that in policy matters [the independent counsel] is to comply to the extent possible with the policies of the Department." *Id.* at 672.

Task Force duties align with the limited authority extended to its members. For example, the statutory provision establishing the Task Force requires that its duties "shall include" "development of additional topic areas for new recommendations and interventions related to those topic areas," 42 U.S.C. § 299b-4(a)(2)(A), and "submission of yearly reports to Congress and

related agencies identifying gaps in research, . . . and recommending priority areas that deserve further examination," 42 U.S.C. § 299b-4(a)(2)(F). These duties are consistent with the limited jurisdiction of the Task Force to "develop[]" and "updat[e]" "recommendations" regarding clinical preventive care.

Furthermore, the Task Force has a statutory duty to develop recommendations not unilaterally or arbitrarily, but in coordination with the Federal Government's health policy and objectives, 42 U.S.C. § 299b-4(a)(2)(C) (duties "shall include . . . improved integration with Federal Government health objectives and related target setting for health improvement"), and by "tak[ing] appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices," 42 U.S.C. § 299b-4(a)(4). And, as mentioned *supra*, the Task Force makes recommendations subject to specific types of care for specific subsets of the healthcare community and must consider certain best practices recommendations for clinical preventive care from other federal entities such as the NIH and the CDC. Thus, the Task Force "does not [have] any authority to formulate policy for the Government or the Executive Branch, nor . . . any administrative duties outside of those necessary to operate [its] office." *Morrison*, 487 U.S. at 671-72.

3. Limited Tenure.

Finally, Task Force members are sufficiently limited in tenure. They each serve a fixed four-year term and have no ongoing duties beyond said term. The Task Force's tenure is even more limited than the independent counsel in *Morrison*, who was statutorily

permitted to serve under an indefinite term until the Special Division or the independent counsel herself decided otherwise.

Another factor the Court has considered is whether an officer is "limited in tenure." *Edmond*, 520 U.S. at 661. In *Morrison*, the Court reasoned that there was "concededly no time limit on the appointment of a particular [independent] counsel," but that the office was nevertheless "'temporary' in the sense that an independent counsel is appointed essentially to accomplish a single task, and when that task is over the office is terminated, either by the counsel herself or by action of the Special Division." 487 U.S. at 672.

The independent counsel from *Morrison* had "no time limit on the appointment" and was still deemed "limited in tenure." *Id.* However, Task Force members serve four-year terms, with annual turnover. Moreover, Task Force members are removable at will, so their terms can be cut short at any time. Neither Respondents nor the Fifth Circuit have pointed to anything in the ACA or any caselaw that would bar the HHS Secretary from removing a member of the Task Force before the end of their four-year term. And there is no language in the ACA indicating that Task Force members maintain responsibilities beyond the end of their term. In other words, Task Force members are "appointed essentially to accomplish a single task, and when that task is over the office is terminated, . . . [with] no ongoing responsibilities that extend beyond the accomplishment of the mission . . . appointed for and authorized by the [Act] to undertake." *Id.*

Two federal appellate decisions are persuasive on this point. Relying on *Morrison*, the Third Circuit has ruled that Appeals Board members appointed by the HHS Secretary were inferior officers even where they served terms "not restricted in duration." *Pennsylvania v. U.S. Dep't of Health & Hum. Servs.*, 80 F.3d 796, 803 (3d Cir. 1996). Balancing the other factors, including that the HHS Secretary could "remove a member for cause or misconduct at any time" and the Appeals Board's "powers and responsibilities [we]re limited by regulation," the court found that the Board members were inferior officers. *Id.* at 803-04. The court specifically rejected an argument that the Board members were principal officers because they "will serve indefinitely unless removed for misconduct." *Id.* at 802. And in *Stanley v. Gonzales*, a former federal bankruptcy trustee appointed by the Attorney General challenged her subsequent removal as a violation of the Appointments Clause. 476 F.3d 653, 655 (9th Cir. 2007). Reasoning that her role was "limited geographically, temporally, and topically" and that she was "initially appointed to a five-year term," the Ninth Circuit ruled that the *Morrison* factors meant that "[i]f she was an officer at all, she was most certainly an inferior officer." *Id.* at 659-60. Here, Task Force members are removable at any time, are supervised by the HHS Secretary, and serve shorter terms than the officers deemed inferior in *Pennsylvania* (indefinite) and *Stanley* (five years).

In sum, the three other factors relied upon to determine if an officer is inferior—narrow jurisdiction, limited duties, and limited tenure—are satisfied and therefore weigh in favor of concluding that Task Force

members are inferior officers. Accordingly, this Court should reverse the Fifth Circuit's determination that Task Force members are not inferior officers.

