No. 23-1275

IN THE

Supreme Court of the United States

EUNICE MEDINA, IN HER OFFICIAL CAPACITY AS INTERIM DIRECTOR, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.,

Respondents.

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

BRIEF OF THE WOMEN'S BAR ASSOCIATION OF THE DISTRICT OF COLUMBIA, WASHINGTON BAR ASSOCIATION, INC., AND NATIONAL ASSOCIATION OF WOMEN LAWYERS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

The Women's Bar Association of the District of Columbia ("WBA-DC") is one of the oldest women's bar associations in the country. Since 1917, the WBA-DC has advocated for the advancement of women and historically oppressed communities and upheld its mission to maintain the honor and integrity of the legal profession, promote the administration of justice, advance and protect the interests of women lawyers, promote their mutual improvement, and encourage a spirit of friendship. In support of its mission the WBA-DC participates as *amicus curiae* before this Court and other courts throughout the nation to advocate for the rights of historically oppressed minorities, including women.

National Association of Women Lawyers ("NAWL") is a national, nonprofit organization providing leadership, a collective voice, and essential resources to advance women in the legal profession and advocate for the equality of women under the law. Since 1899, NAWL has been empowering women in the legal profession, cultivating a diverse membership dedicated to equality, mutual support, and collective success. To advance its mission, NAWL participates as *amicus curiae* before this Court and other federal courts in cases pertaining to women's equal treatment under the law.

Founded almost 100 years ago on May 25, 1925, the Washington Bar Association, Inc. ("WBA") is one

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[1] Pursuant to this Court's Rule 37.6, this brief was not authored in whole or in part by counsel for any party, and no person or entity other than *amici*, their members, or their counsel made a monetary contribution to fund the preparation or submission of this brief.

of the nation's largest voluntary bar associations consisting predominantly of African American attorneys, judges, and law students. Today, WBA is one of the oldest and largest affiliates of the National Bar Association, which also celebrates its 100th anniversary this year. WBA was founded to make equal justice under law a reality, and to that end, WBA participates as amicus curiae before this Court and other courts throughout the nation to advocate for the rights of historically oppressed and underserved minorities, including women.

SUMMARY OF ARGUMENT

This case is about the straightforward application of a federal statute that allows people enrolled in Medicaid, the majority of whom are women, to access a variety of medical care services from "any institution . . . qualified to perform the service or services required." 42 U.S.C. § 1396a(a)(23)(A).

Women across the country confront bleak realities when it comes to their health. Women in the United States top the charts for lowest life expectancy, highest maternal death count, highest number of avoidable deaths, and more significant mental health issues when compared to women living in other high-income countries. Women enrolled in Medicaid—usually low-income women—face even more challenges when it comes to accessing quality health care, as there are many physicians, including primary care physicians, who will not accept their insurance. Even after finding a provider that they want to see, these women then face the stark reality that both getting an appointment with those providers and finding the time, money, childcare, and transportation to attend their medical appointments are not easy tasks.

Women are disproportionately enrolled in Medicaid when compared to men, earn less than men in employment, and still often pay more than men for health care expenses, regardless of whether they are insured. Women are also much more likely than men to shoulder the majority of domestic work and spend time caring for other members of their families, leaving them less time, energy, and capacity to care for their own well-being. For the many women on Medicaid living in rural areas of the country, they must travel significant distances to find a provider who will treat them. Women in metropolitan areas also face transportation barriers that make doctor visits prohibitive, time consuming, and costly. And non-English speaking women face challenges in finding a provider who understands them, causing them to feel less comfortable communicating their symptoms and health concerns to a medical provider. These existing barriers to access often cause women to forgo the health care that they need and to which they are entitled, contributing to the alarming statistics about women's health across the country.

Because women in this country must already overcome many hurdles to access basic, quality health care, it is vital that—at a minimum—women who rely on Medicaid for health insurance have the choice to see any qualified provider who is willing to see them. If the Court were to adopt South Carolina's argument that Congress did not intend for the Medicaid Act's free-choice-of-provider provision to create a private right of action, states could determine that Medicaid providers are not "qualified" because of their own subjective or ideological disagreements with those providers. This would essentially gut the provision, further destabilizing the already fragile health care system that supports women and creating even more

avoidable barriers to accessing qualified health care providers. Of course, many of those providers, such as Planned Parenthood, provide women access to primary and preventive care that can obviate the need for more intensive care later.

