No. 23-1275

IN THE

Supreme Court of the United States

EUNICE MEDINA, DIRECTOR, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*,
Respondents.

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

BRIEF OF MASSACHUSETTS, FIFTEEN OTHER STATES, AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICI CURIAE

Amici are the Commonwealth of Massachusetts; the States of California, Colorado, Delaware, Hawai'i, Maryland, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, and Washington; and the District of Columbia. Amici have an interest in the proper construction of the free-choice-of-provider provision, 42 U.S.C. §1396a(a)(23)(A), in at least three distinct ways.

First, the Court's interpretation of that statute will affect the scope of amici's obligations as states[1] that administer Medicaid plans. By participating in the federal-state Medicaid program, amici have agreed to provide healthcare coverage to individuals with low incomes in exchange for federal financial support. While federal law affords amici substantial discretion to shape their Medicaid plans, §1396a(a) imposes several limitations on that discretion. The free-choice-of-provider provision in §1396a(a)(23)(A) is one such limitation. Amici thus have an interest in ensuring the correct interpretation of the statute. And they have extensive experience that will help the Court arrive at the correct interpretation: from decades of administering their Medicaid plans, amici understand that §1396a(a)(23)(A) is best read to safeguard an *individual* right.

Second, the Court's decision will determine whether amici's officials can be held liable under 42 U.S.C. §1983 for violating the free-choice-of-provider provision. In recent years, this Court has emphasized an important limitation on §1983: that statute allows a

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[1] "The term 'State,'" when used in statutes governing Medicaid, "includes the District of Columbia." 42 U.S.C. §1301(a)(1). This brief adopts the same usage for ease of reference.

plaintiff to sue for violation of another federal statute only if the other statute *unambiguously* confers individual rights. *See generally Health & Hosp. Corp. of Marion Cty.* v. *Talevski*, 599 U.S. 166 (2023). As discussed below, §1396a(a)(23)(A) is one of the rare laws that clears this high bar. Amici have an interest in explaining why that is so, because they have an interest in making sure their officials face liability under §1983 only when—as here—Congress clearly intended that result.

Third, the Court's decision in this case will affect Medicaid recipients' access to critical reproductive health services. Amici share a commitment to ensuring their residents' individual autonomy on matters of sexual and reproductive health. In keeping with that commitment, amici have enacted legal protections for reproductive healthcare, and amici's attorneys general diligently enforce those protections in countering attacks on reproductive health services around the country. In Massachusetts, for example, interference with the right of "[a]ccess to reproductive health care services" is "against the public policy of the commonwealth," Gen. Laws ch. 12, §11I½(b), and the Attorney General's Reproductive Justice Unit works to bolster statewide access to comprehensive sexual and reproductive healthcare. *See also, e.g.*, N.Y. Const. art. I, §11 (prohibiting discrimination on the basis of "pregnancy, pregnancy outcomes, and reproductive healthcare and autonomy"). Consistent with these policies, amici have an interest in empowering their residents to combat threats to patient autonomy and reproductive health posed by restrictions like the one South Carolina imposed here.

SUMMARY OF THE ARGUMENT

I. Access to a variety of qualified providers is essential to Medicaid's success. Medicaid improves health outcomes for some of the country's most vulnerable populations, and these health benefits, in turn, confer significant fiscal and economic benefits on both individual enrollees and the broader community. As amici know from decades of experience, a key driver of these outcomes is enrollees' access to an array of qualified providers. Medicaid recipients have at least the same range of health concerns as patients on private insurance, and so they require access to at least the same range of clinicians as patients on private insurance. Access to a variety of providers is also important for Medicaid recipients in rural or underserved areas, where impeding access to the only available provider can completely deprive someone of required care. As relevant here, Planned Parenthood contributes to this much-needed variety: it offers a host of critical health services—including birth control, STI testing, and cancer screenings—to historically underinsured populations. Yet South Carolina has barred Medicaid recipients from choosing to receive *any* such services at a Planned Parenthood affiliate, solely because the organization provides abortion-related healthcare outside the Medicaid program.

