No. ___

IN THE
Supreme Court of the United States

SECRETARY OF THE INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION,
IN HIS OFFICIAL CAPACITY, ET AL.,

Petitioners,

v.

PLANNED PARENTHOOD OF INDIANA, INC., ET AL.,

Respondents.

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

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

42 U.S.C. § 1396a(a)(23) provides that state Medicaid plans—if they are to remain eligible for full federal reimbursement—must allow Medicaid beneficiaries to obtain medical assistance from any provider "qualified to perform the service or services required." If a state Medicaid plan does not comport with Section 1396a(a)(23), the Secretary of Health and Human Services must decide whether to withhold only part of the state's federal Medicaid reimbursement, or defund the state's Medicaid program in its entirety. *See* 42 U.S.C. § 1396c.

The questions presented are:

1. Does 42 U.S.C. § 1396a(a)(23) create federal "rights" in Medicaid beneficiaries that may be privately enforced under 42 U.S.C. § 1983 by Medicaid beneficiaries and providers?

2. Does a state deprive Medicaid beneficiaries of choice among qualified providers under Section 1396a(a)(23) by mandating that providers refrain from providing elective abortions as a condition of Medicaid eligibility?

PARTIES TO THE PROCEEDING

The following individuals and entities were parties to the proceedings in the courts below:

The Secretary of the Indiana Family and Social Services Administration, currently Michael Gargano; the Director of the Indiana State Budget Agency, currently Chris Atkins; the Commissioner of the Indiana State Department of Health, currently William C. VanNess II, M.D.; the Commissioner of the Indiana Department of Administration, currently Robert D. Wynkoop; the Prosecutor of Marion County, currently Terry Curry; the Prosecutor of Monroe County, currently Chris Gaal; and the Prosecutor of Tippecanoe County, currently Pat Harrington, Defendants-Appellants;

Planned Parenthood of Indiana, Inc., Dr. Michael King, M.D., Carla Cleary, C.N.M., Letitia Clemons, and Dejiona Jackson, by her guardian and next friend Jackie Grubbs, Plaintiffs-Appellees.

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PETITION FOR WRIT OF CERTIORARI

The Secretary of the Indiana Family and Social Services Administration, Director of the Indiana State Budget Agency, and Commissioner of the Indiana State Department of Health, respectfully petition the Court to grant a writ of certiorari to the United States Court of Appeals for the Seventh Circuit in this matter.

OPINIONS BELOW

The Opinion of the United States District Court, Southern District of Indiana, is reported as *Planned Parenthood of Indiana, Inc. v. Commissioner of Indiana State Department of Health*, 794 F. Supp. 2d 892 (S.D. Ind. 2011), and is reprinted in the appendix at 53a. The Seventh Circuit's opinion is reported as *Planned Parenthood of Indiana, Inc. v. Commissioner of Indiana State Department of Health*, 699 F.3d 962 (7th Cir. 2012), and is reprinted in the appendix at 1a.

JURISDICTION

The Court of Appeals entered final judgment on October 23, 2012. On Petitioners' Motion, the deadline for filing a Petition for Writ of Certiorari was extended to February 20, 2013. The Court has jurisdiction to review this case under 28 U.S.C. § 1254.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 1396

> ***[T]here is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

For the complete text of this section, *see* Pet. App. 116a.

42 U.S.C. § 1396a(a)(23)

> (a) A State plan for medical assistance must—
> (23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services . . . .

For the complete text of this section, *see* Pet. App. 117a.

42 U.S.C. § 1396a(p)(1)

> (p) Exclusion power of State; exclusion as prerequisite for medical assistance payments; "exclude" defined
> (1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation in a program under subchapter XVIII of this chapter under section 1320a-7, 1320a-7a, or 1395cc(b)(2) of this title.

42 U.S.C. § 1396c

> If the Secretary . . . finds—
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1902; ***
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) . . . .

For the complete text of this section, *see* Pet. App. 118a.

42 U.S.C. § 1983

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. ***

For the complete text of this section, *see* Pet. App. 119a.

Ind. Code § 5-22-17-5.5

> (b) An agency of the state may not:
> (1) enter into a contract with; or
> (2) make a grant to;
> any entity that performs abortions or maintains or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state.

For the complete text of this section, *see* Pet. App. 119a-120a.

STATEMENT

I. Indiana's Abortion Funding Restrictions

On May 10, 2011, the Indiana General Assembly enacted House Enrolled Act 1210, which prohibits entities that perform abortions from receiving state contracts or grants. *See* HEA 1210, § 1 (codified at Ind. Code § 5-22-17-5.5(b)) (providing that "[a]n agency of the state may not . . . enter into a contract with [] or make a grant to[] any entity that performs abortions or maintains or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state."). This restriction does not apply to hospitals or state-licensed ambulatory surgical centers. *See* Ind. Code § 5-22-17-5.5(a).

Although HEA 1210 prevents Planned Parenthood's abortion clinics from receiving Medicaid funds, nothing in HEA 1210 precludes Medicaid providers who wish also to provide abortion services from continuing to receive funding through the simple expedient of separating their abortion services into a separate yet affiliated entity. In fact, prior to the district court's injunction in this matter, the Indiana Family and Social Services Administration (FSSA) issued a notice of proposed rulemaking announcing that HEA 1210's reference to "any entity that performs abortions or maintains or operates a facility where abortions are performed," Ind. Code § 5-22-17-5.5(b)(2), "does *not*

include a separate affiliate of such entity, if the entity does not benefit, even indirectly, from government contracts or grants awarded to the separate affiliate[.]" Pet. App. 121a (emphasis added). In light of the injunction issued by the district court, however, FSSA has taken no further action to promulgate such a rule.

Indiana enacted this legislation based principally on its "legitimate and substantial interest in preserving and promoting fetal life." *Gonzales v. Carhart*, 550 U.S. 124, 145 (2007). States may promote childbirth and discourage abortion by withholding taxpayer subsidies for abortions. *See Webster v. Reprod. Health Servs.*, 492 U.S. 490, 511 (1989) ("the State need not commit any resources to facilitating abortions"). The Hyde Amendment and Indiana law have long prohibited Medicaid funds from directly funding elective abortions, but these restrictions do not suffice to prevent taxpayer subsidies of abortion. When an abortion clinic provides other medical services (such as family planning), any Medicaid reimbursement it receives for those non-abortion services may be used to support the operation as a whole—including, among other things, the cost of facilities, staffing, and utilities—which indirectly supports its abortion operation. That is, even when a taxpayer subsidy is designated exclusively for non-abortion services, it frees up resources that would have been used for those non-abortion services and makes them available for abortions. *Cf. Knox v. Service*

Employees International Union, Local 1000, 132 S. Ct. 2277, n.6 (2012) (noting that "a union's money is fungible, so even if the new fee were spent entirely for nonpolitical activities, it would free up other funds to be spent for political purposes.").

