Case No. 16-3249

IN THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

PLANNED PARENTHOOD OF KANSAS AND MID-MISSOURI; PLANNED PARENTHOOD OF ST. LOUIS REGION; JANE DOE #1, on her behalf and on behalf of all others similarly situated; JANE DOE #2, on her behalf and on behalf of all others similarly situated; JANE DOE #3, on her behalf and on behalf of all others similarly situated,

Plaintiffs-Appellees

v.

SUSAN MOSIER, Secretary, Kansas Department of Health and Environment, in her official capacity,

Defendant-Appellant

On Appeal from the United States District Court for the District of Kansas
Civil Action No. 2:16-CV-02284-JAR-GLR
Judge Julie A. Robinson

BRIEF OF THE NATIONAL HEALTH LAW PROGRAM, AMERICAN PUBLIC HEALTH ASSOCIATION, CENTER FOR REPRODUCTIVE RIGHTS, IPAS, NATIONAL CENTER FOR LESBIAN RIGHTS, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH, NATIONAL WOMEN'S LAW CENTER, AND SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES (SIECUS) AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND URGING AFFIRMANCE

Martha Jane Perkins
NATIONAL HEALTH LAW PROGRAM
200 N. Greensboro Street, Suite D-13
Carrboro, North Carolina 27510
Tel: (919) 968-6308 (x101)
perkins@healthlaw.org
Counsel for Amici Curiae

CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, the undersigned counsel certifies that *amici curiae* the National Health Law Program, American Public Health Association, Center for Reproductive Rights, IPAS, National Center for Lesbian Rights, National Family Planning and Reproductive Health Association, National Latina Institute for Reproductive Health, National Women‟s Law Center, and Sexuality Information and Education Council of the United States (SIECUS), are not subsidiaries of any other corporation and no publicly held corporation owns ten percent or more of the organizations‟ stock.

Date: December 2, 2016

/s/ Martha Jane Perkins
Martha Jane Perkins

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INTEREST OF THE *AMICI*[1]

The *amici curiae* file this brief pursuant to Fed. R. App. P. 29. All parties have consented to its filing. *Amici* are the National Health Law Program, American Public Health Association, Center for Reproductive Rights, IPAS, National Center for Lesbian Rights, National Family Planning and Reproductive Health Association, National Latina Institute for Reproductive Health, National Women's Law Center, and Sexuality Information and Education Council of the United States (SIECUS). While each *amicus* has particular interests, they collectively bring to the Court a commitment to advocate on behalf of low-income people, women, older adults, people with disabilities, and children. *Amici* also research and provide education on a range of policy and legal issues affecting these populations, including health insurance coverage, access to comprehensive health care, including reproductive health care, and access to the courts. As such, *amici* have an interest in the outcome of this case.

SUMMARY OF ARGUMENT

Medicaid is the largest public health insurance program for low-income people in the United States. In Kansas, Medicaid (along with the Children's Health

[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amici curiae* states that no counsel for a party authored this brief in whole or in part, and no person other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

Insurance Program) helps provide over 420,000 adults and children access to essential health care services. Medicaid.gov, *Medicaid: Kansas*, https://www.medicaid.gov/medicaid-chip-program-information/by-state/kansas.html (last visited Nov. 18, 2016). Federal law requires all state Medicaid programs to cover family planning services and supplies. Low-income women who are enrolled in Medicaid—nationwide and in Kansas—depend on Planned Parenthood clinics for these family planning services and supplies.

Recognizing the importance of meaningful access to health care services, including family planning services and supplies, Congress included a free choice of provider provision in the Medicaid Act. That provision requires Medicaid-participating states to ensure

> that . . . any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services. . . .

42 U.S.C. § 1396a(a)(23)(A).

This free choice of provider provision is enforceable in federal court pursuant to 42 U.S.C. § 1983. The Supreme Court has an established test for determining when a federal statute creates rights that are enforceable pursuant to 42 U.S.C. § 1983. Congress has amended the Social Security Act specifically to recognize the application of the enforcement test. *See* 42 U.S.C. §§ 1320a-2, 1320a-10. The federal courts of appeals understand this test, and every appellate

court to have decided the issue, to date, has applied the test and concluded that the free choice of provider provision of the Medicaid Act creates a federal right under section 1983 that is enforceable by Medicaid beneficiaries. The Supreme Court's recent decision in *Armstrong v. Exceptional Child Center*, *Inc.*, 135 S. Ct. 1378 (2015), does not affect the Supreme Court's section 1983 precedents, Congress' endorsement of the enforcement test, or the federal courts' application of that test to the Medicaid free choice of provider provision.

