IN THE COMMONWEALTH COURT OF PENNSYLVANIA

ALLEGHENY REPRODUCTIVE HEALTH CENTER, *et al.*,	:	No. 26 M.D. 2019
Petitioners,	:	
v.	:	
PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES, *et al.*,	:	
Respondents.	:	

BRIEF OF AMICUS CURIAE NATIONAL HEALTH LAW PROGRAM IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST

Amicus curiae the National Health Law Program (NHeLP) is a 50-year-old public interest organization that works to advance access to quality health care, including the full range of reproductive health care services, and protect the legal rights of low-income and underserved individuals. As such, NHeLP has an interest in the outcome of this case.

No person or entity other than the *amicus curiae*: (1) paid in whole or in part for the preparation of this brief; or (2) authored this brief in whole or in part.

INTRODUCTION

NHeLP submits this brief to provide the Court with relevant background information regarding the Medicaid program and to correct several misstatements the Intervenors made in prior briefing in this case. States that participate in Medicaid must cover comprehensive reproductive health care services, including family planning services and services needed due to pregnancy. While an annual appropriations rider prohibits the use of federal Medicaid funding for abortions except in cases of rape, incest, or life-endangerment, federal law does not prevent states from using their own resources to cover abortions for Medicaid-enrolled individuals when federal funding is not available.

ARGUMENT

I. The Federal Medicaid Program

Title XIX of the Social Security Act establishes the federal-state partnership program known as Medicaid. *See* 42 U.S.C. §§ 1396-1396w-5 (the "Medicaid Act"). Congress enacted the Medicaid program to enable states to provide medical assistance to families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services." *Id*. § 1396-1. States do not have to participate in Medicaid, but all states do. Each participating state must designate a single state agency that is responsible for administering or supervising the administration of the state's Medicaid program. *Id*. § 1396a(a)(5); 42 C.F.R. § 431.10. In addition, each participating state must operate its program according to a state plan that has been approved by the Secretary of the Department of Health and Human Services ("HHS"). *Id*. §§ 1396a, 1396c. The state plan describes the state's program and affirms its commitment to comply with the requirements imposed by the Medicaid Act and its associated regulations.

In return, the federal government reimburses states for a portion of "the total amount expended . . . as medical assistance under the State plan." *Id*. § 1396b(a)(1). *See also id*. § 1396d(b) (establishing reimbursement formulas); U.S. Dep't of Health & Human Servs., Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program,

and Aid to Needy, Aged, Blind, or Disabled Persons for October 1, 2020 Through September 30, 2021, 84 Fed. Reg. 66204 (Dec. 3, 2019) (setting the reimbursement rate for Pennsylvania at approximately 52 percent).

The Medicaid Act describes the population groups that are eligible to receive coverage. *Id*. § 1396a(a)(10)(A), (C). States must provide medical assistance to individuals described in Section 1396a(a)(10)(A)(i) (the "mandatory categorically needy") and have the option to cover individuals described in Section 1396a(a)(10)(A)(ii) (the "optional categorically needy") and Section 1396a(a)(10)(C) (the "medically needy"). To receive coverage, individuals who fall within a covered population group must meet the financial eligibility criteria applicable to that group, reside in the state in which they apply, and have U.S. citizenship or qualified immigration status. *Id*. §§ 1396a(a)(10)(A), (b)(2), (3); 8 U.S.C. §§ 1611, 1641.

Prior to the Affordable Care Act, the covered population groups included children, pregnant women, parents and other caretaker relatives, and individuals who were aged, blind, or disabled. The ACA added an additional mandatory group – adults who are under age 65, not eligible for Medicare, do not fall within another Medicaid eligibility category, and have household income at or below 133% of the federal poverty level ("FPL"). 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), (e)(14). The Supreme Court decision in *NFIB v. Sebelius* effectively gave states the choice of

whether or not to adopt the Medicaid expansion in the first instance. 567 U.S. 519 (2012). Pennsylvania has elected to cover the expansion population.

The Medicaid Act also describes the health care services that beneficiaries can receive. States must cover certain basic services and have the option to cover additional services. 42 U.S.C. §§ 1396a(a)(10)(A) (requiring states to cover at least the services described in Section 1396d(a)(1)-(5), (17), (21), (28), and (29)). For example, mandatory services include inpatient and outpatient hospital services, services provided by a physician, and services provided by a nurse-midwife. *Id*. Optional services include dental services, physical therapy, and outpatient prescription drugs, among many others. *Id*. § 1396d(a)(10), (11), and (12). The Medicaid Act does not define the minimum level of services to be provided. Rather, it requires states to establish reasonable standards, comparable for all eligibility groups, for determining the extent of medical assistance, and these standards must be consistent with the objectives of the Medicaid Act. *Id*. § 1396a(a)(17). Under federal regulations, services must be "sufficient in amount, duration, and scope to reasonably achieve their purpose." 42 C.F.R. § 440.230(b).