II. This Lawsuit

1. Respondents Planned Parenthood of Indiana, Inc., Michael King, M.D., Carla Cleary, C.N.M., Letitia Clemons, and Dejiona Jackson (by her guardian and next friend Jackie Grubbs) filed a complaint in the Southern District of Indiana against several state officials under 42 U.S.C. § 1983, on May 10, 2011. Respondents sought a declaratory judgment and preliminary and permanent relief against Petitioners with regard to various provisions of HEA 1210, including Section 1, codified at Indiana Code § 5-22-17-5.5, which precludes abortion providers from being government grantees or contractors.

Planned Parenthood's theory of the case is that Section 1 of HEA 1210 violates the provider-choice provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(23). That provision requires that, to be eligible for federal matching funds, a "State plan for medical assistance" must 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" such services. 42 U.S.C. § 1396a(a)(23). The State's position is that Medicaid plan requirements are not individually enforceable rights, and that only the Secretary of Health and Human Services can enforce those plan requirements. Indiana has also argued that, because Section 1396a(a)(23) protects only a right to choose among qualified providers, and because 42 U.S.C. § 1396a(p)(1) relatedly authorizes states to set provider qualifications, Section 1 of HEA 1210 is nothing more than a reasonable qualification for Medicaid provider eligibility that does not contravene Section 1396a(a)(23).

2. On June 24, 2011, the district court preliminarily enjoined enforcement of Section 1 as applied to Medicaid payments. Pet. App. 111a-112a. It held that both Medicaid providers and recipients may enforce the Medicaid plan requirement codified at 42 U.S.C. § 1396a(a)(23) via 42 U.S.C. § 1983, Pet. App. 66a-68a, and that Section 1396a(a)(23) precludes a state from disqualifying a Medicaid provider based on "its scope of services" as opposed "to the provider's quality of services[.]" Pet. App. 72a.

3. The Seventh Circuit affirmed the injunction against the operation of Section 1. Pet. App. 51a. It rejected the State's argument that Respondents had no right to enforce 42 U.S.C. § 1396a(a)(23) under the rule set forth in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), that conditions on federal payments

are not privately enforceable absent an unmistakable individual right. Pet. App. 22a-25a. Next, having held that Section 1396a(a)(23) protects an individually enforceable right of provider choice, the Seventh Circuit held that Indiana's government funding restriction violates that right. The court rejected Indiana's argument that the State is permitted to "*reduce* patient choice incident to a qualification targeting some legitimate government objective" without violating the provider-choice requirement. Pet. App. 28a.

Furthermore, the court rejected Indiana's reliance on Section 1396a(p)(1) and instead adopted a non-statutory "plain meaning" of the term "qualified," holding that, as used in Section 1396a(a)(23), that term "unambiguously relates to a provider's fitness to perform the medical services the patient requires." Pet. App. 27a. "To be 'qualified' in the relevant sense is to be capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner," the court concluded. Pet. App. 27a. The court did not address the argument that the State's funding restriction, by precluding even indirect subsidy of abortion, amounted to a fiscal-responsibility qualification.

REASONS FOR GRANTING THE PETITION

I. The Court Should Take this Case to Address the Important Federal Question of the Extent to Which Medicaid Providers and Recipients May Enforce Medicaid Plan Requirements Via Section 1983

In *Gonzaga University v. Doe*, 536 U.S. 273, 283 (2002), the Court held that, to be enforceable through Section 1983, a federal statute must create an "unambiguously conferred" right that the defendant has allegedly violated. In the wake of *Gonzaga*, lower courts have struggled to determine the extent to which Medicaid providers and recipients may enforce the Medicaid Act against states, particularly in view of *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990). The Court should take this case (as well as *Bontrager v. Indiana Family & Social Services Administration*, 697 F.3d 604 (7th Cir. 2012), *petition for writ of certiorari filed*) to address that issue, and, if necessary, to consider overruling *Wilder*.

A. Medicaid remains an outlier of permissive private enforcement, and circuits disagree over whether *Wilder* still controls

1. The Court's private enforcement doctrine has shifted substantially since *Wilder*

The doctrinal touchstone for private enforcement of federal statutes through Section 1983 has shifted over the years from whether the statute broadly reflects an "intended benefit" for the plaintiff to whether it creates an "unambiguously conferred right" for the plaintiff.

In *Wright v. City of Roanoke Redevelopment & Housing Authority*, 479 U.S. 418 (1987), the seminal case representing the older approach of searching broadly for an intent to benefit a plaintiff, the Court held that public housing tenants could sue under Section 1983 to enforce the so-called Brooke Amendment, which precluded federally funded local housing authorities from charging rent that exceeded 30 percent of the tenant's income. While the Court's opinion discussed a hesitancy to infer congressional preclusion of a Section 1983 remedy where a federal right has been infringed, the only basis it cited for finding a federal right in the Brooke Amendment was that a statutory "intent to benefit tenants is undeniable." *Id.* at 430.

With "intent to benefit" the plaintiff as the operative test for deducing an enforceable federal right, a few years later the Court held in *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 524 (1990), that the Boren Amendment was privately enforceable by hospitals through Section 1983. Citing *Wright*, the Court in *Wilder* said that "whether the Boren Amendment creates a 'federal right' that is enforceable under § 1983 . . . turns on whether the provision in question was intended to benefit the putative plaintiff." *Id.* at 509 (internal quotation omitted). Because the Boren Amendment conditioned federal funding on a state's promise to pay "reasonable and adequate" fees to hospitals as part of its Medicaid plan, the Court inferred that Congress intended hospitals to benefit from the provision. *Id.* at 512.

Congress, however, repealed the Boren Amendment as part of the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a), 111 Stat. 251, 507-08 (1997), and in support of doing so the House Committee on the Budget conveyed its intention to undo *Wilder*: "It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of Section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. Rep. No. 105-149, at 591 (1997).

