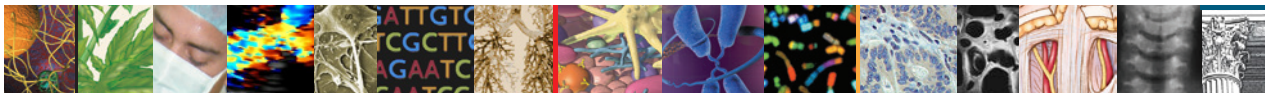

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Perspective

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Medicaid Coverage for Family Planning — Can the Courts Stop the States from Excluding Planned Parenthood?

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In August 2017, the U.S. Court of Appeals for the Eighth Circuit (which includes Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota) decided *Does v. Gillespie*,[1] a case involving Arkansas' efforts to exclude Planned Parenthood from its Medicaid program. The decision focuses on a fundamental, threshold question of law that must be answered before the courts can intervene when unlawful state conduct threatens the welfare of thousands of Medicaid beneficiaries: Can the courts halt the injury before it occurs? In a major departure from other appeals court decisions involving the exclusion of Planned Parenthood, the *Does* court said "no." If the U.S. Supreme Court allows *Does* to stand, other states may try to follow suit at a time of heightened tension over Medicaid funding for Planned Parenthood. Furthermore, *Does* may signal yet a new chapter in the long-running saga about whether, when threatened with injury by illegal state conduct, Medicaid beneficiaries can seek the help of the courts before they experience harm.

Any federal appeals court ruling is important, but for three reasons *Does* is particularly so. First is the sheer number of states that have sought to illegally[2] exclude Planned Parenthood clinics from Medicaid. Second is Planned Parenthood's importance to Medicaid: the Congressional Budget Office estimates that excluding these clinics from Medicaid nationwide would cause 390,000 women to lose access to family-planning services and as many as 650,000 women to face reduced access to preventive care services.[3] Third, the court's ruling comes at a time of great uncertainty over the extent to which the Supreme Court — the ultimate arbiter — will continue to allow Medicaid beneficiaries to turn to the courts in such situations.

A fundamental legal question is whether courts can hear cases involving the threatened unlawful state action before it takes effect. This question is especially urgent for Medicaid given its size: the program covers vital health services for nearly 75 million people. But federal law is silent on this matter. Over several decades, an increasingly conservative Court has narrowed judicial access in

Medicaid cases. In a more progressive era, the Court allowed Medicaid beneficiaries to turn to the courts to stop illegal benefit reductions. But current Court principles now set a high bar: courts can hear such cases only if plaintiffs can first prove that the specific provision within the Medicaid statute on which they rely creates "an unambiguously conferred right."[4]

To prove the existence of an unambiguous right, plaintiffs must demonstrate three things: first, that the legal provision in question is designed to help individuals rather than simply being a general directive regarding how a state should operate its program; second, that the provision is not so vague that it is beyond the competence of a court to measure state compliance; and third, that the provision creates a true state obligation as opposed to a state administrative option. In other words, before proceeding to decide the merits of plaintiffs' claims, courts first decide whether a particular Medicaid provision qualifies for early intervention, rather than intervention only after a ruling by the secretary of health and human services (HHS). HHS reviews can take years; furthermore, HHS lacks the power of the courts to stop a state from taking action before it rules on the question. Instead, it can act only after the fact.

The uncertainty surrounding Medicaid as an enforceable right is a matter of high drama. The consequences of losing this threshold battle can be severe, since beneficiaries are left without the protection of the courts while HHS proceeds with its review.

The enforceable-rights test is especially challenging for Medicaid. Legendarily complex, federal Medicaid law contains hundreds of federal directives regarding state administration, only some of which may rise to the level of unambiguous rights meriting added judicial protection. In 2015, the Court ruled in *Armstrong v. Exceptional Child Center, Inc.*[5] that Medicaid's equal access statute, also intended to ensure that beneficiaries can secure the health care to which they are entitled, did not create enforceable rights. The *Armstrong* majority concluded that the second prong of the Court's enforceable-rights test — Are the courts capable of deciding the case? — was not satisfied even though courts decide rate-setting cases all the time.

Now the question of whether Medicaid's free-choice-of-provider guarantee — dating to 1965, with special, explicit protections for family-planning services added in 1981 — can be privately enforced is under scrutiny in a case involving beneficiaries' ability to obtain essential, covered services from Planned Parenthood clinics. Indiana was the first state to attempt such an exclusion, but its actions were halted by the courts in 2012. As other states moved to follow Indiana, other courts followed suit, finding first that they had the power to intervene and then halting the state policy.