ARGUMENT

I. PLANNED PARENTHOOD IS A CRITICAL PROVIDER OF WOMEN'S HEALTH CARE SERVICES.

Across the country, specialized family planning clinics like Planned Parenthood play an important role in caring for low-income individuals. *See*, *e.g.*, Jennifer J. Frost, Rachel Benson Gold, & Amelia Bucek, *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 WOMEN'S HEALTH ISSUES e519 (2012); Kinsey Hasstedt, Yana Vierboom, & Rachel Benson Gold, *Still Needed: The Family Planning Safety Net Under Health Reform*, 18 GUTTMACHER POLICY REV. 56 (2015). Six in ten women receiving contraceptive care at a family planning clinic consider that provider their usual source of health care, and for four in ten women, it is their only source of care. Jennifer J. Frost, Guttmacher Inst. *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of*

Care and Factors Associated with Use, 1995-2010 at 43 (2013), http://www.guttmacher.org/pubs/sources-of-care-2013.pdf; Frost, Gold, & Bucek, 22 WOMEN'S HEALTH ISSUES at e519, e522.

Further, approximately six in ten women who accessed contraceptive care from a specialized family planning provider specifically chose to obtain this care from a provider with family planning expertise, even while obtaining some other care from another provider in their community. Frost, Gold, & Bucek, 22 WOMEN'S HEALTH ISSUES at e524. Women often prefer to access reproductive and sexual health care services from providers that specialize in the provision of such care. *Id.* at e524-e526. Specialized family planning clinics, including Planned Parenthood, thus play a critical role in ensuring that women have consistent and timely access to the full-range of reproductive health care services, including contraception, that they need. Timely access to comprehensive family planning services and supplies is particularly important given that forty-five percent of all pregnancies in Kansas are unintended. *See* Kathryn Kost, Guttmacher Inst., *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002* at 8 (2015), https://www.guttmacher.org/pubs/StateUP10.pdf.

Not only are Planned Parenthood clinics a preferred provider of care for many women, they also offer a broader scope of contraceptive methods than do other types of publicly funded health clinics. *See* Mia R. Zolna & Jennifer J. Frost,

Guttmacher Inst., *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols* 12, 35 (2016), https://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015. Ensuring the availability of a broad range of contraceptive methods makes it more likely that a woman can choose and use the method that is best for her, thereby increasing the likelihood of correct and consistent use. *See* Jennifer J. Frost, Jacqueline E. Darroch, & Lisa Remez, Guttmacher Inst., *Improving Contraceptive Use in the United States* 5 (2008), https://www.guttmacher.org/report/improving-contraceptive-use-united-states (finding that "being dissatisfied with one's [contraceptive] method is associated with incorrect or inconsistent use"); Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 40 PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 94, 103 (2008); Frost, Gold, & Bucek, 22 WOMEN'S HEALTH ISSUES at e523 ("Contraceptive method availability (can get the method I want or can get supplies, not just a prescription) was very important to 84% of respondents. . . ."). This is particularly important since the two-thirds of United States women at risk of unintended pregnancy who use contraception consistently and correctly throughout the course of any year account for only five percent of all unintended pregnancies. Adam Sonfield, Kinsey Hasstedt, & Rachel Benson Gold, Guttmacher Inst.,

Moving Forward: Family Planning in the Era of Health Reform 8 (2014), https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

Planned Parenthood clinics are more likely than other types of publicly funded clinics to provide most contraceptive methods. *See* Zolna & Frost, *Publicly Funded Family Planning Clinics in 2015* at 12. Planned Parenthood clinics are more likely to offer a wide range of reversible contraceptive methods—99% of Planned Parenthood clinics offer at least ten reversible methods, compared with 81% of health departments, 71% of FQHCs, and 74% of other publicly funded centers. *Id*. at 35.