Since then, the Court has come to look for more than congressional intent to *benefit* the plaintiff when deciding if a federal spending statute creates individual rights enforceable through Section 1983. In *Gonzaga University v. Doe*, 536 U.S. 273, 283 (2002), the Court held that in order for a federal statute to be enforceable through Section 1983, it must "unambiguously confer[]" a right. This standard is much more difficult to meet than the intend-to-benefit rubric. Observing the undeniable tension that exists between that standard and the result in *Wilder*, the Court in *Gonzaga* expressly limited *Wilder*'s holding by explaining that the Boren Amendment was exceptional because it "explicitly conferred specific monetary entitlements upon the plaintiffs." *Gonzaga*, 536 U.S. at 280. Underscoring the point that *Wilder* was a marginal case, the Court noted that "more recent decisions . . . have rejected attempts to infer enforceable rights from Spending Clause statutes." *Id*. at 281.

Plainly, *Gonzaga* left *Wilder* hanging by a thread.

2. Circuits are in conflict over whether *Wilder* still controls

Notwithstanding the Court's brief attempt in *Gonzaga* to reconcile *Wilder*, lower courts have understood *Gonzaga* to represent a significant doctrinal shift. *See, e.g.*, *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456 (7th Cir. 2007) (acknowledging that *Gonzaga* "may have taken a

new analytical approach"); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004) ("Whether *Gonzaga* is a tidal shift or merely a shift in emphasis, we are obligated to respect it[.]"); *Sabree ex rel. Sabree v. Richman*, 367 F. 3d 180,182 (3d Cir. 2004) ("The [*Gonzaga*] Court, no doubt, has set a high bar for plaintiffs."); *D.G. ex rel. Stricklin v. Henry*, 594 F. Supp. 2d 1273, 1276 (N.D. Okla. 2009) ("In [*Gonzaga*], the Supreme Court tightened the first requirement [of the *Blessing* test.]"); *Mendez v. Brown*, 311 F. Supp. 2d 134, 140 (D. Mass. 2004) (recognizing that after *Gonzaga* private cause of action claims must survive "heightened analysis").[1]

Yet *Wilder* continues to have narrow precedential value for Medicaid cases in nine circuits, while two (the Tenth and Eleventh) do not rely on it, and a

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[1] *See also* Devi M. Rao, *"Making Medical Assistance Available": Enforcing the Medicaid Act's Availability Provision Through § 1983 Litigation*, 109 Colum. L. Rev. 1440, 1454 (2009) ("*Gonzaga* represents a departure from prior case law addressing the enforceability of federal statutes through § 1983."); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. Davis L. Rev. 413, 434 (2008) (*Gonzaga* "narrowed, and attempted to clarify" *Blessing* and "expressed deep skepticism regarding private parties enforcing federal conditions on spending against states"); Brian J. Dunne, *Enforcement of the Medicaid Act Under 42 U.S.C. § 1983 After* Gonzaga University v. Doe*: The "Dispassionate Lens" Examined*, 74 U. Chi. L. Rev. 991, 999 (2007) (noting *Gonzaga* "marked [a] departure from the more broad-based inquiry into legislative intent demonstrated in *Wilder* and other Court precedent").

third jurisdiction, the D.C. Court of Appeals, has expressly rejected reliance on *Wilder* in view of *Gonzaga*.

a. Even though *Wilder* looked for individual benefits rather than individual rights, most circuits continue to rely on it to justify private enforcement of various Medicaid provisions by way of Section 1983. *See, e.g.*, *Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002) (citing *Wilder* to establish private enforceability of the Medicaid Act under Section 1983); *Rabin v. Wilson-Coker*, 362 F.3d 190, 202 (2d Cir. 2004) (same); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004) ("[T]he Court has refrained from overruling *Wright* and *Wilder*, which upheld the exercise of individual rights under statutes that contain similar (or, in the case of *Wilder,* identical) provisions to 42 U.S.C. § 1396."); *Doe v. Kidd*, 501 F.3d 348, 356 (4th Cir. 2007) (citing *Wilder* and stating that the "Medicaid Act does not explicitly forbid recourse to § 1983."); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 605 (5th Cir. 2004) (finding that the "provisions at issue are no more 'vague and amorphous' than other statutory terms that this court, as well as other courts, have found capable of judicial enforcement" such as in *Wilder*); *Westside Mothers v. Haveman*, 289 F.3d 852, 862 (6th Cir. 2002) (citing *Wilder* for the proposition that "in some circumstances a provision of the Medicaid scheme can create a right privately enforceable against state officers through § 1983"); *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456-57 (7th

Cir. 2007) (observing that *Wilder* "held that one portion of the Medicaid Act may be enforced via § 1983, and that *Gonzaga University* did not overrule *Wilder*") (internal citation omitted); *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 443 F.3d 1005, 1015 (8th Cir. 2006) (noting that *Wilder* "has already considered whether (now-repealed) provisions of the Medicaid Act . . . conferred a § 1983 right of action on behalf of health care providers . . . [and a]lthough *Gonzaga* takes a more restrictive view of rights-creating statutes, it did not overrule *Wilder*"); *Watson v. Weeks*, 436 F.3d 1152, 1157-58 (9th Cir. 2006) (invoking *Wilder* to permit private enforcement of the Medicaid Act through Section 1983).

b. Two other circuits, the Tenth and Eleventh, reject this approach, however. In *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006), the court found no enforceable rights under Section 1396a(a)(30)(A) because "[e]ven though *Wilder* addressed a similar statute, our approach is controlled by *Gonzaga*[.]" Similarly, in *Martes v. Chief Executive Officer of South Broward Hospital District*, 683 F.3d 1323 (11th Cir. 2012), the court did not cite *Wilder* but instead employed *Gonzaga*'s "unambiguously conferred right" test exclusively and held that Section 1396a(a)(25)(C) does not create individual rights because it "is formulated as a requirement of a Medicaid State plan as it relates to third party liability for payment of Medicaid patients' medical expenses." *Id.* at 1328-

30. Plainly this method of analyzing whether Section 1396a(a) of the Medicaid Act bestows individual rights cannot be reconciled with the decision below, which gave no account of the plan requirement context when deducing whether an individual right exists under the statute. Pet. App. 5a-6a.