II. The Task Force Makes Critical, Evidence-Based Recommendations to Improve Health Outcomes Nationwide.

Congress has ensured that the Task Force provides evidence-based recommendations that allow millions of Americans to access critical preventive health care services at no-cost.

A. The Task Force's Mandate Is Narrow, But Critical to Developing Objective and Evidence-Based Preventive Care Services Recommendations.

Congress codified the Task Force by statute in the face of increasing "public pressure to improve health care quality" in the United States.[23] Escalating instances of medical errors served as one cause of "growing public concern," with a reputable study at the time "of more than 30,000 hospital patients in New York f[inding] that nearly 4[%] suffered serious injuries that were related to the management of their illness rather than the illness itself."[24] Congress asked whether the

---

[23] *Agency for Health Care Policy and Research Role in Health Care Quality Improvement*: *Hearing Before the Subcomm. on Public Health and Safety of the S. Comm. on Labor and Human Resources*, 105th Cong. 2 (1998) [hereinafter *Hearing*] (opening statement of Sen. William H. Frist).

[24] S. Rep. No. 106-82, at 12 (1999).

Federal Government had "the ability … to make a difference."[25]

Congressional hearings uncovered an overall "lack of information available to consumers. . . . to make appropriate choices" about their care as one "primary" barrier to improved health care quality in the United States.[26] Despite the country's "growing investment in basic and biomedical research," Congress recognized that any benefits would be forfeited if "physicians and patients [we]re unable to make the best use of the knowledge in everyday care."[27] The answer: provide "objective, science-based information" so that "patients and those who deliver care [have] the information they need to make informed decisions regarding treatment options."[28]

Set against this backdrop, it makes perfect sense that Congress structured the Task Force so that it could focus on its limited mandate to develop objective, evidence-based recommendations on the effectiveness of different preventive services. It is further well within the authority of Congress to ultimately determine that such research findings should be covered by insurers to encourage better preventive health outcomes for people across the United States. *Cf. Mistretta v. United States*, 488 U.S. 361, 385 (1989) ("[M]ere anomaly or innovation"

---

[25] *Hearing*, *supra* note 23, at 2.

[26] S. Rep., *supra* note 24, at 9.

[27] *Id.* at 13.

[28] *Id.* at 12.

does not violate the separation of powers). This Court has recognized that Congress has the authority to make these judgments, and such judgments do not offend the President's removal power. *See, e.g.*, *Morrison*, 487 U.S. at 686 (reasoning that Congress could limit the President's power of removal through a for-cause provision without offending the Constitution).

B. The Task Force's Recommendations Have Had an Immeasurable Impact on the Southern Black and Brown LGBTQ+ Communities *Amici* Serve.

Americans have reaped the benefits of Congress's decision to ensure that the Task Force's objective, evidence-based recommendations inform which preventive services are covered by private insurers without cost-sharing. People have increased access to life-saving preventive care, and taxpayer dollars are not being spent to treat preventable conditions.[29] Under the current structure, the Task Force remains subject to the HHS Secretary's supervisory authority while properly focused on developing recommendations that allow both patients and healthcare providers to better "prevent unnecessary diseases and conditions, things like obesity and type 2 diabetes, heart disease, mental health conditions, and some forms of cancer."[30]

---

[29] *See generally* Marquisha Jones & Jill Rosenthal, *How the Affordable Care Act Improved Access to Preventive Health Services*, Ctr. for Am. Progress (July 10, 2024), https://bit.ly/43h94ro.

[30] *Prevention and Public Health: The Key to Transforming Our Sickcare System: Hearing Before the S. Comm. on Health,*

The impact of the Task Force's recommendations cannot be overstated, especially in the context of breaking down the numerous barriers to equitable health care access faced by the Black and Brown communities that *amici* serve in the Southern United States. Historically and presently, Southerners face greater risk of "certain chronic illnesses" and are disproportionately likely "to experience worse health outcomes" than the rest of the United States.[31] Recent studies have identified "a high prevalence of chronic disease" in the South, recognizing that many such illnesses are leading causes of death nationwide despite being "preventable and treatable."[32] Such illnesses include cancer, diabetes, heart disease, and, particularly for Black and Brown Southerners, HIV.[33]

Education, Labor, and Pensions, 110th Cong. 2 (2008) (opening statement of Senator Tom Harkin).

[31] Samantha Artiga & Anthony Damico, *Health and Health Coverage in the South: A Data Update*, Kaiser Family Found., at 3 (Feb. 10, 2016), https://bit.ly/4gQkfdQ.

[32] Gabriel A. Benavidez et al., *Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area*, 21 Prev. Chronic Disease 1 (Feb. 2024).