Planned Parenthood clinics are also more likely than other publicly funded clinics to offer long-acting reversible contraceptive methods (LARCs), *i.e.*, intrauterine devices and implants. *Id.* LARCs are the most effective contraceptive method—more "effective in preventing unintended pregnancy than contraceptive pills, patch, or [the] ring." Brooke Winner et al., *Effectiveness of Long-Acting Reversible Contraception*, 366 NEW ENG. J. MED. 1998, 1999 (2012); *see also* Am. Coll. of Obstetricians & Gynecologists Comm. on Gynecologic Practice, Long-Acting Reversible Contraception Working Group, Comm. No. 642, *Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancies* 1 (2015) (recommending reducing barriers to LARCs to reduce

unintended pregnancies); Jeffrey F. Peipert, Tessa Madden, Jenifer E. Allsworth, & Gina M. Secura, *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291, 1291-92 (2012) (concluding that providing access to no-cost contraception greatly increased the ability of adolescents and women in the St. Louis region to select LARCs, thereby allowing them to reduce unintended pregnancies). Specifically, 98% of Planned Parenthood clinics offer a LARC method. Zolna & Frost, *Publicly Funded Family Planning Clinics in 2015* at 35. By comparison, 77% of health departments, 69% of FQHCs, and 76% of other publicly funded centers offer a LARC method. *Id.*

Planned Parenthood clinics also excel at ensuring that women have timely access to family planning services and supplies. Planned Parenthood clinics are more likely to dispense oral contraceptive supplies and refills on-site at the clinic, as compared to clinics operated by other types of agencies where women are given a prescription and then need to go to a pharmacy to have that prescription filled. *Id.* at 19, 38. Similarly, Planned Parenthood clinics are much more likely than other publicly funded clinics to insert a LARC device during the same appointment when the method was requested. *Id*. at 22. Eighty-one percent of Planned Parenthood clinics that offer intrauterine devices provide same-day insertion, compared with 35% of health departments, 30% of FQHCs, and 48% of other publicly funded centers. *Id*. Making multiple trips to access health care can be hard

for women, especially low-income women, and can thereby reduce the overall efficacy of family planning services. Further, 89% of Planned Parenthood clinics provide patients with emergency contraception pills in advance to ensure that women have contraception on hand in case they need it, as compared to 36% of health departments, 34% of FQHCs, and 48% of centers operated by different types of agencies. *Id.* at 38. Emergency contraception is used to prevent pregnancy after unprotected intercourse or contraceptive failure. Am. Coll. of Obstetricians & Gynecologists, Comm. on Healthcare for Underserved Women, Comm. Op. No. 542, *Access to Emergency Contraception* 1 (2012). The American College of Obstetricians and Gynecologists recommends writing advance prescriptions for emergency contraception. *Id.* at 3.

In addition, Planned Parenthood health clinics are more likely than other types of clinics to offer same-day appointments for family planning services. Zolna & Frost, *Publicly Funded Family Planning Clinics in 2015* at 34. Overall, Planned Parenthood clinics also have shorter wait times for women to access care than other types of providers. *Id*. Specifically, women seeking an appointment at a Planned Parenthood clinic can expect to wait, on average, 1.2 days, compared to average wait times of 4.1 days at a health department, 2.5 days at an FQHC, and 3.9 days at other types of publicly funded clinics. *Id*. While patients at a Planned Parenthood clinic are likely to receive walk-in services or experience short wait

times for an appointment, more than half of the providers listed as participating in a Medicaid managed care plan do not offer appointments to Medicaid enrollees. *See* U.S. Dep't of Health & Human Servs., Office of Inspector Gen., *Access to Care: Provider Availability in Medicaid Managed Care* 8 (2014), http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf. Among these Medicaid providers actually offering appointments, the median wait time is two weeks, over 25% of enrollees had wait times of longer than one month, and 20% had wait times of more than two months. *Id.* at 10. Finally, Planned Parenthood clinics are the most likely type of publicly funded family planning clinic to offer clinic hours in the evenings and/or on weekends. Zolna & Frost, *Publicly Funded Family Planning Clinics in 2015* at 9, 34. Ensuring timely access to family planning services is particularly important given the time-sensitive nature of these services. Expanded business hours, like those offered by Planned Parenthood clinics, are an effective means of improving access to this important Medicaid service. *See* Frost, Gold, & Bucek, 22 WOMEN'S HEALTH ISSUES at e523 (eighty-nine percent of women reported that "location, hours, or wait time" was very important to their decision to visit a clinic).