Furthermore, the D.C. Court of Appeals has rejected the vitality of *Wilder* in particularly direct terms. In *Jones v. District of Columbia*, 996 A.2d 834, 845 (D.C. 2010), the court found no enforceable rights among several sections of the Medicaid Act and rejected plaintiffs' reliance on *Wilder* because "the Court's *Gonzaga* decision in 2002 was a game-changer for § 1983 suits." Moreover, said the court, "to the extent that *Wilder* retains any validity, whatever it said 'as a general matter' about the Medicaid Act is not—indeed under *Blessing*, cannot be—particularly instructive as to the enforceability of the specific provisions [in the Medicaid Act]." *Id.* "Finally," said that court, "plaintiffs' reliance on *Wilder* is undermined by the fact that Congress repealed the provision at issue in *Wilder* not long after the Court held that that provision was privately enforceable." *Id.*

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In short, while the Court has otherwise reigned in the circumstances where beneficiaries of federal spending may sue to enforce conditions on that spending, federal courts of appeals are in conflict

regarding whether to rely on the old permissive doctrine of *Wilder* when it comes to Medicaid. And they do this despite the fact that Congress expressly repealed the Boren Amendment and a House Committee suggested a desire to overturn *Wilder*. Whether any sections of the Medicaid Act may properly be enforced through Section 1983 in the wake of *Gonzaga* is undoubtedly a nationally important question, the correct answer to which is unclear, particularly in view of the methodology adopted by the Tenth and Eleventh Circuits and the D.C. Court of Appeals. The Court should therefore grant certiorari to review this question.

3. Lower courts also split over the private enforceability of many Medicaid Act provisions, including Section 1396a(a)(23)

Even when they apply *Wilder*, lower courts are split over whether various Medicaid plan requirements, including the one at issue here, are privately enforceable. For starters, while the decisions below and in *Harris v. Olszewski*, 442 F.3d 456, 459 (6th Cir. 2006), have declared that Section 1396a(a)(23) confers individual rights, Pet. App. 16a, the court in *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003), held that Section 1396a(a)(23) does "not contain the unambiguous rights-creating language of *Gonzaga,* and consequently, there is no private right of action[.]" Other disagreements include the following:

<u>Section 1396a(a)(1)</u>: *Compare Sobky v. Smoley*, 855 F. Supp. 1123, 1133-34 (E.D. Cal. 1994) (privately enforceable), *with Boatman v. Hammons*, 164 F.3d 286, 290-92 (6th Cir. 1998) (not privately enforceable);

<u>Section 1396a(a)(10)</u>: *Compare Bontrager v. Indiana Family & Social Servs. Admin.*, 697 F.3d 604, 606-07 (7th Cir. 2012) (privately enforceable), *with Casillas v. Daines*, 580 F. Supp. 2d 235, 243 (S.D.N.Y. 2008) (not privately enforceable);

<u>Section 1396a(a)(17)</u>: *Compare Mendez v. Brown*, 311 F. Supp. 2d 134, 137-40 (D. Mass. 2004) (privately enforceable), *with Watson v. Weeks*, 436 F.3d 1152, 1162-63 (9th Cir. 2006) (not privately enforceable);

<u>Section 1396a(a)(25)</u>: *Compare Mallo v. Pub. Health Trust of Dade County, Florida*, 88 F. Supp. 2d 1376, 1379-91 (S.D. Fla. 2000) (privately enforceable), *with Martes v. Chief Executive Officer of S. Broward Hosp. Dist.*, 683 F.3d 1323, 1325-30 (11th Cir. 2012) (not privately enforceable);

<u>Section 1396a(a)(30)</u>: *Compare Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1015-16 (8th Cir. 2006) (privately enforceable), *with Sanchez ex rel. Hoebel v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005) (not privately enforceable).

In all, the plan requirements enumerated in Section 1396a(a) comprise 83 subparts, at least 32 of which lower courts have addressed for purposes of deducing individual rights. A table in the appendix to this Petition lists each of these plan requirement sections and cites at least one case, if any could be found, that permits or refuses enforcement via Section 1983. Pet. App. 123a. A separate table similarly cites other provisions of the Medicaid Act whose private enforceability has been the subject of litigation. Pet. App. 132a. It is clear from these tables that lower courts need further guidance from this Court concerning the extent to which the Medicaid Act creates individual rights privately enforceable through Section 1983.

4. **The Court should address Medicaid Act enforceability under Section 1983 before returning to enforceability under the Supremacy Clause**

The Court has otherwise been interested of late in the implications of *Gonzaga* for private enforcement of Medicaid. Last term, in *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204, 1212 (2012), the Court issued a writ of certiorari to consider whether 42 U.S.C. § 1396a(a)(30)(A) can be enforced via the Supremacy Clause where it was undisputed "that there is no statutory private right of action to enforce 42 U.S.C. § 1396a(a)(30)(A), either under 42 U.S.C. § 1983 or

directly under the Medicaid Act." Brief for the United States as Amicus Curiae Supporting Petitioner at 9, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (Nos. 09-958, 09-1158, 10-283), 2011 WL 2132705 at *9.

The Court, however, never reached the issue whether the Supremacy Clause affords a private right of action to enforce Medicaid plan requirements. Instead, the Court voted 5-4 to remand after a decision from CMS changed the posture of the case. The Chief Justice dissented from the remand and would have foreclosed a private right of action in all events because the Court's precedents had "emphasized that 'where the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit, whether under § 1983 or under an implied right of action.'" *Douglas*, 132 S. Ct. at 1213 (Roberts, C.J., dissenting) (quoting *Gonzaga*, 536 U.S. at 286). The Chief Justice said that when "the law established by Congress is that there is no remedy available to private parties to enforce the federal rules against the State[,]" but courts grant an equitable right to enforce the statute anyway, it "raise[s] the most serious concerns regarding both the separation of powers (Congress, not the Judiciary, decides whether there is a private right of action to enforce a federal statute) and federalism (the States under the Spending Clause agree only to conditions clearly

specified by Congress, not any implied on an ad hoc basis by the courts)." *Id.* (Roberts, C.J., dissenting).

In terms of enabling orderly development of the law, it may have been fortuitous that the Court remanded *Douglas* without deciding whether the Supremacy Clause affords a last-ditch mechanism for private enforcement of Medicaid plan requirements. The logically antecedent question is whether, and to what extent, those plan requirements may be enforced through Section 1983. The Court has not addressed that question apart from *Wilder*, which *Gonzaga* was careful to limit to its facts. In the wake of *Gonzaga*, the Court would be well advised to revisit the private enforceability of Medicaid plan requirements via Section 1983 more generally before taking another case presenting the Supremacy Clause enforcement issue. Both this case and its companion, *Bontrager v. Indiana Family & Social Services Administration*, 697 F.3d 604 (7th Cir. 2012), *petition for writ of certiorari filed*, provide the Court with suitable opportunities to do just that.

