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INTEREST OF *AMICI*[1]

The American Cancer Society, American Cancer Society Cancer Action Network (ACS CAN), American Kidney Fund, Arthritis Foundation, Cancer Support Community, Crohn's & Colitis Foundation, Epilepsy Foundation of America, Hemophilia Federation of America, National Minority Quality Health Forum, National Multiple Sclerosis Society, National Patient Advocate Foundation, LUNGevity Foundation, and The Leukemia and Lymphoma Society (collectively, "patient organizations *amici*") are among the largest, most prominent organizations representing the interests of patients, survivors, and families affected by chronic conditions. These conditions are frequently prevented or detected in early stages by preventive services, including those recommended by the U.S. Preventive Services Task Force ("Task Force") pursuant to the preventive care mandate of the Patient Protection and Affordable Care Act (ACA), 42 U.S.C. §

preventive care would have an immediate and devastating impact on health outcomes.

SUMMARY OF ARGUMENT

As organizations representing the interests of patients, survivors, families, and their clinicians across the country, *amici* know that preventive care without cost-sharing improves health outcomes and enables healthier lifestyles.[3] All Americans use or will use health care services, and the lifetime risk that an individual American will contract a serious or chronic disease or condition is high. Preventive services aid in prevention, early detection and treatment of many conditions, increasing patients' chances of recovery and extending life expectancies. Preventive care also helps control costs of treating these conditions.

The Task Force is "a group composed of nationally recognized non-Federal experts in prevention and evidence-based medicine."[4] "Task Force members' considerations of proposed recommendations must be guided by the members' expert and impartial judgment."[5] The ACA preventive services provision requiring private insurers cover Task Force-recommended services without cost-sharing increases patients' ability to receive care that can prevent disease outright, identify conditions early, and reduce the physical and nancial burdens of

[3] *See* HHS Br. at 4, 8 (cleaned up)

treating severe illnesses. Detecting severe diseases early allows for less invasive, more effective, and lower-cost treatment options and substantially improves

survived three prior challenges in this Court.[7] This framework includes insurance coverage for preventive services without cost-sharing so that Americans will have greater access to preventive services. Preventive care can "help people avoid acute illness, identify and treat chronic conditions, prevent cancer or lead to earlier detection, and improve health."[8] "When provided appropriately, these services can identify diseases at earlier stages when they are more treatable or may reduce a person's risk for developing a disease."

Another study published in January 2025 found that if the ACA's requirement that plans cover Task Force-recommended services without cost-sharing was overturned, it would result in millions of commercially-insured individuals losing access to no-cost cancer screenings. According to this research, individuals at risk of losing no-cost coverage include 9 million individuals who are currently getting screened for breast cancer and 5 million more that are eligible for breast cancer screening; 3 million individuals who are currently getting screening for CRC and 11 million rle ftmee t nd tode

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appropriate time intervals and with the recommended follow-up.[15]

- Screenings for CRC increased from 57.3% to 61.2% between 2008 and 2013, especially among individuals with low income, lower education attainment, and Medicare insurance. These results are likely associated with the ACA provisions removing cost-sharing for these screenings.[16]
- The ACA provision at issue also requires preventive services without cost-sharing for the Medicaid expansion population. Improvement in screening rates for CRC in early Medicaid expansion states translated to an additional 236,573 low-income adults receiving screenings in 2016 and, if the same increases were experienced in non-expansion states, 355,184 more low-income adults would have had CRC screening as of 2019.[17] CRC screenings in accordance with Task Force recommendations have reduced the incidence of CRC and have led

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[15] *Colorectal Cancer Facts & Figures 2023-2025*, AM. CANCER SOC'Y (2023), https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2023.pdf.

[16] Stacey A. Fedewa et al., *Elimination of cost-sharing and receipt of screening for colorectal and breast cancer*, 121 CANCER 3272 (2015), https://acsjournals.onlinelibrary.wiley.com/doi/10.1002/cncr.29494.

[17] Jeff Legasse, *First states to expand Medicaid saw larger screening rate increases*, Hcal7CERca/J [(ca)3/J [(J3cAs]TJ /T1_/)-1.1 0.002 w 0.337 2 .1 (c)-l(r)-3.2.3

to earlier stage diagnosis and better survival rates among those diagnosed.[18]

- Cervical cancer incidence and mortality rates have decreased by more than 50% over the past three decades and the decrease can be attributed to regular screenings, which can detect both precancerous lesions and cervical cancer at an early stage.[19]
- The risk of breast cancer death is reduced due to early detection by regular mammography,

Smoking Cessation:

- Smoking cessation reduces the risks of twelve different cancers and can help improve health outcomes after a cancer diagnosis.[22] Smoking cessation also reduces risk and improves health outcomes after a diagnosis of cardiovascular diseases, strokes, aneurisms, respiratory diseases,

blood pressure, cholesterol, Type 2 diabetes

- Obesity increases the risk for high blood pressure and high cholesterol which are risk factors for heart disease.[29]
- Eliminating mandatory coverage without cost-sharing for the preventive blood pressure, cholesterol, diabetes, obesity, and other screenings related to cardiovascular diseases would reduce patient access, meaning risk factors for heart disease would go undetected.