II. Section 1396a(a)(23)(A) ensures that Medicaid recipients have access to a wide variety of qualified providers by conferring an *individual* right to patient choice. To be sure, states enjoy substantial discretion to shape their Medicaid programs—a discretion both guaranteed by the Medicaid statute and backed up by well-established constitutional constraints. But the free-choice-of-provider provision is an exception to states' usual flexibility: the statute falls within a

narrow class of laws that unambiguously confer individual rights enforceable through §1983. In addition to its text and structure, the provision's historical context supports that conclusion. All parties agree that Congress enacted §1396a(a)(23)(A) because, in the first two years of the Medicaid program, "some states were forcing recipients to choose from a very narrow list of public providers." Pet. Br. 5. Against this historical backdrop, Congress granted Medicaid recipients an *individual* right, rather than giving government actors primary responsibility for protecting patient choice.

III. The events giving rise to this case only underscore the importance of safeguarding an individual right to choose one's Medicaid provider. There is no genuine dispute that Planned Parenthood South Atlantic (PPSAT) is a "qualified" provider within the meaning of §1396a(a)(23)(A) because it is "capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." Pet. App. 139a. Instead, South Carolina's only reason for ending its agreements with PPSAT is the state's objection to lawful services that Planned Parenthood provides *outside* of Medicaid. Section 1396a(a)(23)(A) does not permit a state to stymie patient choice in this way, and situations like this show why Congress thought it necessary to confer an individual right.

ARGUMENT

I. Access to a variety of qualified providers is key to Medicaid's success.

A. Medicaid improves health outcomes and benefits the public at large.

Created in 1965 and jointly funded by state and federal expenditures, Medicaid offers our country's

most vulnerable populations access to "quality and affordable health care."[2] The program allows each participating state to develop and administer its own unique health plans; as long as a state satisfies threshold statutory criteria and receives federal approval, it can tailor its plans' eligibility standards and coverage options to its residents' needs.[3] Amici have deep experience with that process: they have been administering their respective plans for more than half a century. In that time, amici have seen firsthand how Medicaid benefits both individual patients and the public at large.

1. For individual patients who might not otherwise be able to afford private insurance, Medicaid appreciably improves health outcomes. Studies have shown that access to Medicaid lowers the incidence of preventable diseases and staves off problematic long-term health issues by ensuring that enrollees have access to regular preventative health screenings like annual physicals.[4] One recent study found, for example, that enrollment in Medicaid "decreased the probability of having unmet needs for medical care by 7.5 percentage points and the probability of experiencing

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[2] Ctrs. for Medicare & Medicaid Servs., *History*, https://www.cms.gov/about-cms/who-we-are/history (Sept. 10, 2024); *see* Social Security Amendments of 1965, Pub. L. No. 89-97, §121, 79 Stat. 286, 343-352 (codified as amended at 42 U.S.C. §1396 *et seq.*).

[3] Ctrs. for Disease Control & Prevention, *Medicaid*, https://www.cdc.gov/nchs/hus/sources-definitions/medicaid.htm (July 31, 2024); *see* 42 U.S.C. §13696a.

[4] *See* Xuesong Han *et al.*, *Health-Related Outcomes Among the Poor: Medicaid Expansion vs. Non-Expansion States*, 10 PLOS One 1, 4-9 (2015); Toni Romero *et al.*, *The Effect of Medicaid Expansion on Access to Healthcare, Health Behaviors and Health Outcomes Between Expansion and Non-Expansion States*, 99 Eval. & Program Plan. 1, 7-8 (2023).