The threat of what will occur if the Court deviates from Congress's clear intent to allow women enrolled in Medicaid to see the provider of their choice is not hypothetical. Planned Parenthood is known for eliminating many of the existing barriers to accessing health care that so many women on Medicaid already face: it accepts Medicaid; it offers services in many rural communities; it offers extended and weekend hours for women who cannot attend appointments during normal working hours; it offers interpretation and translation services for non-English speaking patients; and many of its locations are accessible by public transit. Planned Parenthood offers much more than abortion and family planning care; it offers primary gynecological care, cancer and HIV screenings, and other preventive well-woman care.

Allowing South Carolina to eliminate Planned Parenthood as a Medicaid provider is not only contrary to Congress's intent, but would also unfairly penalize the women who rely on Planned Parenthood for any number of primary and preventive health care services. On top of the legal reasons articulated in Planned Parenthood's brief, this Court should consider the severe detrimental impacts that a decision in favor of South Carolina will have on women's health care across the country. The Court should affirm the Fourth Circuit's decision holding that the Medicaid Act provides a private right of action to enforce its free-choice-of-provider provision.

ARGUMENT

I. Women's Health Care in the United States Is Alarmingly Worse Compared to Other High-Income Countries

Women enrolled in Medicaid navigate a fragile health care system in which women generally—and particularly those enrolled in Medicaid—suffer disproportionately negative health outcomes. When compared to women in other high-income countries around the world, women in the United States are significantly more likely to die at a younger age from preventable illnesses and suffer from more mental health issues and physical disabilities during their lives.

For many years, women in the United States have consistently had a lower life expectancy compared to women in other high-income countries.[2] In fact, women's life expectancy in the United States "remains at its lowest point since 2006."[3] Contributing to that lower life expectancy, the United States also has the highest rate—by far—of *avoidable* deaths for women among other high-income countries. As of 2021, 270 of every 100,000 deaths of women could have been

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[2] Munira Z. Gunja et al., *Health Care for Women: How the U.S. Compares Internationally*, THE COMMONWEALTH FUND (Aug. 15, 2024), https://tinyurl.com/5n97zmns; *see also* Mark Mather & Paola Scommegna, *The Sorry State of Women's Health in the United States*, POPULATION REFERENCE BUREAU (Feb. 19, 2025), https://tinyurl.com/ypfcc96k (In 2021, the United States ranked thirty-third of thirty-eight countries in the Organisation for Economic Co-operation and Development for women's life expectancy.).

[3] Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care*, THE COMMONWEALTH FUND (July 18, 2024), https://tinyurl.com/ycxnu9cs.

prevented with adequate medical care.[4] This number is significantly higher than Chile, the country with the next highest rate at 182 avoidable deaths for every 100,000 women.[5] And the avoidable deaths in the United States more than triple those in South Korea, the country with the lowest number of avoidable deaths. There, only eighty-one of every 100,000 women's deaths are avoidable.[6]

Many of these avoidable deaths are related to inadequate prenatal and maternal care. The United States has "by far the highest rate of maternal deaths of any high-income nation,"[7] with 22.3 maternal deaths for every 100,000 live births.[8] The United States' maternal death rate is "more than double, sometimes triple, the rate for most other high-income countries."[9] These women did not have to die. Of more than 1,000 pregnancy-related deaths that occurred in the United States between 2017 through 2019, more than eighty percent "were determined to

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[4] Gunja, *supra* note 2.

[5] *Id.*

[6] *Id.*

[7] *Id.*

[8] Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, THE COMMONWEALTH FUND (June 4, 2024), https://tinyurl.com/mudysbth; *see also* Ai-ris Y. Collier & Rose L. Molina, *Maternal Mortality in the United States: Updates on Trends, Causes, and Solutions* at 1, NEOREVIEWS (Oct. 2019), https://tinyurl.com/yactvbbw ("The rising trend in pregnancy-related deaths during the past [two] decades in the United States stands out among other high-income countries where pregnancy-related deaths are declining.").

[9] Gunja, *supra* note 8. The next highest maternal death rate is 14.3 of every 100,000 live births in Chile. *Id.*

be preventable," including deaths caused by mental health issues, hemorrhage, cardiac and coronary conditions, infections, and blood clots.[10] Adding to these concerns, the United States is the *only* high-income country with no federally mandated paid leave policy for birthing parents, which hinders women from managing the "physiological and psychological demands of motherhood" and "ensur[ing] financial security for [their] families."[11]

Moreover, women in the United States have "among the highest rates of mental health needs and social needs compared to women in other countries."[12] As of 2023, forty-nine percent of women in the United States reported having been told they had depression, anxiety, or other mental health issues, or reported that they received counseling or mental health treatment in the last year.[13] Suicide rates have also risen in women ages twenty-five to thirty-four in the

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[10] *Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 36 U.S. States, 2017–2019*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://tinyurl.com/ms3s4caw (last visited Mar. 11, 2025); Regine A Douthard et al., *U.S. Maternal Mortality Within a Global Context: Historical Trends, Current State, and Future Directions*, 30 J. WOMEN'S HEALTH 168, 170 (2021) (outlining the gradual decline in maternal mortality and pregnancy-related deaths from the 1930s to the 1980s which then "reversed course" and began to increase significantly through the 2010s).