These studies con rm that access to preventive services, facilitated by insurance coverage, increases the likelihood that healthcare providers will diagnose conditions earlier than they otherwise could and that diseases can be prevented before they develop. The data also illustrates that when providers diagnose conditions early, the likelihood of successfully treating patients and extending their lives increases. As organizations dedicated to preventing, treating, and addressing the devastating impact of these conditions, *amici* know that access to affordable preventive health care is fundamental to successful health outcomes.

II. PREVENTIVE CARE RECOMMENDATIONS REDUCE COST BURDENS FOR INDIVIDUALS AND THE NATIONAL HEALTHCARE SYSTEM.

Congress enacted the ACA, including its preventive care mandate, in response to our health care system's failures and the high costs of health insurance. Because these known failures impeded the nation's economic wellbeing, one of Congress's primary aims for

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[29] *Consequences of Obesity*, CTRS. FOR DISEASE CONTROL AND PREVENTION (2022), https://www.cdc.gov/obesity/basics/consequences.html.

elimination led to increases in utilization for select preventive services."[32]

For example, while most people with cystic brosis (CF) are insured, this insurance does not shield them from burdensome out-of-pocket costs. Even when individual co-payments or cost-sharing are relatively modest for any single drug or service, the multitude of out-of-pocket expenses incurred by people with CF can quickly add up. According to a 2020 Health Insurance study by the George Washington University, 71% of people with CF have experienced nancial hardship due to medical expenses.[33]

Furthermore, 45% of people with CF delayed their care in some way due to cost (including skipping medication doses, taking less medicine than prescribed, delaying the re ll of a prescription, or not getting a provider-recommended treatment or test).[34] Reinstituting nancial barriers to preventive services could force people with CF to forego essential care, jeopardizing their health and leading to costly hospitalizations and fatal lung infections.[35]

Individuals with multiple sclerosis (MS) also struggle with the cost of care even with insurance. In one survey, 40% of respondents altered their use of a

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[32] Hope C. Norris, et al., *Utilization Impact of Cost-Sharing Elimination for Preventive Care Services: A Rapid Review*, 79 MED. CARE. RSCH. & REV. 175, 192 (2022), https://www.deepdyve.com/lp/sage/utilization-impact-of-cost-sharingelimination-for-preventive-care-bpUvb2r4Lr?key=sage.

[33] *The Importance of Cost and Affordability for People with CF*, CYSTIC FIBROSIS FOUND. (2022), https://www.cff.org/about-us/importance-cost-and-affordability-people-cf.

[34] *Id*.

[35] *Id*.

disease-modifying therapy (DMT) due to cost, including skipping or delaying treatment.[36] Forty percent also said they experience stress or other emotional impact due to high out-of-pocket costs and are making lifestyle sacri ces to be able to pay for their DMT.[37] More than half of MS patients are concerned about being able to afford their DMT over the next few years. These challenges can cause delays in starting a medication or changing medications when a treatment is no longer working. Delays may result in new MS activity (risking disease progression without recovery) and cause even more stress and anxiety about the future for people already living with the complex challenges and unpredictability of MS. Similarly, 21% of adults with epilepsy reported not being able to afford prescription medications within the last year.[38]

Studies show preventive services recommended by the Task Force also reduce costs for individuals and the U.S. health system. Preventive services facilitate early detection of conditions, leading to treatment of those conditions at less severe stages, which reduces individual and collective healthcare costs. Reduced healthcare costs for individuals not only has immediate positive health outcomes resulting from treatment but can also mitigate chronic stress arising from nancial barriers to care. Chronic stress can increase an individual's risk of anxiety, depression, digestive

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[36] *Make MS Medications Accessible*, NAT'L MULTIPLE SCLEROSIS SOC'Y (2022), https://www.nationalmssociety.org/Treating-MS/Medications/Make-MS-Medications-Accessible.

[37] *Id*.

[38] David J. Thurman, et al., *Health-care access among adults with epilepsy: The U.S. National Health Interview Survey, 2010 and 2013*, 55 EPILEPSY & BEHAVIOR 184 (Feb. 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5317396/.

issues, headaches, heart disease, heart attack, high blood pressure, stroke, and immunosuppression.[39]

Examining preventive services generally, research shows that required cost-sharing, including co-pays, co-insurance, and deductibles, can be a signi cant barrier for patients who need preventive services. This nding is especially true for lower-income patients and patients on a xed income, for whom these payments can represent a significant percentage of their income.[40] Removing cost-

problems, some people may skip such care if cost-sharing is required.[42]

range of specialized care without cost-sharing, including well-woman visits, prenatal screenings, birth control, and cancer screenings.[46]

Numerous disease-speci c studies further support the conclusion that Task Force-recommended preven-

bene ts that accrue primarily at ages [less than or equal to] 65 years under Medicare."[49]

Smoking Cessation:

- Smoking cessation interventions reduce the likelihood that individuals will develop smoking-related diseases and conditions, which ultimately cuts healthcare costs on a system-wide basis.[50]

Kidney Disease:

- T2D is the leading cause of chronic kidney disease (CKD) and end-

and treatment intervention to limit CKD progression in all populations, particularly in people with T2D and cardiovascular risk factors.[51]

PrEP Services:

- The percentage of individuals with no existing co-pay who would not ll a PrEP prescription if a co-pay were required increased as the amount of the co-pay increased, with 11.1% of patients stopping the prescription with the implementation of a co-pay of less than $10 and 42.9% dropping the medication if the co-pay were more than $500.[52]

In sum, preventive care services recommended by the Task Force, provided without cost-sharing, facilitate earlier diagnosis and less invasive, more successful treatment, which reduces costs to individual patients and the U.S. health system as a whole.