delays getting prescription drugs by 7.7 percentage points" and "increased the probability of having a usual source of care by 16.5 percentage points, the probability of having a routine checkup by 17.1 percentage points, and the probability of having a flu shot in [the] past year by 12.6 percentage points."[5] Another study found that enrollment in Medicaid reduces the risk of developing or dying from certain cancers: because "most cases of breast, invasive cervical, and colorectal cancer and subsequent mortality can be prevented with regular screening and appropriate care," the study explained, "public insurance prior to diagnosis is critical to preventing distant stage disease among low-income individuals."[6]

In addition to improving individual recipients' health outcomes, Medicaid also confers significant economic benefits. Studies have found, for example, that the availability of Medicaid coverage decreases individuals' debt and reduces their rates of bankruptcy.[7] Other studies have shown that enrollment in Medicaid early in life leads to "higher rates of employment, higher earnings, lower rates of disability and

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[5] Steven C. Hill *et al.*, *The Effects of Medicaid on Access to Care and Adherence to Recommended Preventive Services*, 56 Health Servs. Res. 84, 84 (2020).

[6] Cathy J. Bradley *et al.*, *Role of Medicaid in Early Detection of Screening-Amenable Cancers*, 31 Cancer, Epidemiology, Biomarkers & Prevention 1202, 1202, 1207 (2022).

[7] Luojia Hu *et al.*, *The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing*, 163 J. Pub. Econ. 99, 111-112 (2018); Tal Gross *et al.*, *Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid*, 95 J. Pub. Econ. 767, 776-777 (2011).

lower rates of public assistance receipt."[8] Still other studies have found that childhood access to Medicaid decreases the probability of incarceration by age 28, an effect driven by a reduction in financially motivated offenses.[9]

In achieving these important results, Medicaid lessens health and economic disparities between individuals who are able to purchase private insurance and those who cannot afford it.[10] Massachusetts' experience is a case in point: the state-administered Medicaid program, MassHealth, has become a key driver of healthcare equity in the Commonwealth. As a recent analysis explained, MassHealth "advances access to preventive care, improves overall health, and enhances economic security."[11]

2. These individual benefits also redound to the benefit of the states themselves. By improving residents' health and economic outlook, Medicaid reduces

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[8] Rose C. Chu *et al.*, Dep't of Health & Human Servs., Office of Health Pol'y, Issue Brief HP-2024-18, *Medicaid: The Health and Economic Benefits of Expanding Eligibility*, at 1, 10 (2024) (citing Andrew Goodman-Bacon, *The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcome*, 111 Amer. Econ. Rev. 2550 (2021); David W. Brown *et al.*, *Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood*, 87 Rev. Econ. Stud. 792 (2020)).

[9] Samuel Arenberg *et al.*, *The Impact of Youth Medicaid Eligibility on Adult Incarceration*, 16 Amer. Econ. J.: Applied Econ. 121, 123-125 (2024); Chu, *supra* n. 8, at 10.

[10] Han, *supra* n. 4, at 6-9; Yilu Lin *et al.*, *Effects of Medicaid Expansion on Poverty Disparities in Health Insurance Coverage*, 20 Int'l J. for Equity in Health 1, 9 (2021).

[11] MassHealth Impact Series, *MassHealth's Role Promoting Health Care Coverage and Access* (June 2021), https://bit.ly/MH-Impact.

long-term costs that states would otherwise bear—for example, the cost of providing public assistance when a preventable disease goes untreated and eventually forces a resident out of work. Data shows that "the cohorts covered by Medicaid as young children in the 1960s and 1970s[] gr[e]w up to be healthier adults who work[ed] more and receive[d] public assistance less often."[12] As a result, Medicaid has "saved the government more than twice its original cost."[13]

B. These outcomes require that Medicaid recipients have access to an array of qualified providers.

1. Critical to the success of Medicaid is the ability of patients to access a wide variety of providers. Individuals who are enrolled in Medicaid have *at least* the same variety and breadth of health concerns as individuals with private insurance,[14] and so they require access to the same range of health professionals, covering the same range of medical specialties. Access to a wide array of providers is also essential for individuals residing in rural or underserved areas. Residents of rural counties rely on Medicaid significantly more than those living in urban counties.[15] If Medicaid

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[12] Goodman-Bacon, *supra* n. 8, at 2588.