[11] Gunja, *supra* note 8; *see also* Gretchen Livingston & Deja Thomas, *Among 41 countries, only U.S. lacks paid parental leave*, PEW RSCH. CTR. (Dec. 16, 2019), https://tinyurl.com/yffazphb (explaining that the other forty countries evaluated provided at least two months of paid leave).

[12] Gunja, *supra* note 2.

[13] *Id.*

United States, nearly doubling from women in Generation X to Millennial women.[14]

The high number of avoidable deaths of women in the United States is largely attributable to inadequate access to primary and preventive health care.[15] Illnesses such as heart disease, cancer, stroke, and chronic or exacerbated mental health conditions can be prevented through primary care visits—such as those provided by Planned Parenthood—which routinely screen for these conditions.[16] Primary care gives patients the opportunity to manage their health care proactively, rather than allow their health to decline to the point of needing hospitalization or other intensive care.[17] "Having a regular doctor or place of care, such as a primary care physician or a medical home, is important for getting screenings, vaccinations, and other preventive services needed to ensure good health outcomes," and "[h]aving a usual source [of] care is also essential to minimizing health disparities and improving population health."[18] In short, primary care leads to longer, healthier lives.

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[14] Mather & Scommegna, *supra* note 2; *see also* MATTHEW F. GARNETT & SALLY C. CURTIN, NAT'L CTR. FOR HEALTH STAT., SUICIDE MORTALITY IN THE UNITED STATES, 2002–2022 (Sept. 2024), https://tinyurl.com/z97ejefz (From 2002 to 2022, suicide rates for females increased for all age groups.).

[15] *See* Laurie C. Zephyrin et al., *Transforming Primary Health Care for Women–Part 1: A Framework for Addressing Gaps and Barriers,* THE COMMONWEALTH FUND (July 16, 2020), https://tinyurl.com/bdck7464.

[16] *See id.*

[17] *Primary Care*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://tinyurl.com/4cwykph2 (last visited Mar. 11, 2025).

[18] Gunja, *supra* note 2.

Despite the vital role primary and preventive care plays in public health, millions of Americans have difficulty accessing it. As of 2023, fourteen percent of women in the United States aged nineteen through sixty-four lacked access to health care because they were uninsured, either through public or private health insurance.[19] Again, the United States is the outlier among other high-income countries, which generally provide health care coverage to all residents.[20]

II. Women Enrolled in Medicaid Face Additional Barriers to Accessing Basic Health Care

Within our country's already fragile health care system, women enrolled in Medicaid face numerous challenges, including limits on providers who accept their insurance, economic restrictions, time poverty, sparse providers in rural areas, and language or cultural barriers to health care. Any one of these barriers could present an insurmountable challenge to accessing health care. But these barriers are often intertwined, making health care functionally unavailable to many of our country's most vulnerable women.

***Limited Numbers of Medicaid Providers*:** Up to one third of all physicians do not accept Medicaid patients.[21] For primary care providers specifically,

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[19] *Id.*

[20] *Id.*

[21] Steven B. Spivack et al., *Avoiding Medicaid: Characteristics Of Primary Care Practices With No Medicaid Revenue*, 40 HEALTH AFFS. 98, 98 (Jan. 2021); *see also* Kayla Holgash et al., *Physician Acceptance of New Medicaid Patients* at 6, MACPAC (Jan. 24,

only sixty-eight percent of physicians accept new Medicaid patients, while ninety percent of physicians accept new Medicare patients and ninety-one percent accept new patients with private insurance.[22] The number of primary care providers that accept Medicaid also varies significantly across different localities. Data from 2018 revealed that Medicaid networks had seventy-two percent fewer primary care providers in Miami and forty percent fewer primary care providers in New York than commercial insurance networks.[23] It is unsurprising, then, that nearly one-third of women with Medicaid have reported that a doctor they wanted to see was not covered by their plan.[24]

A primary reason that many doctors do not accept Medicaid patients "is that those claims are paid at a

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2019), https://tinyurl.com/yrkf9vr5 (2019 study completed by the Medicaid and CHIP Payment and Access Commission ("MACPAC") with the State Health Access Data Assistance Center on physicians' acceptance of new Medicaid patients).