Medicaid is a vendor payment program in which, for the most part, providers enter into agreements to provide services in exchange for payment. In its early years, Medicaid was structured as a fee-for-service program, meaning states reimbursed individual health care providers for each service delivered. Now,

however, most states contract with managed care plans to provide Medicaid services to enrollees. *See* 42 U.S.C. §§ 1396b(m), 1396d(t), 1396n(b), 1396u-2; 42 CFR §§ 438.1 to 438.930. Nationwide, nearly 70 percent of beneficiaries are enrolled in capitated managed care organizations (MCOs) through which they receive some or all of their Medicaid services. Kaiser Comm'n on Medicaid and the Uninsured, *State Health Facts,* Total Medicaid MCO Enrollment (2017) https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Eighty percent of Pennsylvania's Medicaid beneficiaries are enrolled in MCOs. *Id*

A. Medicaid Coverage of Family Planning Services

Intervenors suggest that if Pennsylvania is forced to cover abortion services, it could choose to terminate coverage of family planning services and supplies to save money. Application for Leave to Intervene of the Speaker of the House Mike Turzai et al., ¶ 60. That is not the case. If Pennsylvania were to terminate or substantially reduce coverage of family planning services, it would violate the Medicaid Act, putting all of its Medicaid funding at risk. *See* 42 U.S.C. § 1396c.

The Medicaid Act requires states to cover "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active)

who . . . desire such services and supplies."[1] *Id*. §§ 1396d(a)(4)(C), 1396a(a)(10)(A). The federal government reimburses states for 90 percent of the cost of "offering, arranging, and furnishing" family planning services and supplies. *Id*. § 1396b(a)(5). While the statute does not define "family planning services and supplies," HHS has made clear that services to prevent or delay pregnancy as well as services to treat infertility, qualify for the enhanced reimbursement rate. Ctrs. for Medicare & Medicaid Servs., State Medicaid Manual, § 4270. Abortion services do not qualify as family planning services. *Id*. Federal regulations require states to ensure that Medicaid enrollees are "free from coercion and mental pressure and free to choose the method of family planning to be used." 42 C.F.R. § 441.20. Consequently, states must cover a range of family planning services that is sufficient to give beneficiaries meaningful alternatives. In fact, HHS has recommended that states cover all FDA-approved contraceptive methods.[2] Ctrs. for Medicare & Medicaid Servs., Dear State Health Official Letter #16-008 (June 14, 2016).

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[1] Notably, the Medicaid Act prohibits states from charging enrollees any cost sharing for family planning services and supplies. 42 U.S.C. §§ 1396o(a)(2)(D), 1396o(b)(2)(D), 1396o-1(b)(3)(B)(vii).

[2] Federal law requires states to cover all FDA-approved contraceptive methods, as well as contraceptive counseling, initiation of contraceptive use, and follow-up care, for Medicaid beneficiaries receiving services through an Alternative Benefit Plan ("ABP"). 42 C.F.R. § 440.347(a) (requiring ABPs to cover the Essential Health Benefits); 45 C.F.R. §§ 156.115(a)(4) (defining EHBs to include preventive health services), 147.130(a)(1)(iv) (setting forth preventive health services, including women's preventive care as provided for in HRSA guidelines, that must be covered without cost sharing); Health Resources & Servs. Admin., Women's Preventive Services Guidelines, https://www.hrsa.gov/womens-guidelines-2016/index.html (last visited March 8, 2020). Most individuals eligible for Medicaid as a result of the Medicaid expansion

B. Medicaid Coverage of Services for Pregnant Women

Each state must cover "qualified pregnant women" – those whose pregnancy is medically verified and whose household income meets state requirements, which cannot go below the eligibility limit in effect on May 1, 1988 for the cash assistance program Aid to Families with Dependent Children ("AFDC"). *Id*. §§ 1396a(a)(10)(A)(i)(III), 1396d(n)(1). These individuals are entitled to full-scope Medicaid coverage.[3] 42 C.F.R. § 435.116(d)(1), (4).

In addition, states must cover pregnant women whose household income is at or below 133% of the FPL, which is about $35,000 for a family of four (or depending on the state, at or below up to 185% of the FPL, which is about $48,000 for a family of four). *Id*. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(1)(A), (2)(A); Annual Update of the HHS Poverty Guidelines, 85 Fed. Reg. 3060 (Jan. 17, 2020). States have the option to cover pregnant women at higher income levels. *Id*. § 1396a(a)(10)(A)(ii)(IX).