II. CONGRESS AND THE SUPREME COURT RECOGNIZE THE RIGHT OF INDIVIDUALS TO ENFORCE PROVISIONS OF THE SOCIAL SECURITY ACT PURSUANT TO 42 U.S.C. § 1983.

Medicaid beneficiaries depend on states to adhere to the various Medicaid Act requirements. *See* 42 U.S.C. § 1396a. Given the importance of family planning services and supplies, such as those provided by Planned Parenthood clinics, Congress included a mandate in the Medicaid Act requiring states to

> provide that . . . any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services. . . .

42 U.S.C. § 1396a(a)(23)(A) ("section (23)(A)" or "free choice of provider provision").

A Medicaid provision, 42 U.S.C. § 1396c, does allow the federal government to terminate or withhold funding to states that do not comply with the federal law. That provision has rarely—if ever—been enforced by the federal government. It is not, however, the only remedy that Congress and the Supreme Court recognize. Entitlement to Medicaid triggers legal rights, including the right to enforce certain statutory requirements that are placed on the states. As explained below, the Medicaid Act is part of the Social Security Act, and Medicaid beneficiaries, like the plaintiffs in this case, can enforce certain provisions of the Medicaid Act, including the free choice of provider provision, in actions for prospective, injunctive relief pursuant to 42 U.S.C. § 1983.

A. Controlling Supreme Court Precedent Establishes the Right of Individuals to Enforce Provisions of the Social Security Act Pursuant to 42 U.S.C. § 1983.

Section 1983 litigation has protected the federal rights that Congress guaranteed in the Social Security Act. As Justice Harlan observed in a Social Security Act case filed by program beneficiaries pursuant to section 1983:

> It is, of course, no part of the business of this Court to evaluate, apart from federal constitutional or statutory challenge, the merits or wisdom of any welfare programs, whether state or federal, in the large or in the particular. It is, on the other hand, peculiarly part of the duty of this tribunal, no less in the welfare field than in other areas of the law, to resolve disputes as to whether federal funds allocated to the States are being expended in consonance with the conditions that Congress has attached to their use.

Rosado v. Wyman, 397 U.S. 397, 422-23 (1970) (holding that suits in federal court under section 1983 are proper to secure compliance with provisions of the Social Security Act). Indeed, on multiple occasions, the Supreme Court has recognized that provisions of the Social Security Act may be enforced through section 1983. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 524 (1990) (allowing enforcement of a Medicaid Act provision concerning payment for institutional services); *Maine v. Thiboutot*, 448 U.S. 1, 6-8 (1980) (holding "the phrase 'and laws,' as used in § 1983, means what it says" and applies not only to constitutional rights but also to rights defined in federal statutes and allowing enforcement of a Social Security Act provision); *Edelman v. Jordan*, 415 U.S. 651, 675 (1974) ("[S]uits in federal court under § 1983 are proper to secure compliance with the provisions of the Social

Security Act on the part of participating States."); *King v. Smith*, 392 U.S. 309, 333-34 (1968) (allowing enforcement of the "reasonable promptness" provision of a Social Security Act program). *See generally Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17-18 (1981) (Rehnquist, J.) (citing *King v. Smith* with favor in case involving the Developmentally Disabled Assistance and Bill of Rights Act, which is not part of the Social Security Act, and stating "where Congress has intended the States to fund certain entitlements as a condition of receiving federal funds, it has proved capable of saying so explicitly").

In *Wilder*, a hospital association filed suit under section 1983 alleging that state officials were violating the hospitals' rights under a payment provision of the Medicaid Act. 496 U.S. at 501. After acknowledging that *Maine v. Thiboutot* authorized a section 1983 action for violations of federal statutes, the Court noted two exceptions to this general rule of enforcement: when the statute does not create individual rights within the meaning of section 1983 and when Congress has foreclosed enforcement through section 1983 in the underlying statute itself. *Id.* at 508-09. The Court then stated a test for determining whether a statutory provision creates a "federal right" under section 1983:

> Such an inquiry turns on whether the provision in question was intend[ed] to benefit the putative plaintiffs . . . . If so, the provision creates an enforceable right unless it reflects merely a congressional preference for a certain kind of conduct rather than a binding obligation on the governmental unit, . . . or unless the interest the

> plaintiff asserts is too vague and amorphous such that it is beyond the competence of the judiciary to enforce.