[13] *Id.*

[14] Amaya Diana *et al.*, *A Look at Navigating the Health Care System: Medicaid Consumer Perspectives*, KFF (Nov. 7, 2023), https://www.kff.org/medicaid/issue-brief/a-look-at-navigating-the-health-care-system-medicaid-consumer-perspectives. In fact, Medicaid recipients report poorer health compared to those with other coverage. *See id.*

[15] Aubrianna Osorio *et al.*, Geo. Univ. Ctr. for Children & Families, *Medicaid's Coverage Role in Small Towns and Rural Areas* (Aug. 17, 2023), https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas.

does not cover all the qualified providers—sometimes just a single clinician for a given service—in a particular rural area, residents risk losing access to essential services altogether.

Broad access to a variety of qualified providers through Medicaid has proven particularly critical for women of reproductive age, especially for managing risk factors that may complicate pregnancy for certain patients. Enrollment in Medicaid has been associated with "increased healthcare coverage and utilization, better self-rated health, and decreases in avoidance of care because of cost, heavy drinking, and binge drinking"—all of which may contribute to risk factors during pregnancy.[16] Access to healthcare providers who are well-versed in the risk factors for women of reproductive age is thus critical to providing the full spectrum of healthcare to these patients.

2. Planned Parenthood is an essential part of this network of Medicaid providers. This case arose because South Carolina objects to Planned Parenthood's provision of abortion-related healthcare. *See* Pet. Br. 7. But Planned Parenthood's clinics offer a host of services unrelated to abortion, including pregnancy testing and counseling; birth control; breast-cancer screening; screening and treatment for cervical cancer; screening and treatment for sexually transmitted infections; and screening for conditions like diabetes, depression, anemia, high cholesterol, thyroid disorders, and high blood pressure. *See* J.A. 19-22; Pet. App. 86a-87a. Notably, these clinics often provide services in places where individuals might otherwise lack

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[16] *See* Claire E. Margerison *et al.*, *Impacts of Medicaid Expansion on Health Among Women of Reproductive Age*, 58 Am. J. Preventative Med. 1, 1 (2020).

access to a provider: according to Planned Parenthood, 76% of its health centers are located in rural or medically underserved areas.[17]

Amici have direct experience with the vital role that Planned Parenthood plays in serving historically underinsured individuals. For example, Planned Parenthood League of Massachusetts (PPLM) reports that approximately 27% of the patients it saw for non-abortion-related care in 2024—*i.e.*, some 5,341 Massachusetts residents—were Medicaid recipients. A decision barring the use of Medicaid to cover services at PPLM clinics would thus have jeopardized needed care for thousands of individuals.

II. The free-choice-of-provider provision ensures that patients have access to a range of health providers and services.

Section 1396a(a)(23)(A) vindicates the important interests just discussed. Enacted to counter state policies that restricted Medicaid recipients to a narrow subset of state-sanctioned healthcare providers, the statute safeguards patients' medical decisions from government micromanagement. Given Congress's intent to secure *individual* patient autonomy, Congress unsurprisingly chose to frame the statute's protections as an *individual* right. In doing so, Congress crafted a narrow but important limitation on states' otherwise considerable control over their Medicaid offerings.

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[17] Planned Parenthood Federation of America, *The Irreplaceable Role of Planned Parenthood Health Centers*, at 1 (April 2024), https://bit.ly/PPFA-Role.

A. States enjoy substantial discretion to shape their Medicaid programs.

Petitioner begins by observing (Br. 2) that Medicaid is a "cooperative-federalism program" that affords "substantial discretion" to participating states. On that much, at least, petitioner and amici generally agree: consistent with our federal system's well-established limitations on Congress's authority, Medicaid leaves significant power in the hands of the individual states.