As a legal matter, the decision by the Eighth Circuit — coincidentally, the only federal appeals court to hold that nonprofit organizations can, on religious grounds, deny the Affordable Care Act's guarantee of contraceptive coverage — is troubling. The decision fails to follow the Supreme Court's test, while ignoring the clear statutory text of Medicaid's freedom-of-choice protection. Rather than hewing to the Court's principles, the *Does* court focused on the fact that the HHS secretary has the authority to enforce the freedom-of-choice guarantee. In my opinion, that question is plainly the wrong one. Every provision of Medicaid is one that must be enforced by HHS, since every provision imposes a program participation standard. Instead, I believe what the court should have considered is whether the legal provision involved is one that also creates a concrete right that courts can step in to protect in advance of injury. Making such a determination requires that a court examine the precise text of the provision at issue, which the Eighth Circuit failed to do. Instead, it characterized the law simply as an "aggregate" provision that commands state conduct rather than protecting individuals.

As I see it, this assertion appears wrong on its face: the free-choice-of-provider statute states explicitly that "any individual eligible for medical assistance may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the services required." The law specifically protects individuals — it does not merely speak to general state requirements.

The Eighth Circuit has the power to reconsider and change its ruling, upon an appeal from the plaintiffs. Should it decline to do so, the Supreme Court may have the final say, in yet another acid test of whether Medicaid beneficiaries can seek the help of the courts when state conduct threatens harm. The stakes could

An audio interview with Prof. Rosenbaum is available at NEJM.org

not be higher, either for family-planning access or for justice.

Disclosure forms provided by the author are available at NEJM.org.

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1. Jane Does 1–3 v. Gillespie, No. 15-3271, F.3d (2017) (http://media.ca8.uscourts.gov/opndir/17/08/153271P.pdf).
2. Centers for Medicare & Medicaid Services. Clarifying "free choice of provider" requirement in conjunction with state authority to take action against Medicaid providers. Letter to state Medicaid directors. April 19, 2016 (https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf).
3. Defund Planned Parenthood Act of 2015, H.R. 3134, July 21, 2015 (https://www.cbo.gov/publication/50825).
4. Gonzaga University v. Doe, 536 U.S. 273 (2002).
5. 135 S. Ct. 1378 (2015).

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Which Road to Universal Coverage?

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According to a June 2017 poll, Americans agree by a 60-to-39 margin that the federal government bears a responsibility to ensure health care for all Americans; 33% said that they favored a "single-payer" health system, 12% more than in 2014.[1] The prevailing belief that the government should actively promote broader health insurance coverage contrasts strikingly with the nearly successful effort this year to repeal the Affordable Care Act (ACA), executive orders that threaten to destabilize ACA marketplaces, and repeated calls by the majority party in Congress to slash Medicaid spending.

As of 2016, the Census Bureau reported that 216 million Americans were covered by private, employer-sponsored, or individually purchased plans. Government plans — mostly Medicare, Medicaid, and Tricare (the military health system) — covered an additional 119 million people. Altogether, 91.2% of the population was insured. The 8.8% without insurance was the lowest proportion in history, down 4.5 percentage points since 2013, just before implementation of the major provisions of the ACA. Spending on health care stood at $3.4 trillion, 18.3% of the gross domestic product — the highest on record.

Two broad strategies exist to extend insurance coverage. One is exemplified by a House bill (H.R.676), introduced by Representative John Conyers (D-MI) and 120 Democratic cosponsors on January 24, 2017, and by a Senate bill (S.1804), introduced by Senator Bernie Sanders (I-VT) and 16 Democratic cosponsors on September 13, 2017. Each would replace the current insurance system with a national, tax-financed system. The other approach would extend various components of the current public–private system to fill in coverage gaps.

How would each approach work? And which is more promising?

Although S.1804 is vague or silent on some key issues, it is more fully developed than H.R.676 or any other proposal for full government-managed coverage. After a 4-year transition period, S.1804 would replace all current coverage — private and public (other than veterans' health care and the Indian Health Service, which would remain as separate systems) — with a unified national system. Private insurance that duplicates coverage outlined in the bill would be barred.

All U.S. residents, including undocumented residents, would be provided coverage encompassing essential health benefits as defined in the ACA. S.1804 would bar balance billing of patients and patient cost sharing, other than up to $200 a year for prescription drugs. In ACA terms, coverage would be at the "platinum plus" level, which is substantially more generous than most current plans, public or private.

Long-term care services would remain a joint federal–state responsibility through Medicaid. States would be barred from tightening Medicaid eligibility rules.

During the 4-year period before conversion to the new insurance system, people older than a gradually lowered age threshold would be permitted to buy in to Medicare at an unsubsidized community rate. All licensed physicians and Medicare-approved institutional providers would be eligible to provide service. Payment arrangements would be "consistent with" Medicare's procedures and methods but are otherwise unspecified. A national health care budget would cap spending on included services.

S.1804 would move roughly 40% of all health care spending