Id. at 509 (citations and internal quotations omitted). Applying this test, *Wilder* held that the Medicaid provision at issue created a right enforceable by hospitals under section 1983. *Id.* at 509-10.

Thereafter, in *Blessing v. Freestone*, the Supreme Court instructed courts to use this "traditional" enforcement test for determining whether Congress intended a federal statute to create rights under section 1983. 520 U.S. 329, 344 (1997). Specifically, courts must ascertain whether "each separate claim" satisfies the test. *Id*. at 342; *see also Suter v. Artist M.*, 503 U.S. 347, 358 n.8 (1992) (instructing that each federal statute "must be interpreted on its own terms"). The three-part enforcement test asks whether the provision cited by the plaintiff: (1) creates a right intended to benefit the plaintiff, (2) is written with sufficient clarity for a court to enforce, and (3) is mandatory on the state. *See Blessing*, 520 U.S. at 340-41; *Wilder*, 496 U.S. at 509. *Gonzaga University v. Doe* clarified that the first prong of the enforcement test is met only by federal provisions that contain unambiguous "rights-creating terms." 536 U.S. 273, 284 (2002) (involving a provision of the Family Educational Rights and Privacy Act, which is not part of the Social Security Act).

When the three-part test is met, "the right is presumptively enforceable by § 1983." *Id*. The presumption can be overcome only by demonstrating that Congress

foreclosed private enforcement expressly or by creating a "„comprehensive enforcement scheme that is incompatible with‟" private enforcement. *Id*. at 284 n.4 (quoting *Blessing*, 520 U.S. at 341); *see also Blessing*, 520 U.S. at 346 (stating this is a "difficult showing").[2] The *Wilder* Court held that Medicaid‟s administrative process "to curtail federal funds to States whose plans are not in compliance with the Act [42 U.S.C. § 1396c] . . . cannot be considered sufficiently comprehensive to demonstrate a congressional intent to withdraw the private remedy of § 1983." 496 U.S. at 521-22; *see also City of Rancho Palo Verdes v. Abrams*, 544 U.S. 113, 121-22 (2005) (Scalia, J.) (including *Wilder* and Medicaid in listing of previous cases and statutes where section 1983 enforcement is not foreclosed by a statutory enforcement scheme); *Gonzaga Univ.,* 536 U.S. at 280-81 (noting *Wilder* held the Medicaid Act contains "no sufficient administrative means of enforcing the requirement against States that failed to comply").

B. Congress Clearly Intends Private Enforcement of Social Security Act Provisions Under 42 U.S.C. § 1983.

Congress is well aware of the basic ground rules established by the Supreme Court: When a provision of a spending clause enactment is couched in terms that

[2] The Court has found enforcement under § 1983 foreclosed in only a few cases: *City of Rancho Palos Verdes*, 544 U.S. 113 (2005) (regarding Telecommunications Act); *Smith v. Robinson*, 468 U.S. 992 (1984) (regarding Education of the Handicapped Act); *Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1 (1981) (regarding Water Pollution Control and Marine Protection, Research and Sanctuaries of 1972 Acts).

are "precatory," *Pennhurst*, 451 U.S. at 17, or that have an "'aggregate' focus," *Gonzaga Univ.*, 536 U.S. at 288, or included in a statute that provides alternative, comprehensive private enforcement mechanisms, *see Smith*, 468 U.S. at 1012, it will not give rise to a section 1983 remedy. However, when the provision at hand binds states and confers entitlements on individuals, those will be regarded as "rights secured by the . . . laws of the United States" under section 1983. 42 U.S.C. § 1983.

Congress has evinced its understanding of this design on a number of occasions. Following the Supreme Court decision in *Suter v. Artist M.*, 503 U.S. 347 (1992), Congress amended the Social Security Act to make clear that beneficiaries can enforce provisions of the Act that meet the traditional enforcement test. *Suter* held that plaintiffs could not use section 1983 to enforce a provision of the Adoption Assistance and Child Welfare title of the Social Security Act. *Id.* at 363. The *Suter* Court further stated that a Social Security Act provision did not create enforceable rights if it was placed in a statute that listed mandatory elements of state plans submitted to receive federal funds. *Id.* at 358. This part of the decision had potentially far-reaching ramifications because most Social Security Act titles, including Medicaid, are written in terms of what a state plan must include for a state to receive federal funds to operate the plan. Indeed, soon after *Suter* was decided, some courts began to hold that entire titles of the Social

Security Act could not be enforced. *See*, *e.g.*, *Mason v. Bradley*, 789 F. Supp. 273 (N.D. Ill. 1992) (finding no private right to enforce Aid to Families with Dependent Children program).