B. Under *Gonzaga*, the Medicaid plan requirements are not privately enforceable individual rights

Selective private enforcement of Medicaid plan requirements through Section 1983 is particularly troublesome because, without the *Wilder* decision as an overlay, no portion of 42 U.S.C. § 1396a(a) can reasonably be read to confer individual rights, as

Gonzaga requires. Section 1396a(a) establishes conditions under which states may qualify to receive federal funding and begins as follows: "A State plan for medical assistance must . . . ." 42 U.S.C § 1396a(a). Each subsection then delineates requirements and prohibitions (with varying degrees of specificity) for state plans to qualify for federal matching grants. In context, these provisions say nothing about individual rights, even if some may incidentally yield individually recognizable benefits.

1. The text and structure of the Medicaid Act provide guidance for states and HHS, but that is not the same as creating individual rights

The Medicaid Act is not a civil rights statute imposing duties and restraints on states with respect to healthcare financing. Rather, it creates a program that states may elect to use to finance their own healthcare benefits for the poor and disabled. Under the Medicaid model, states may establish healthcare benefits programs and, if their programs are satisfactory to the Secretary of Health and Human Services, seek federal matching grants. States are in no way obligated to implement a Medicaid program in accordance with the conditions required for federal funding. *See*, *e.g.*, *Harris v. McRae*, 448 U.S. 297, 301 (1980) ("participation in the Medicaid program is entirely optional"). Furthermore, states participating in Medicaid remain free to amend their programs, even if that

means the Secretary will deny federal funding as a consequence. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c).

The Medicaid Act provides discretion for states in designing and administering their programs within broad federal guidelines. A few baseline requirements exist, such as providing coverage to "categorically needy" groups for certain basic services. *See* Barbara S. Klees, Christian J. Wolfe & Catherine A. Curtis, Ctrs. for Medicare & Medicaid Servs., *Brief Summaries of Medicare & Medicaid: Title XVIII & Title XIX of The Social Securities Act* 22-26 (Dec. 31, 2012). In virtually all other matters, however, states can choose the most suitable option; they can, for example, establish eligibility standards, opt to provide coverage for other medical services, define the amount, duration, and scope of services, and determine the payment methodology and payment rate for services. *Id.* at 22-28. The Secretary determines whether the state has met the requirements of the Act and, if not, whether to dock some or all of a non-conforming state's funding. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c).

Thus, by its terms, the Medicaid Act imposes legal obligations *only* on the Secretary, who must ensure that states substantially comply with plan requirements before approving federal matching grants. *See* 42 U.S.C. § 1396c. If the Secretary finds that a state plan "has been so changed that it no longer complies" with the requirements of Section

1396a or that "in the administration of the plan there is a failure to comply substantially with any such provision[,]" then the Secretary "shall notify [the] State [] that further payments will not be made to the State." *Id.* Payments will be discontinued "until the Secretary is satisfied that there will no longer be any such failure to comply." *Id.* Or, rather than cutting off payments completely, the Secretary may, in her discretion, "limit payments to categories under or parts of the State plan not affected by [the] failure [to comply]." *Id.*

Yet Medicaid *permits* states to establish non-compliant programs that will not qualify for federal funds. Even after a state accepts federal funds, Section 1396c recognizes that state's continuing prerogative to alter its Medicaid program. Any state that administers a non-compliant program runs the risk that the Secretary will turn off the funding spigot, but this remains a *lawful* option for the state under the statute.

2. This case has upended Indiana's right to determine the parameters of its own plan

The Medicaid funding statute at issue in this case has triggered the statutory enforcement mechanism contemplated by the Medicaid Act, consideration of which remains pending before the Centers for Medicare and Medicaid Services (CMS). To execute the changes in Indiana Medicaid law imposed by

HEA 1210, the Indiana Office of Medicaid Policy and Planning submitted a state plan amendment to CMS. *See* 42 C.F.R. § 430.12(c)(1) (requiring a participating state to file a plan amendment with CMS whenever the state enacts a "[m]aterial change[] in State law, organization, or policy" respecting Medicaid). CMS responded by disapproving the proposed amendment on June 1, 2011, and then by holding a hearing on December 15, 2011. *See* 42 C.F.R. § 430.18(a). On June 20, 2012, the hearing officer issued recommended findings rejecting the plan amendment. The State filed its exceptions to the findings, briefing on which was completed on September 11, 2012, but no final determination has yet been issued.

Permitting the Respondents to proceed with a Section 1983 claim in this case has now overrun the administrative process that Congress provided for the Secretary to enforce Medicaid's preconditions for federal matching funds. If CMS had formally rejected Indiana's plan amendment, and that rejection had been upheld on appeal, it would ultimately likely have penalized the State by denying some portion of federal matching grants. In that event, Indiana—meaning the Indiana General Assembly—would then have had to decide whether prohibiting indirect Medicaid subsidization of abortion clinics was worth whatever price CMS imposed.

The court below acknowledged that "non-compliance with the requirements of § 1396a(a) may serve as a basis for the Secretary's disapproval of a state's Medicaid plan and withholding of Medicaid funds," Pet. App. 22a-23a, but concluded that "private enforcement of § 1396a(a)(23) . . . in no way interferes with the Secretary's prerogative to enforce compliance using her administrative authority." Pet. App. 19a. Yet now that a federal appeals court has affirmed an injunction precluding state officials from enforcing the provision, CMS has apparently chosen not to issue a final ruling. Indiana may never learn what price CMS would charge for Indiana's supposed non-compliance with the plan requirements of Section 1396a(a)(23), and never get to decide whether its decision not to subsidize abortion clinics is worth it.

In any event, the fundamental question is not whether granting a private right of action would "interfere" with this administrative process. It is whether the statute creates individually enforceable rights. Instructions to state and federal officials concerning the parameters of a joint federal-state program—instructions that do not affirmatively command states to do anything, let alone cast any mandatory duties in terms of individual rights—do not qualify.

The focus of the plan requirement section of the Medicaid Act is on "the person regulated," *i.e.*, state and federal officials, not "the individuals protected."

Alexander v. Sandoval, 532 U.S. 275, 289 (2001) (internal quotation omitted). There is "no implication of an intent to confer rights on a particular class of persons." *Id.* (internal quotation marks omitted). The Court should address the significance of the Medicaid Act's lack of rights-creating language to ensure that private litigation does not unjustly deprive states of control over their Medicaid plans.