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[51] Janet B. McGill, et al., *Making an impact on kidney disease in people with type 2 diabetes: the importance of screening for albuminuria*, 10 BMJ O

screenings for HIV, depression and unhealthy drug use if out of pocket expenditure was required. More than a third stated that they would not even pay for cancer screenings.[55] Similarly, a study in 2023 found 58% of cancer patients and survivors would be less likely to maintain preventive care, including recommended cancer screenings, if the mandate for coverage is overturned and results in patient out-of-pocket costs.[56]

The ACA's framework sought to increase use of preventive care by requiring health insurers to cover Task Force-recommended services with "A" and "B" grades. Congress's goal was to allow individuals greater access to evidence-based care as science evolves.

Numerous Task Force recommendations have changed as science has evolved. For example, in 2008, the Task Force recommended CRC screenings for adults 50 and older.[57] The current CRC screening recommendation has reduced the screening age to 45 and added screening modalities not present in and/or not yet developed at the time of the original recommendation.[58]

Similarly, the Task Force first recommended lung cancer screenings in 2013 and updated its

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[55] *Id*.

[56] *Survivor Views: Majority Less Likely to Get Recommended Screenings if Coverage is Lost*, AM. CANCER SOC'Y ACTION NETWORK (May 11, 2023), https://www.fightcancer.org/policy-resources/survivor-views-majority-less-likely-get-recommended-screenings-if-coverage-lost.

recommendation in 2021.[59] The Task Force developed its new recommendation based, in part, on data from the National Lung Cancer Screening Trial (NLST). NLST provided direct evidence of moderate certainty that lung cancer screening in high-risk populations was effective in reducing lung cancer deaths.[60] These screenings are essential to catching lung cancer early, when it is more treatable. The ve-year survival rate when lung cancer is diagnosed at an early stage is 64%—a stark contrast to the 9% survival rate for late-stage diagnoses.[61]

In February 2019, the Task Force recommended counseling interventions for pregnant and post-partum individuals at increased risk (i)-9 (n)-3 (i).583 Tw -1 -e4(e)-4 (

In August 2022, the Task Force recommended use of statins for adults aged 40 to 75 with one or more risk factors for cardiovascular disease.[69]

In August 2018, the Task Force recommended cervical cancer screening, at either three or ve-year intervals, for women aged 21 to 65.[70] This update to the 2003 recommendation added the option for HPV testing and information regarding speci c testing modalities and intervals.[71]

In March 2020, the Task Force updated its Hepatitis C Virus screening recommendation.[72] The new version "incorporates new evidence" and "expands the ages for screening to all adults from 18-79 years."[73]

In June 2019, the Task Force added HIV screening and treatment recommendations, leading to an extension of mandatory screening coverage to adolescents and adults aged 15-65, adolescents and adults at increased

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[69] *Statin Use for the Primary Prevention of Cardiovascular Disease in Adults*, U.S. PREVENTIVE SERVS. TASK FORCE (Aug. 23, 2022), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/statin-use-in-adults-preventive-medication.

[70] *Final Recommendation Statement: Cervical Cancer: Screening*, U.S. PREVENTIVE SERVS. TASK FORCE (Aug. 21, 2018), https://www.uspreventiveservicestaskforce.org/uspstf/recommen

risk of infection, and pregnant individuals.[74] It simultaneously extended its PrEP recommendation to individuals at high risk of HIV acquisition.[75] These recommendations are especially important because many people experience no symptoms of HIV infection, meaning the only way to identify an infection and prevent the spread of HIV is to test/screen.[76] Between 2012 and 2021, states with the highest PrEP coverage rates had signi cantly greater decreases in HIV diagnosis, with the top ten states reducing HIV diagnosis rates by 8%, while the bottom ten states reduced HIV diagnosis rates by just 1.7%.[77]

Comparing the pre-ACA preventive care requirements with the post-ACA recommendations from the Task Force illustrates the improvements in preventive care services that directly result from those recommendations.

include new screening modalities not previously available and new recommendations based on current

diabetes, all of which have been the subject of the Task Force's updated recommendations.[82]

The Task Force has recommended lifesaving screenings and treatments for a wide array of diseases and conditions, including those which *amici* and their members seek to treat, prevent, and eradicate. These recommendations and their implementation have reduced nancial barriers to preventive care services, increased utilization of those services, and saved and

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Court reverse the court of appeals' decision as to constitutionality of the provisions relating to the Task Force's recommendations. The ACA's preventive care mandate has saved lives and should continue to do so.