Congress reacted decisively to correct the *Suter* error and reestablish the private right of action as it existed previously in cases such as *Wilder*, *Thiboutot*, and *Rosado*. Specifically, Congress amended the Social Security Act to provide:

> In an action brought to enforce a provision of [the Social Security Act], such provision is not to be deemed unenforceable because of its inclusion in a section of [the Act] requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in *Suter v. Artist M.*, 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in *Suter v. Artist M.* that section 671(a)(15) of [the Act] is not enforceable in a private right of action.

42 U.S.C. §§ 1320a-2, 1320a-10. The Conferees explained that:

> The intent of this provision is to assure that individuals who have been injured by a State"s failure to comply with the Federal mandates of the State plan titles of the Social Security Act are able to seek redress in federal courts to the extent they were able to prior to the decision in *Suter v. Artist M*.

H.R. Conf. Rep. No. 761, 103d Cong., 2d Sess., at 926 (1994), *reprinted in* 1994 U.S.C.C.A.N. 2901, 3257. According to the House Ways and Means Committee:

> Prior to this decision, the Supreme Court has recognized, in a substantial number of decisions, that beneficiaries of Federal-State programs could seek to enjoin State violations of Federal statutes by

> suing under 42 U.S.C. § 1983. *See Rosado v. Wyman*, 397 U.S. 397 (1970); *Maine v. Thiboutot*, 448 U.S. 1 (1980).

Report of the Comm. on Ways & Means, House of Representatives, No. 102-631, 102 Cong., 2d Sess., at 364 (1992). The Committee also noted that:

> Social Security beneficiaries, parents, and advocacy groups have brought hundreds of successful lawsuits alleging failure of the State and/or locality to comply with State plan requirements of the Social Security Act. . . . Much of this litigation has resulted in comprehensive reforms of Federal-State programs operated under the Social Security Act, and increased compliance with the mandates of the Federal statutes . . . . *Suter v. Artist M* could also result in the dismissal of many suits brought to enforce the State plan titles of the Social Security Act pending on or commenced after the date of the Court"s decision in the case. Lower courts have already relied on the *Suter v. Artist M*. decision to dismiss lawsuits brought to enforce the program requirements. . . .

Id. at 364-65. Congress provided yet further evidence of its intent when it stated:

> [When] Congress places requirements in a statute, we intend for the States to follow them. If they fail in this, the Federal courts can order them to comply with the congressional mandate. For 25 years, this was the reading that the Supreme Court had given to our actions in Social Security Act State plan programs. The *Suter* decision represented a departure from this line of reasoning.

139 Cong. Rec. S173, S3, 189 (1993). As is evident from the face of the statute itself, the purpose of the law is to "restore[ ] the right of individuals to turn to Federal courts when States fail to implement Federal standards under the Social Security Act." 138 Cong. Rec. S17689-01 (1992) (statement of Sen. Riegle).[3]

[3] In 1981, 1985, 1987, and 1996, Congress rejected bills that would have limited

C. The Courts of Appeals Consistently Apply the Enforcement Test to Decide Whether a Provision Creates a Federal Right Under 42 U.S.C. § 1983.

In *Gonzaga*, the Supreme Court addressed confusion surrounding application of the first (intent-to-benefit) prong of the enforcement test by clarifying that a general intent to benefit individuals will not do; rather, the federal law at issue must contain unambiguous "rights-creating terms." 536 U.S. at 282-84. Since 2002 when *Gonzaga* was decided, the federal courts of appeals have reviewed the enforceability of twenty-five Medicaid Act provisions. The decisions are consistent in their holdings, with courts finding just over half of these Medicaid provisions privately enforceable and with no splits among the circuits.[4] *See* Jane Perkins, *Pin the Tail on the Donkey: Beneficiary Enforcement of the Medicaid Act Over Time*, 9 ST. LOUIS U. J. HEALTH L. & POL'Y 207, 223, 226-27 (2016).