II. The Court Should Address Whether, Consistent with the Medicaid Act, States May Preclude Abortion Providers from Receiving Medicaid Subsidies

A. The decision below incorrectly invalidated Indiana's abortion subsidy disqualification and thereby created tension with decisions from other circuits allowing states to set qualifications for Medicaid providers

The decision below rejected Indiana's bid to set Medicaid provider qualifications on the theory that a restriction on abortion subsidies violates a statutory right—derived from 42 U.S.C. § 1396a(a)(23)—for Medicaid recipients to choose among qualified providers. The Seventh Circuit's holding and reasoning, however, cannot be reconciled with decisions from other circuits permitting incidental reductions in recipients' provider choices and permitting states broad leeway over provider

qualifications. *See Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991); *First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007); *Guzman v. Shewry*, 552 F.3d 941 (9th Cir. 2008), and *Plaza Health Labs., Inc. v. Perales*, 878 F.2d 577, (2d Cir. 1989). It also is inconsistent with the clear-statement rule that this Court established in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), which holds that "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." *Id.* at 17. Accordingly, certiorari is warranted to resolve the extent to which states may design their Medicaid programs in ways that incidentally reduce the number of qualified providers.

1. In *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170 (2d Cir. 1991), the Second Circuit held that mere incidental reduction in patient choice among providers does not violate Section 1396a(a)(23). The case arose after Westchester County, New York, exercised its contractual and statutory right to terminate Kelly Kare's contract for Medicaid reimbursement without cause and without a hearing. The court found that even if Kelly Kare had a property right in remaining "qualified"—a question it did not reach—nothing in New York law entitled it to remain a Medicaid provider. *Id.* at 176. The court "emphasize[d] that defendants' action does not bear on Kelly Kare's status as a qualified provider." *Id.*

The court next turned to the claims raised by a class of Medicaid recipients who "argue[d] that if Kelly Kare's status as a qualified provider had not been affected, they would have had a right to choose Kelly Kare as their provider[.]" *Id.* at 177. The Second Circuit rejected that argument based on *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 785 (1980), which held that the provider-choice plan requirement speaks only to providers that "continue[] to be qualified" in the Medicaid program. The court "read *O'Bannon* as holding that a Medicaid recipient's freedom of choice rights are necessarily dependent on a provider's ability to render services. No cognizable property interest can arise in the Medicaid recipient unless the provider is both qualified and participating in the Medicaid program." *Kelly Kare*, 930 F.2d at 178.

The *Kelly Kare* court observed that *O'Bannon* "distinguished between direct Medicaid benefits—financial assistance—and indirect ones—*e.g.*, freedom of choice." *Id.* The Medicaid recipients in that case suffered merely "an incidental burden on their right to choose among qualified and participating health-care providers. Their direct benefits clearly have not been altered. They shall continue to receive government-sponsored home health assistance, albeit from a different provider." *Id.*

In other words, in light of *O'Bannon*, government action that incidentally affects provider choice is

permissible under Section 1396a(a)(23). And in *Kelly Kare*, regardless of the reason for the county's refusal to execute a provider agreement (*i.e.*, regardless whether it related to provider "qualifications" or some other barrier to entry), Medicaid recipients were not able to obtain Medicaid-reimbursed services from Kelly Kare. *Id*. Yet, the court ruled, such lost choice was only an "incidental burden on their right to choose" under Section 1396a(a)(23). *Id.* "Medicaid's freedom of choice provision is not absolute," the Second Circuit said. *Id*. at 177. It provides at most that a state plan must afford the right to choose among providers who have been able to enter the market. *See id*. at 178.

This understanding of the provider-choice requirement cannot be squared with the decision below, which implied that Section 1396a(a)(23) grants an absolute choice of provider to Medicaid recipients. Pet. App. 17a-18a. Yet the Seventh Circuit deemed *Kelly Kare* irrelevant because, unlike *Kelly Kare*, "[t]his is not a due-process case," *i.e.*, "Planned Parenthood and its patients are not suing for violation of their procedural rights; they are making a substantive claim that Indiana's defunding law violates § 1396a(a)(23)." Pet. App. 25a. The due process context of *Kelly Kare*, however, does not mean that the Second Circuit addressed something other than the essential question here, *i.e.*, whether incidental reduction of providers is a deprivation of free choice rights. The first thing the Second Circuit

decided was that the Medicaid recipients were not entitled to absolute choice among qualified providers under Section 1396a(a)(23). *Kelly Kare*, 930 F.2d at 177-78. Only after finding "that a Medicaid recipient's freedom of choice rights are necessarily dependent on a provider's ability to render services[,]" was the court able to determine whether due process rights had been violated. *Id.* at 178. The point remains that patients did not have access to their desired provider, but that mere fact did not contravene the provider-choice plan requirement.

To be sure, there are circumstances where courts have found violations of the provider-choice plan requirement, but only where the state's rules eliminated all choice whatever. For instance, the State of Louisiana was not allowed to force school-aged children to seek services at their respective schools, as opposed to an independent provider. *Chisholm v. Hood*, 110 F. Supp. 2d 499, 506-07 (E.D. La. 2000). In another instance, the City of New York was enjoined from implementing a program by which Medicaid eligible providers bid for *exclusive* contracts to serve a borough of the city. *Bay Ridge Diagnostic Lab. Inc. v. Dumpson*, 400 F. Supp. 1104, 1105, 1108 (E.D.N.Y. 1975). The program would have created only one provider for each borough and prohibited beneficiaries from seeking services from any other provider. *Id.* at 1105.

By stark contrast, HEA 1210 does not limit Medicaid recipients to one or even a few providers.

To the contrary, approximately 800 family planning providers across the State who do not perform abortions would remain available for Medicaid beneficiaries. Decl. of Michael A. Gargano (Trial Dkt. 56-1) at ¶ 2, *Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't of Health*, 794 F. Supp. 2d 892 (S.D. Ind. 2011) (No. 1:11-cv-630-TWP-TAB). Moreover, HEA 1210 does not limit options of care *within* the sphere of state Medicaid-qualified providers; the law does nothing to prevent a beneficiary from receiving care from a provider that is eligible to receive Medicaid funds.