[33] *See Leading Causes of Death*, CDC, https://bit.ly/4k7m1dI (last reviewed Oct. 25, 2024); *The Impact of HIV on Black People in the United States*, KFF (Sept. 9, 2024), https://bit.ly/4b2l2qV ("[I]n 2021 HIV was the 8th leading cause of death for Black men and for Black women ages 25-34."); *The Impact of HIV on Hispanic/Latino People in the United States*, KFF (Oct. 15, 2024), https://bit.ly/41k3a7z ("Rates for deaths where HIV was indicated as the leading cause of death are second highest among Hispanic/Latino people (after Black people) compared to people of other race/ethnicities."); *Cancer Facts & Figures for*

For each of these conditions, among others, the Task Force developed recommendations for critical preventive services that have mitigated their impact nationwide.[34] While increased access to preventive care without cost-sharing has decreased the divide, Black Southerners, especially Black women and members of the LGBTQ+ community, remain particularly vulnerable to fully preventable conditions.

One condition exemplifying the continuing importance of Task Force recommendations is HIV. Unlike in decades past, preexposure prophylaxis, or PrEP, makes HIV a preventable condition, having an incredible 99% efficacy rate.[35] However, "[w]hile an estimated 94% of white people [nationwide] who could benefit from PrEP have a prescription,"[36] only 10% of Black women in the United States who could benefit from being prescribed PrEP are receiving it.[37] Instead,

---

Hispanic/Latino People 2024-2026 American Cancer Society, Inc. (2024) ("Cancer is the second leading cause of death among Hispanic people, accounting for 17% of deaths.").

[34] *See generally A & B Recommendations*, U.S. Preventive Services Task Force, https://bit.ly/3JnxC7m (last visited Feb. 25, 2025).

[35] *Pre-Exposure Prophylaxis*, HIV.gov, https://bit.ly/4h2VifD (last updated Feb. 7, 2025).

[36] Nick Armstrong & Rachel Klein, *Pre-Exposure Prophylaxis: Coverage, Compliance, and Ending the HIV Epidemic*, The Aids Inst. 2 (2024), https://bit.ly/3D6HC54.

[37] Whitney C. Irie et al., *Where do we go from here? Reconciling implementation failure of PrEP for Black women in the South. Leveraging critical realism to identify unaddressed barriers as we*

Black women acquire HIV 20 times more frequently than white women.[38] Non-Hispanic Black people are four times more likely to die from HIV than any other racial or ethnic group.[39]

Consider the story of Alexis Perkins, a twenty-five-year-old Black cisgender woman living in Atlanta, Georgia. After learning more about the risk of contracting HIV during a sexual health education course, she visited her healthcare provider to request a prescription for PrEP.[40] But she left empty-handed after being told that while the "provider had heard of it" they were not comfortable prescribing it given the provider's limited experience with PrEP.[41]

Alexis Perkins's story is commonplace among members of the communities that *amici* serve. It is important to emphasize that the higher prevalence of HIV among people of color is not due to individuals engaging in risky behavior.[42] Limited education in

---

move forward., Frontiers Reprod. Health, at 2 (2024), https://bit.ly/41u8wx9.

[38] *Id.*

[39] National Center for Health Statistics, *Health, United States, 2020-2021: Annual Perspective*, at 12 (2023), https://bit.ly/3CW0bZT.

[40] Sam Whitehead, *PrEP Prevents HIV Infections, But it's Not Reaching Black Women*, NPR (Oct. 3, 2023), https://bit.ly/41hheid.

[41] *Id.*

[42] *See, e.g.*, Tiara C. Willie et. al., *Where's the "Everyday Black Woman"? An Intersectional Qualitative Analysis of Black Women's Decision-making Regarding HIV Pre-exposure*

preventive strategies among healthcare providers is just one of many barriers that continue to stymie access to preventive care in the South, despite the preventive care mandates of the ACA. Rurality, transportation barriers, and limited access to providers also generally impede access to preventive care. And Black and Brown adults are "much more likely than their white counterparts to report having negative interactions during health care visits."[43]

Cost serves as another critical barrier to preventive care for Black and Brown Southerners. To maintain a PrEP prescription, for example, patients not only have to secure medication, which, if uncovered, costs thousands of dollars per month, but also commit to periodic doctor's visits and related preventive services including, among other things, HIV testing, STI screening and counseling, and testing regarding their

---

Prophylaxis (PrEP) in Mississippi, 22 BMC Public Health 1604 (2022), https://bit.ly/4ieMXWP; *see also* Steven W. Thrasher, *The Viral Underclass: The Human Toll When Inequality and Disease Collide* 179 (2022) ("Black queer men's behavior doesn't account for our heightened viral risk; we actually have been shown to have fewer sexual partners and engage in less recreational drug use than our white peers. What we have is more exposure to racism and less protection from prophylaxis.").