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private enforcement under section 1983. *See* S. 584, 97th Cong., 1st Sess. § 1 (1981); S. 436, 99th Cong., 1st Sess. § 1 (1985); S. 325, 100th Cong., 1st Sess., § 1 (1987); H.R. 4314, 104th Cong., 1st Sess., § 309(a) (1996). In *Thiboutot*, the Court invited Congress to change the law if it thought the Court's interpretation of congressional intent was in error. 448 U.S. at 8. That Congress has not done so also evidences enforcement rights under section 1983.

[4] Soon after *Gonzaga*, the Eighth Circuit allowed enforcement of 42 U.S.C. § 1396a(a)(30)(A) in a law-of-the-case decision that was subsequently vacated. *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1015 (8th Cir. 2006), *vacated on other grounds*, *Selig v. Pediatric Specialty Care*, 551 U.S. 1142 (2007). *See Minn. Pharmacists Ass'n v. Pawlenty*, 690 F. Supp. 2d 809, 820-21 & n.8 & 9 (D. Minn. 2010) (discussing *Gonzaga*, *Pediatric Specialty Care*, and other Eighth Circuit precedent and holding § (30)(A) unenforceable).

All of the cases in which a court has found a Medicaid Act provision enforceable refer to protections or benefits that run to individual Medicaid beneficiaries. The Second Circuit has explained that the crux of the *Gonzaga* holding was that provisions containing traditional, individual rights-granting language support a private action while those focusing on state "policy or practice" in the aggregate do not. *Rabin v. Wilson-Coker*, 362 F.3d 190, 201 (2d Cir. 2004). The Second Circuit found enforceable a Medicaid provision regarding transitional Medicaid coverage, 42 U.S.C. § 1396r-6, which "contains no qualifying language akin to [*Gonzaga's*] „policy or practice.‟" *Id*. *See also*, *e.g.*, *Sabree ex rel. v. Richman*, 367 F.3d 180, 190 (3d Cir. 2004) (noting that a Medicaid provision‟s reference to "individual" recipients was indistinguishable from Title VI‟s reference to "no person" as discussed with favor in *Gonzaga*); *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 74 (1st Cir. 2005) ("The mere fact that all the Medicaid laws are embedded within the requirements for a state plan does not, by itself, make all of the Medicaid provisions into ones stating a mere institutional policy or practice rather than creating an individual right."). The free choice of provider provision at issue in the instant dispute does not contain the phrase "policy or practice" or any other comparable qualifying language.

Similarly, the Fifth Circuit has observed that provisions concerning "systemwide administration" have an aggregate focus, but that a Medicaid

provision directed to services for "individuals" passes muster under *Gonzaga*. *S.D. ex rel. Dickson v. Hood*, 391 F.3d 591, 603-04 (5th Cir. 2004). Because the free choice of provider provision does not address "systemwide standards and measures employed by the state Medicaid agency in its administration of the [Medicaid] program," *see id*. at 604 n.29, the provision does not have an aggregate focus.

Finally, the courts of appeals that have reviewed the free choice of provider requirement to date—the Fifth, Sixth, Seventh, and Ninth—have all concluded that the provision creates a federal right for Medicaid beneficiaries. In his opinion for the Sixth Circuit, Judge Sutton thoroughly assessed the free choice of provider provision against the section 1983 enforcement test and concluded that it contains the requisite rights-creating language. *See Harris v. Olszewski,* 442 F.3d 456, 460-65 (6th Cir. 2006). Among other things, he noted that the provision is directed to "*any individual* eligible for medical assistance," 42 U.S.C. § 1396a(a)(23), and that these words comprise individually-focused, rights-creating language. *Harris*, 442 F.3d 462-62 (emphasis in original). And, "by saying that „[a] State plan . . . must . . . provide" this free choice, the statute uses the kind of „rights-creating," „mandatory language," that the Supreme Court and our court have held establishes a private right of action." *Id.* at 461-62 (citation omitted). *See also Planned Parenthood of Gulf Coast, Inc. v. Gee*, 837 F.3d 477, 489 (5th Cir. 2016) ("We . . . conclude that § 1396a(a)(23) affords the Individual Plaintiffs a private right of action under

§ 1983."); *Planned Parenthood of Ariz. v. Betlach*, 727 F.3d 960, 963 (9th Cir. 2013) ("[W]e hold that the Medicaid Act's free-choice-of-provider requirement confers a private right of action under 42 U.S.C. § 1983."); *Planned Parenthood of Ind. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 974 (7th Cir. 2012) ("Medicaid patients are the obvious intended beneficiaries" of section (23)(A), which "does not simply set an aggregate plan requirement, but instead establishes a personal right to which all Medicaid patients are entitled.").