The court below found these restrictions to be a "significant loophole for restricting patient choice, contradicting the broad access to medical care that § 1396a(a)(23) is meant to preserve." Pet. App. 27a. The State's theory of Section 1396a(a)(23), however, still provides broad access to medical care: a state may not use a qualification to target patient choice as such—for example by eliminating *all* choice in the market—but it may *reduce* patient choice incident to a qualification targeting some legitimate government objective, such as the desire not to subsidize abortion even indirectly.

By contrast, reading Section 1396a(a)(23) to preclude provider qualifications that incidentally happen to *reduce* the range of provider choices available to beneficiaries would not only render Section 1396a(p)(1) meaningless but also suddenly call into question *all* provider qualifications

heretofore assumed valid—*every* qualification limits provider choice in some way. The Seventh and Second Circuits fundamentally disagree on this point, however, which is why certiorari is justified.

2. What is more, the decision below rejected Indiana's authority to establish provider qualifications on terms that cannot be reconciled with decisions from other circuits.

The key to understanding the provider choice plan requirement is to recognize that it presupposes *qualified* providers. That is, a Medicaid plan must allow a beneficiary to receive care from a provider "qualified to perform the service." 42 U.S.C. § 1396a(a)(23). Indeed, the Court has already said that the provider-choice plan requirement speaks only to providers that "continue[] to be qualified" in the Medicaid program. *O'Bannon*, 447 U.S. at 785.

States, in turn, determine what it means to be "qualified" as a Medicaid provider. First, the Medicaid Act specifically provides that "[i]n addition to any other authority, a State may exclude any individual or entity [from participating in its Medicaid program] for any reason for which the Secretary could exclude the individual or entity from participation in [Medicaid]." 42 U.S.C. § 1396a(p)(1). Second, Senate Report 100-109 shows that Congress intended Section 1396a(p)(1) to protect the States' broad authority over qualifications, specifying the authority to safeguard against fraud and

incompetent practitioners, but adding that Section 1396a(p)(1) "is not intended to preclude a State from establishing, under State law, *any other bases for excluding individuals or entities* from its Medicaid program." S. Rep. No. 100-109, at 2, 20 (1987) (emphasis added). Third, federal regulations implementing Section 1396a(p)(1) provide that "[n]othing contained in this part should be construed to limit a State's own authority to exclude an individual or entity from Medicaid for any reason or period authorized by State law," 42 C.F.R. § 1002.2(b), and thereby carry forward what the plain text and legislative history of the section already provide—broad state authority over qualifications.

Yet the decision below concluded that while "[i]t is true that Medicaid regulations permit the states to establish 'reasonable standards relating to the qualifications of providers[,]'" Indiana did not have the authority to determine what providers were "qualified" based on legitimate state interests generally. Pet. App. 25a (quoting 42 C.F.R. § 431.51(c)(2)).

This holding cannot be reconciled with *First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007). There the First Circuit interpreted the qualifications authority provided by Section 1396a(p)(1) not as a limitation on the power of the state to regulate its Medicaid program, but as a specific delegation of power to the state. The court, citing the legislative history of Section 1396a(p)(1),

held that the provision "was intended to permit a state to exclude an entity from its Medicaid program for *any* reason established by state law." *Id.* at 53.

Indeed, pursuant to this qualifications authority, states have enacted and carried out all manner of provider disqualifications. States disqualify providers who commit fraud (*see Guzman v. Shewry*, 552 F.3d 941, 950 (9th Cir. 2008)), pose financial conflicts-of-interest (*Vega-Ramos*, 479 F.3d at 53), keep poor records (*Triant v. Perales*, 491 N.Y.S.2d 486, 488 (N.Y. App. Div. 1985)), and pollute (*Plaza Health Labs., Inc. v. Perales*, 878 F.2d 577, 578-80 (2d Cir. 1989)), among others.

Yet the court below interpreted Section 1396a(p)(1) to permit only those state provider qualifications that relate to the "capab[ility] of performing the needed medical services in a professionally competent, safe, legal, and ethical manner." Pet. App. 27a. The court concluded that the statutory language "in addition to any other authority" actually "signals only that what follows is a nonexclusive list of specific grounds upon which states may bar providers from participating in Medicaid. It does not imply that the states have an unlimited authority to exclude providers for any reason whatsoever." Pet. App. 29a.

This is not a fair reading of Section 1396a(p)(1), which does two things: first, it *directly* confers on state administrators authority over qualifications

commensurate with that of the Secretary; second, it makes clear that this direct conferral of authority is not exclusive of other authority, but "*in addition to any other authority*" a state administrator might already have, such as by virtue of state statutes and regulations. Thus, state law can *expand upon* federally conferred powers that state plan administrators already have. The HHS secretary's authority serves as the *floor* of the state administrator's authority to exclude, not the ceiling.

Further, the notion that Medicaid qualifications may relate solely to the provider's "capab[ility] of performing the needed medical services" is contradicted by federal regulations. Under 42 C.F.R. § 1001.1501, for example, the Office of the Inspector General may disqualify providers from participation in Medicare and Medicaid if they have defaulted on health education loan and scholarship obligations. Such disqualification in no way relates to the provider's "capab[ility] of performing" services, nor does it relate to any rules broken in the course of providing care. Instead, this rule carries out another important federal policy concern—"[t]here is plainly a connection between requiring a physician who is benefitting from government programs to meet his or her financial obligations to the government, by repayment of loans." Health Care Programs: Fraud and Abuse; Amendments to OIG Exclusion and CMP Authorities Resulting From Public Law 100-93, 57 Fed. Reg. 3298-01, 3313 (Jan. 29, 1992).

Such a policy is directly comparable to Indiana's disqualification of abortion providers, as is the prohibition against conflicts of interest upheld as a qualification in *Vega-Ramos*. If the Secretary can disqualify Medicaid providers to avoid indirect financing of particular "non-Medicaid" conduct, why cannot Indiana do the same?

The Seventh Circuit ultimately dismissed the significance of *Vega-Ramos* because it "involved a conflict-of-interest rule applicable only in Puerto Rico; [and] the First Circuit had no reason to consider the effect of the free-choice-of-provider requirement, which does not apply to Puerto Rico's Medicaid program." Pet. App. 30a. The court also distinguished *Guzman* by stating that although "[n]o one disputes that the states retain considerable authority to establish licensing standards and other related practice qualifications for providers[,]" *Guzman* was not helpful because it "involved state action falling within the core of the state's residual authority[.]" Pet. App. 31a.