That commitment to state discretion is apparent from the text and structure of the Medicaid statute itself. States can choose whether to participate in Medicaid in the first place: the statute "offers the States a bargain" that they are free to reject. *Armstrong* v. *Exceptional Child Center, Inc.*, 575 U.S. 320, 323 (2015); *see* 42 U.S.C. §§1396a-1396b. And even after a state signs up, Medicaid is not a take-it-or-leave-it proposition. Instead, the statute affords each participating state "substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage." *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985); *see* §1396a(a); *cf.* §1396c(2) (allowing HHS to withhold payments for "failure to comply *substantially* with" program requirements (emphasis added)).

These statutory safeguards work in tandem with well-established constitutional constraints that ensure that exercises of the federal spending power do not invade traditional areas of state concern. This Court has stressed, for example, that states must have a genuine choice about whether to join federal spending programs: a congressional "offer" that effectively compels a state's participation offends the Constitution. *See NFIB* v. *Sebelius*, 567 U.S. 519, 577-578 (2012) (plurality opinion) (explaining that, while

Congress may "create incentives for States to act in accordance with federal policies," it may not "directly command[] a State to regulate or indirectly coerce[] a State to adopt a federal regulatory system"); *accord id.* at 681-689 (joint dissent). Similarly, because the legitimacy of a cooperative federal-state program "rests on whether the State voluntarily and knowingly accept[ed] the [program's] terms," Congress must "impose a condition on the grant of federal moneys . . . unambiguously." *Pennhurst State School & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981). That requirement applies with equal force to efforts to subject participating states to liability under §1983: to open the door to private lawsuits, a federal statute "must *unambiguously* confer individual federal rights." *Health & Hosp. Corp. of Marion County* v. *Talevski*, 599 U.S. 166, 180 (2023).

B. The free-choice-of-provider provision is a limited exception to states' otherwise substantial discretion.

Section 1396a(a)(23)(A) falls within the narrow category of statutes that unambiguously confer individual rights. The Fourth Circuit held, and respondents have explained, why the statute's text supports that conclusion. *See* Pet. App. 24a-31a; Resp. Br. 19-29. But the provision's text does not exist in a vacuum: in amici's view, the provision's historical context is also key to understanding why §1396a(a)(23)(A) differs from the mine run of federal statutes in its creation of an individually enforceable right. *See, e.g.*, *Federal Republic of Germany* v. *Philipp*, 592 U.S. 169, 183 (2021) (situating a statute in its "[h]istory and context" to understand its meaning); *Niz-Chavez* v. *Garland*, 593 U.S. 155, 167 (2021) (same).

All parties acknowledge that Congress enacted §1396a(a)(23)(A) to address a specific problem: during the first two years of Medicaid's existence, some states "forc[ed] recipients to choose from a very narrow list of public providers." Pet. Br. 5; *see* Resp. Br. 29-33; Pet. App. 6a. Massachusetts, for example, declined to cover services that Medicaid recipients obtained from private physicians at one of the Commonwealth's 19 teaching hospitals. Hearings on H.R. 5710 Before the H. Comm. on Ways & Means, 90th Cong., at 2301 (1967) (Massachusetts Medical Society). Puerto Rico imposed similar restrictions, requiring its Medicaid recipients to seek their care at "governmental facilities." *Id.* at 2237 (Asociación de Hospitales de Puerto Rico).

These concerns came to the fore as Congress weighed various amendments to the Medicaid program in 1967. The legislative record is replete with expressions of support from an array of individuals and organizations—using unmistakably rights-based language—for the proposed "freedom of choice" provision that eventually became §1396a(a)(23)(A). *See id.* at 1637-1638, 1664, 1674, 1686, 1710, 1932, 1949-1951, 1977, 2273, 2300-2301, 2303-2304. Tellingly, this testimony often emphasized the importance of medical choice *to the individual*. The Puerto Rico Medical Association, for example, supported the provision because:

> Freedom of choice of physician by the patient enhances the concept of progress and democracy in action. It destroys apathy and dependence upon others [and] enhances personal initiative[,] which is an essential spark in any democratic form of government.