III. THE SUPREME COURT'S *ARMSTRONG* DECISION DOES NOT IMPLICATE ENFORCEMENT ACTIONS BY MEDICAID BENEFICIARIES UNDER 42 U.S.C. § 1983.

Armstrong does not alter the section 1983 enforcement test or the conclusion that section (23)(A) creates a federal right for Medicaid beneficiaries. *Armstrong* was filed by health care providers, not beneficiaries. 135 S. Ct. at 1382. The health care providers in *Armstrong* did not assert any claim under section 1983; rather, they sought to bring their claim under the Supremacy Clause or in equity. *Id.* at 1382-83. Their case focused not on the free choice of provider requirement that extends its protection to "any individual eligible for medical assistance," but instead on 42 U.S.C. § 1396a(a)(30)(A) ("section (30)(A)"), a provision that requires states to use "methods and procedures" relating to utilization of and payment for services. *Id.*

The *Armstrong* majority rejected the notion that the Supremacy Clause confers a private right of action and thereafter concluded that Congress did not intend to allow the providers to enforce section (30)(A) in an action for equitable relief. 135 S. Ct. at 1385 (finding that the provision authorizing the Secretary to withhold funding, coupled with the "judicially unadministrable nature of § (30)(A)'s test" evidenced congressional intent to preclude equitable relief); *but see id*. at 1383 (Breyer, J., concurring) (stating there is no "simple, fixed legal formula separating federal statutes that may underlie this kind of injunctive action from those that may not. . . . Rather . . . several characteristics of the federal statute before us, when taken together, make clear that Congress intended to foreclose respondents from bringing *this particular action* for injunctive relief.") (emphasis added); *see generally Va. Office for Prot. & Advocacy v. Stewart*, 131 S. Ct. 1632, 1639 n. 3 (2011) ("The fact that the Federal Government can exercise oversight of a federal spending program and even withhold or withdraw funds—which are the chief statutory features respondents point to—does not demonstrate that Congress has ‚displayed an intent not to provide the more complete and more immediate relief that would otherwise be available under *Ex parte Young.*"') (quoting *Verizon Md., Inc. v. Pub. Serv. Comm'n of Md*., 535 U.S. 635, 647 (2002)).

Armstrong did not concern, and certainly did not overrule, the precedents established in *Wilder*, *Blessing*, and *Gonzaga* for discerning when there is a private

right of enforcement under section 1983; it did not address 42 U.S.C. §§ 1320a-2, 1320a-10, which contain Congress‟ express recognition of beneficiaries‟ rights to enforce provisions of the Social Security Act; finally, it did not address or undermine the consistent appellate court track record holding that Medicaid beneficiaries have a federal right under section 1983 to enforce 42 U.S.C. § 1396a(a)(23)(A). *See Planned Parenthood of Gulf Coast, Inc.*, 837 F.3d at 491-92 (rejecting state‟s argument that *Armstrong* affects private enforcement of § 1396a(a)(23)(A) under §1983).

CONCLUSION

For the foregoing reasons, *amici curiae* ask that this Court affirm the District Court‟s decision.

Dated: December 2, 2016

Respectfully submitted,

/s/ Martha Jane Perkins
Martha Jane Perkins
NATIONAL HEALTH LAW PROGRAM
200 N. Greensboro Street, Suite D-13
Carrboro, North Carolina 27510
Tel: (919) 968-6308 (x101)
perkins@healthlaw.org
Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(a)(7)(B) and 29(a)(5), and that the total number of words in this brief is 5,582 according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

Date: December 2, 2016

/s/Martha Jane Perkins
Martha Jane Perkins

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I hereby certify that with respect to the foregoing:

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Martha Jane Perkins

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I certify that on this December 2, 2016, I electronically filed the forgoing brief with the Clerk of the Court by using the CM/ECF system.

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Martha Jane Perkins