States must provide these individuals with coverage for "services related to pregnancy (including prenatal, delivery, postpartum, and family planning services)" and for "other conditions which may complicate pregnancy." *Id*.

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receive coverage through an ABP. *See* 42 U.S.C. §§ 1396a(k)(1), 1396u-7(a)(2)(B) (listing population groups that cannot be required to enroll in an ABP).

[3] Pregnant women with dependent children and/or in their last trimester of their pregnancy could also be eligible for full-scope Medicaid coverage under the parents and caretaker relatives eligibility category. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(I), 1396u-1(a).

§ 1396a(a)(10)(G)(VII). Pregnancy-related services are "those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant" and "include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services." 42 C.F.R. § 440.210(a)(2)(i). HHS has made clear that "because the health of a pregnant woman is intertwined with the health of her expected child, the scope of [pregnancy-related] services is necessarily comprehensive . . ." Medicaid Program; Eligibility Changes under Affordable Care Act of 2010, 77 Fed. Reg. 17,143, 17,149 (March 23, 2012). In fact, if a state requests not to cover certain services for pregnant women that it covers for other adults, it must describe its basis for determining that such services are not pregnancy-related. *Id*. Services for any other condition which may complicate pregnancy include "those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus." 42 C.F.R. § 440.210(a)(2)(ii). Notably, the Medicaid Act explicitly allows states to provide services for pregnant women that it does not provide to other adults, so long as the services are pregnancy-related or related to any other condition which may complicate pregnancy and are provided in equal amount, duration, and scope to all pregnant women covered under the state plan. 42 U.S.C. § 1396a(a)(10)(G)(V); 42 C.F.R. § 440.250(p).

Women who applied for, were eligible for, and received Medicaid while they were pregnant remain eligible for Medicaid through the end of the month in which the 60-day period following the last day of pregnancy ends, regardless of any change in income or household composition.[4] *Id*. § 1396a(e)(6); 42 C.F.R. § 440.210(a)(3).

Like many other states, Pennsylvania does not distinguish between "qualified pregnant women" and pregnant women with higher incomes. Instead, Pennsylvania provides full-scope Medicaid coverage to all pregnant women whose household income is at or below 215% of FPL, which is about $56,000 annually for a family of four. State Plan Amendment PA-14-0012-MM1 (2014); Annual Update of the HHS Poverty Guidelines, 85 Fed. Reg. 3060 (Jan. 17, 2020). What is more, Pennsylvania covers an array of services only for pregnant women, including care coordination, home visits by a nurse or social worker, home care, in-depth nutrition counseling, and exercise classes. State Plan Amendment PA-90-13 (1990).

II. Coverage of Abortion Services for Individuals Enrolled in Medicaid

Since 1976, Congress has passed an appropriations rider restricting the use of federal Medicaid funding for abortion services. *See* Departments of Labor and

[4] States are prohibited from imposing cost sharing on most pregnancy-related services and services necessary to treat medical conditions that may complicate pregnancy or delivery. 42 U.S.C. §§ 1396o(a)(2)(B), 1396o(b)(2)(B), 1396o-1(b)(3)(B)(iii); 42 C.F.R. §§ 447.53(d), 447.56(a)(vii). They may only charge premiums to certain pregnant people with incomes above 150% of the FPL. 42 U.S.C. §§ 1396o(c)(1); 42 C.F.R. § 447.55(a)(1).

Health, Education, and Welfare Appropriation Act, 1977, Pub. L. 94-439, § 209, 90 Stat. 1418, 1434 (1976). The exact scope of the restriction has changed over time. Currently, federal funding is only available for abortion services when a pregnancy is the result of rape or incest or when "a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed." Further Consolidated Appropriations Act, 2020, Pub. L. 116-94, § 506, 507, 133 Stat. 2534, 2606-07 (2019). HHS has made clear that state Medicaid programs must cover abortion services for which federal funding is available. *See* Dep't of Health & Human Servs., Health Care Fin. Admin., Dear State Medicaid Director Letter (Feb. 12, 1998), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd021298.pdf.

In addition, nothing prevents states from using their own funds to cover abortion services for Medicaid-eligible individuals when federal funding is not available. Pub. L. 116-94, § 507(b), 132 Stat. at 2607. In fact, many states do just that. *See* Guttmacher Inst., *State Laws and Policies, State Funding of Abortion Under Medicaid* (2020), https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid#.