[43] Maria Godoy, *Black Americans Expect to Face Racism in the Doctor's Office, survey finds*, NPR (Dec. 5, 2023), https://bit.ly/4hHMoVQ; *see also* Samantha Artiga et al., *Survey on Racism, Discrimination and Health: Experiences and Impacts Across Racial and Ethnic Groups*, KFF (Dec. 5, 2023), https://bit.ly/4hIegJx.

kidney function.[44] Inability to pay the associated costs of PrEP has been shown to be a driving force in people not taking, or not remaining on, a lifesaving medication.[45] Congress's decision to remove cost burdens for the Task Force's A- and B-grade recommendations addresses this critical problem in ensuring improved quality of healthcare for all Americans.

HIV prevention provides just one example of the impact that no-cost coverage of the Task Force's preventive care recommendations has had. "[I]ncreases in blood pressure screenings, cholesterol screenings, colorectal cancer screenings, human papillomavirus vaccines, and flu vaccines" followed the ACA's requirement to cover key preventive services without cost-sharing.[46]

For most types of cancer, Black people have the highest death rates and shortest survival rates of any racial/ethnic group in the United States. Black women are 41% more likely to die from breast cancer than white

---

[44] Armstrong & Klein, *supra* note 36, at 10.

[45] *See* Lorraine T. Dean et. al., *Estimating the Impact of Out-of-Pocket Cost Changes On Abandonment of HIV Pre-Exposure Prophylaxis*, 43 Health Affairs 36, 36-37 (2024), https://bit.ly/4kg5BzG; Sayward E. Harrison et al., "*Do I want PrEP or do I want a roof*?": *Social Determinants of Health and HIV Prevention in the Southern United States*, 34 AIDS Care 1435, 1437 (2022).

[46] Laura Skopec & Jessica Banthin, *Free Preventive Services Improve Access to Care*, Urban Inst., at 2 (2022).

women.[47] That statistic is even more striking because fewer Black women are diagnosed with breast cancer than white women.[48] With the advent of ACA preventive care coverage, Black women are 2.4% more likely to get a mammogram, a low percentage with a large impact.[49] This increase in screenings, especially for Black and Brown communities, is directly tied to decreasing cancer deaths and increasing the chances of early diagnoses and treatment.[50]

If the Fifth Circuit's decision is left standing by this Court, the cost will be dire. To speak plainly, without access to the coverage of the preventive care recommended by the Task Force, Black and Brown Southerners are going to die. It is counterintuitive to abandon a statutory structure that has increased the availability of lifesaving, evidence-based preventive care services, when now, even though their provision is mandated, Black Southerners still struggle to access them.

Under these circumstances, the Task Force plays a critical role. The Task Force's "recommendation

---

[47] *Cancer Facts & Figures for African American/Black People 2022-2024*, Am. Cancer Soc'y, Inc., at 12 (2022).

[48] *Id.*

[49] Cagdas Agirdas & Jordan G. Holding, *Effects of the ACA on Preventive Care Disparities*, 16 Applied Health Econ. & Health Pol'y 859 (2018).

[50] *See generally* Marquisha Jones & Jill Rosenthal, *supra* note 29 (noting that access has led to "better health outcomes, disease prevention, and health promotion activities").

statements are more than just the letter grade and contain detailed information about the primary evidence, how one might implement the recommendation, and about populations that are disproportionately burdened by the condition we seek to prevent."[51] Healthcare providers in Southern communities who wish to better serve their patients have access to important information on the efficacy of preventive care strategies. Patients are provided the information they need to access the best care, without cost barriers and based on objective, evidence-based recommendations. This work is done by the Task Force under the supervision and at-will removal authority of the HHS Secretary, as Congress intended, and the Constitution allows.

[51] *Examining the United States Preventive Task Force*, *supra* note 3, at 8.

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Court reverse the decision below.

February 25, 2025

Respectfully submitted,

S. MANDISA MOORE-O'NEAL
KAE GREENBERG
CENTER FOR HIV LAW AND POLICY
147 Prince Street
Brooklyn, NY 11201

JULIUS J. MITCHELL
JENNER & BLOCK LLP
1155 Avenue of the Americas
New York, NY 10036
(212) 891 1600

DAVID W. DEBRUIN
Counsel of Record
EMANUEL POWELL III
ILLYANA A. GREEN
JENNER & BLOCK LLP
1099 New York Avenue NW
Suite 900
Washington, DC 20001
(202) 639-6000
ddebruin@jenner.com

Counsel for Amici Curiae