But this rationale for distinguishing *Vega-Ramos* and *Guzman* ignores this Court's teaching in *O'Bannon*, which says that the provider-choice requirement is subject to permissible state qualifications, not the other way around. *O'Bannon*, 447 U.S. at 785. So the question at this stage of the analysis is, what constitutes a permissible state qualification? And on that score, the decision below cannot be reconciled with *Vega-Ramos*, not to

mention *Guzman* and *Plaza Health Labs*. If Section 1396a(p)(1) permits states to exclude providers for any reason established by state law, then Indiana's actions are permissible.

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The Seventh Circuit's decision has created tension with the First, Second and Ninth Circuits on the subject of state authority to set Medicaid provider qualifications. The Court should take this case to explain what the provider-choice plan requirement really means and how it interacts with state authority over provider qualifications.

B. The ability of states to avoid subsidizing abortion providers through Medicaid programs is a nationally important issue meriting the Court's immediate attention

Indiana is not alone in its desire to prevent taxpayer dollars from being spent on abortions. Even prior to HEA 1210, other states were experimenting with ways to prevent taxpayer cross-subsidy of abortions. *See*, *e.g.*, *Planned Parenthood of Mid-Mo. & E. Kan., Inc. v. Dempsey*, 167 F.3d 458, 463 (8th Cir. 1999); *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 342 (5th Cir. 2005) (upholding as applied to Title X family-planning funds statutes resembling HEA 1210 enacted in Missouri and Texas, respectively).

The movement to prevent such indirect abortion subsidies picked up steam in 2010, when 240 members of the United States House of Representatives voted in favor of a bill that would have done the same. *See House Vote 93 - Eliminates Funding for Planned Parenthood*, *available at* http://politics.nytimes.com/congress/votes/112/house/1/93. That Bill did not ultimately become law, but it set off a national wave of efforts to accomplish the same thing at the state level.

Since 2010, several states have passed laws that would keep abortion providers from receiving federal family planning funds or would prevent them from receiving state contracts. Much like Indiana's law, Arizona has banned abortion providers from receiving family planning contracts, including under Medicaid. Ariz. Rev. Stat. § 35-196.05 (2012). This law has been challenged and a district court decision enjoining it has been appealed to the Ninth Circuit. *See Planned Parenthood Arizona, Inc. v. Betlach*, No. CV-12-01533-PHX-NVW, 2013 WL 495555 (D. Ariz. Feb. 8, 2013) (holding that Section 1983 does provide a cause of action to enforce Section 1396a(a)(23) and that Arizona's funding provision violated the free-choice plan requirement).

Other states have targeted taxpayer cross-subsidy of abortions in other ways. For example, the St. Lucie, Florida County Children's Services Council made the decision to revoke $485,000 in government contracts with Planned Parenthood.

The Council then directed those funds to other organizations that do not provide abortions. *See* Jim Mayfield, *Planned Parenthood Voted Out as St. Lucie County Agency's Teen Services Provider*, TCPalm, Sept. 8, 2011. New Jersey's Governor, Chris Christie, has vetoed state taxpayer funding of family planning services three times during his term. *See* Bill Wichert, *Cory Booker Blasts Chris Christie for Slashing Funding to Planned Parenthood, Causing a Reduction in Health Services*, PolitiFact, Sept. 4, 2012. Wisconsin cut funding for Planned Parenthood out of its budget. *See* Maggie Fox, *Wisconsin Cuts Funds to Planned Parenthood*, National Journal, June 26, 2011.

Oklahoma's Health Department recently announced it was ending a contract with Planned Parenthood. *See* Sean Murphy, *Oklahoma to End Planned Parenthood Contracts*, USA Today, Oct. 4, 2012. Planned Parenthood's request for an injunction was denied. *See Planned Parenthood of Ark. & E. Okla. v. Cline*, No. CIV-12-1245-F, 2012 WL 6700364, at *12 (W.D. Okla. Dec. 24, 2012) (refusing to preliminarily enjoin the Oklahoma Commissioner of Health from terminating Planned Parenthood's WIC contract).

The Tennessee legislature has dictated that Title X family planning funds could only be used by government agencies, which effectively defunded abortion providers. *See Planned Parenthood Defunded in Tennessee*, NewsChannel5.com, June

10, 2011. The New Hampshire Executive Council voted to reject a $1.8 million Title X contract with Planned Parenthood. *See* Paula Tracy, *Council Rejects $1.8 Million Contract with Planned Parenthood*, Union Leader, June 22, 2011.

Both Kansas and North Carolina have also redirected Title X family planning funding away from abortion providers. *See* Brad Cooper, *Kansas Set to Defund Planned Parenthood*, The Wichita Eagle, Apr. 25, 2011; Jon Camp, *NC Budget Cuts Funding to Planned Parenthood*, ABC11.com, July 4, 2012. Both laws are currently being challenged in court. *See Planned Parenthood of Kan. & Mid-Mo. v. Brownback*, 799 F. Supp. 2d 1218, 1232 (D. Kan. 2011); *Planned Parenthood of Cent. N.C. v. Cansler*, 877 F. Supp. 2d 310, 330-32 (M.D.N.C. 2012).

Texas has disqualified abortion providers from its Women's Health Program, which is entirely state funded. That program was recently upheld by the Fifth Circuit against challenges under the First and Fourteenth Amendments. *See Planned Parenthood Ass'n of Hidalgo County Tex., Inc. v. Suehs*, 692 F.3d 343, 352 (5th Cir. 2012).

At least four other states have also introduced bills that, if they had passed, would have prioritized family planning funding in a way that would have restricted funds from going to abortion providers. *See* H.B. 2435, 84th Gen. Assem., Reg. Sess. (Iowa 2012); L.B. 925, 102d Leg., 2d Sess. (Neb. 2012);

H.B. 298 & S.B. 201, 129th Gen. Assem., Reg. Sess. (Ohio 2011); H.B. 2405, 196th Gen. Assem., Reg. Sess. (Pa. 2012).

Precluding abortion providers from being government grantees or contractors is being debated and tried all over the country, and significant questions remain about whether such restrictions are permissible. *See*, *e.g.*, Mary Ziegler, *Sexing Harris: The Law and Politics of the Movement to Defund Planned Parenthood*, 60 Buff. L. Rev. 701, 747 (2012) ("How will courts react to the new laws promoted by the [defunding] movement? There are no straightforward answers to these questions. What is clear, however, is the difference they will make to the future of the abortion debate."). As such, the validity of Indiana's law under the Medicaid Act is clearly a matter of national importance. This Court should take this case and decide whether such laws are permissible.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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