Id. at 1637.

Against this historical backdrop, it should come as no surprise that Congress chose to grant Medicaid recipients an *individual* right, rather than to give government actors primary responsibility for safeguarding patient choice. Congress had no reason to leave the protection of this right to the states—after all, it was precisely *because* of how state governments chose to restrict patient choice that Congress perceived a need to enact the protections now found in §1396a(a)(23)(A). Neither would it have made sense for Congress to rely exclusively on the federal government to enforce these protections; it is impractical to expect the federal government to vindicate each of the millions of Medicaid recipients' statutory right to choose a qualified provider.

In sum, states have considerable discretion to fashion their Medicaid programs, and only a clear congressional enactment can intrude on that discretion by authorizing a §1983 suit. But the history confirms that §1396a(a)(23)(A), which Congress enacted to prohibit a specific practice in which states had been engaging, is precisely this kind of rare check on state discretion.

III. South Carolina's efforts to stymie patient choice show why Congress thought it necessary to confer an individual right.

The events giving rise to this case only underscore the importance of safeguarding an *individual* right to choose one's Medicaid provider. As South Carolina's actions make clear, efforts to restrict individual patient choice are just as real today as they were when Congress enacted §1396a(a)(23)(A) more than half a century ago.

There is no genuine dispute that respondent PPSAT is a "qualified" provider of the health services

at issue, and that South Carolina is therefore not engaging in a legitimate exercise of its power to exclude unqualified providers. A provider is "qualified" within the meaning of §1396a(a)(23)(A) if it is "capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." Pet. App. 139a.[18] And "[t]here has never been any question during the long path of this litigation"—indeed, petitioner "has not contested"—that PPSAT satisfies that standard, *i.e.*, that it "is professionally qualified to provide the care that the plaintiff seeks." Pet. App. 33a; *see also* Pet. App. 74a (observing that "the record is [de]void of any argument or evidence PPSAT was unqualified to perform any services"). As Judge Wilkinson put it, "[i]n this case, PPSAT's qualifications are simply not in dispute." Pet. App. 98a n. 3.

Instead, the only basis for South Carolina's attempt to terminate its agreements with PPSAT is its objection to lawful services that Planned Parenthood provides "outside of the Medicaid program." Pet. App. 87a. In other words, South Carolina is doing exactly what led Congress to pass §1396a(a)(23)(A) in the first place (*see supra* pp. 13-14): it is attempting to substitute its own judgment—unrelated to provider qualifications—for the judgment of its Medicaid recipients regarding their care. The statute does not permit it to do so.

Situations like this show why Congress thought it necessary to confer an individual right. South Carolina has elected to restrict patients' right to choose an

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[18] *Accord* Pet. App. 9a, 47a, 90a; *Planned Parenthood of Kansas* v. *Andersen*, 882 F.3d 1205, 1230 (10th Cir. 2018); *Planned Parenthood of Indiana, Inc.* v. *Comm'r of the Ind. Dep't of Health*, 699 F.3d 962, 978 (7th Cir. 2012); *Planned Parenthood Arizona Inc.* v. *Betlach*, 727 F.3d 960, 969 (9th Cir. 2013).

undisputedly qualified provider, despite the clear command of §1396a(a)(23)(A). And the federal government has not taken action to enforce the statute. Reading the statute to preclude the only other avenue of relief—individual action—would turn its guarantee of choice into an empty promise.

That is not the best understanding of the statute. For the reasons discussed, the free-choice-of-provider provision confers an individual right precisely because Congress was concerned about actions like those that South Carolina has taken here.

CONCLUSION

The Court should affirm the judgment of the Fourth Circuit.

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Respectfully submitted.

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