III. Preventing Medicaid-Eligible Individuals from Accessing Abortion Services is Not a Cost-Saving Measure.

While Intervenors suggest that covering abortion services for Medicaid-eligible individuals will result in additional expenditures for Pennsylvania, *see* Application for Leave to Intervene of the Speaker of the House Mike Turzai, at ¶¶ 55-65, that is far from clear. State restrictions on abortion coverage "divert a significant number of Medicaid-eligible women toward childbirth and its additional expenses," and as a result, "undermine, rather than further, the State's interest in reducing costs." *State v. Planned Parenthood of the Great Northwest*, 436 P.3d 984, 1005 (2019).

Repeated research shows that these funding restrictions force many Medicaid-eligible individuals to carry a pregnancy to term against their will. According to a 2009 review of that research, "a reasonable estimate is that lack of funding influences about a quarter of Medicaid-eligible women to continue unwanted pregnancies." *See* Henshaw et al., Guttmacher Inst., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, 27 (2009), https://www.guttmacher.org/sites/default/files/report_pdf/medicaidlitreview.pdf. A recent study of pregnant women in Louisiana reached a similar estimate, finding that "about 29% . . . of Medicaid-eligible pregnant women who would have an abortion if Medicaid covered abortion instead give birth." Sarah C.M. Roberts et al., *Estimating the proportion of Medicaid-eligible pregnant women in Louisiana*

who do not get abortions when Medicaid does not cover abortion, BMC WOMEN'S HEALTH, 4 (2019), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-019-0775-5. The authors concluded that every year, approximately 3,000 women in Louisiana give birth instead of having an abortion due to the lack of abortion coverage for Medicaid-eligible individuals. *Id*.

Being unable to access a wanted abortion can have serious consequences for a person's health and financial well-being. *See, e.g.*, Sarah Miller, et al., *The Economic Consequences of Being Denied An Abortion, Working Paper 26662*, Nat'l Bureau of Economic Research (2020) https://www.nber.org/papers/w26662.pdf; Caitlin Gerdts et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 WOMEN'S HEALTH ISSUES 55 (2016), https://www.whijournal.com/article/S1049-3867(15)00158-9/fulltext; Sarah C.M. Roberts et al., *Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion*, BMC MEDICINE (2014), https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-014-0144-z. Preventing Medicaid-eligible individuals from accessing abortion care also comes with significant costs to the State. In 2014, the average cost for a surgical abortion at 10 weeks gestation was $508, and the average cost for a medication abortion

was $535. Rachel K. Jones, et al., Guttmacher Inst., *Differences in Abortion Service Delivery in Hostile, Middle-ground and Supportive States in 2014*, 28 WOMEN'S HEALTH ISSUES 212 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5959790/pdf/nihms960428.pdf. While abortions performed later in pregnancy are more expensive – the median charge for an abortion at 20 weeks gestation was $1,195 in 2014, *id*. at 7 – they make up a very small percentage of all abortions, *see* Guttmacher Inst., *Fact Sheet: Induced Abortion in the United States* (2019), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf (finding that 5.4% of abortions occur at 16 weeks gestation or later).

In comparison, the costs associated with childbirth are substantially higher. When Medicaid-eligible individuals have no choice but to carry a pregnancy to term, the state covers prenatal care, labor and delivery, postpartum care, and at least one year of Medicaid coverage for the infant. 42 U.S.C. § 1396a(e)(1); 42 C.F.R. § 435.117. In 2010, the average cost of providing those services in Pennsylvania was $11,015. Adam Sonfield & Kathryn Kost, Guttmacher Inst., *Public Cost from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care, National and State Estimates for 2010*, 12 (2015), https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf. That does not include the cost of providing ongoing

Medicaid coverage and/or additional public benefits to the child. *See id*. (finding that in 2010, the average cost of providing Medicaid coverage for a child from age one through age five in Pennsylvania was $11,580). Indeed, given the substantial costs associated with childbirth, researchers have estimated that covering abortion services for Medicaid-eligible individuals would result in significant public savings overall. Henshaw et al., Guttmacher Inst., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, 23 (2009) https://www.guttmacher.org/sites/default/files/report_pdf/medicaidlitreview.pdf.

CONCLUSION

Amicus Curiae respectfully requests that this Court overrule Respondents' and Intervenors' preliminary objections.

Dated: May 14, 2020

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CERTIFICATE OF COMPLIANCE

I certify that this filing complies with the provisions of the *Case Records Public Access Policy of the Unified Judicial System of Pennsylvania* that require filing confidential information and documents differently than non-confidential information and documents.

Dated: May 14, 2020

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