[22] Holgash, *supra* note 21; *see also* Qian Luo et al., *Primary Care Provider Medicaid Participation Across the United States, 2016* at 704, J. OF HEALTH CARE FOR THE POOR AND UNDERSERVED (2023) ("'Secret shopper' and provider survey studies focus on Medicaid acceptance and have found that between ten and thirty percent of primary care providers did not accept new Medicaid patients, and providers accepted Medicaid patients less often than those with private insurance or Medicare.").

[23] Robin Duddy-Tenbrunsel et al., *Medicaid Networks More Than 60% Narrower Than Commercial in Some Areas*, AVALERE (March 11, 2021), https://tinyurl.com/yc57c4kc.

[24] Michelle Long et al., *Women's Health Care Utilization and Costs: Findings from the 2020 KFF Women's Health Survey*, KFF (Apr. 21, 2021), https://tinyurl.com/3v3j375k (compared to fifteen percent of women with employer-sponsored insurance).

lower rate than other insurance."[25] Simply put, private insurers and Medicare reimburse physicians at higher rates than Medicaid,[26] and "[m]ore providers would be interested in Medicaid if the program's reimbursements were similar to Medicare payments."[27] Critically, while the Affordable Care Act of 2010 included an optional expansion as to who may be covered by Medicaid, that expansion "has had no impact on whether doctors accept the insurance."[28] This is a complex issue in its own right, which could become even more complex if states are allowed to arbitrarily exclude qualified providers who accept Medicaid. And it ultimately means that women who are enrolled in Medicaid already face restrictions on seeing the medical provider of their choice.

***Economic Barriers to Health Care*:** Medicaid coverage is the primary source of health care for

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[25] Les Masterson, *Doctors less likely to accept Medicaid than other insurance*, HEALTHCARE DIVE (Jan. 28, 2019), https://tinyurl.com/59c5zspb; Spivack, *supra* note 21.

[26] Cindy Mann et al., *How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost*, THE COMMONWEALTH FUND (Aug. 17, 2022), https://tinyurl.com/58v4jzfw.

[27] Masterson, *supra* note 25; *see also* David Raths, *George Washington U. Researchers Track Medicaid Provider Shortages*, HEALTHCARE INNOVATION (Aug. 3, 2023), https://tinyurl.com/52wrms9e ("We know that many providers do not accept Medicaid because reimbursement is low and the administrative burden is high.").

[28] Holgash, *supra* note 21, at 9; Luo, *supra* note 22, at 709 (Increased Medicaid expansion under the Affordable Care Act "was largely due to existing Medicaid providers increasing their proportion of Medicaid patients rather than new providers entering the Medicaid market.").

almost half of all low-income nonelderly adults.[29] Medically underserved[30] women rely on Medicaid at a higher rate than their male counterparts. In 2023, nineteen percent of adult women were enrolled in Medicaid, compared to just fourteen percent of men.[31] Women are disproportionately enrolled in Medicaid because of the persistent economic hardships they face. Compared to men, women are employed in more minimum wage and other low-paying jobs,[32] many of which do not offer insurance.[33] And although the pay gap between men and women has narrowed over time, American women still earn only eighty-three cents for every dollar earned by men on average.[34] This pay gap is even wider in South Carolina, where nearly seventeen percent of women live below the poverty

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[29] Alice Burns et al., *10 Things to Know About Medicaid*, KFF (Feb. 18, 2025), https://tinyurl.com/2artk92x.

[30] A medically underserved area is one with a shortage of primary care health services. *See What is Shortage Designation*, HEALTH RESOURCES & SERVS. ADMIN., https://tinyurl.com/y5abm949 (last visited Mar. 11, 2025).

[31] *Women's Health Insurance Coverage*, KFF (Dec. 12, 2024), https://tinyurl.com/59vb78ky.

[32] Diana Boesch et al., *Raising the Minimum Wage Would Be Transformative for Women*, CTR. FOR AM. PROGRESS (Feb. 23, 2021), https://tinyurl.com/4f4ft9ze.

[33] *Lower-wage workers less likely than other workers to have medical care benefits in 2019*, U.S. BUREAU OF LAB. STAT. (Mar. 3, 2020), https://tinyurl.com/mr3dhu7r ("[T]wenty-four percent of private industry workers in the lowest [ten] percent wage category had access to employer-sponsored medical plans in March 2019, while [ninety-four] percent of workers with an average wage in the highest [ten] percent had access to such plans").

[34] *The Wage Gap by State for Women Overall–Sept. 2024*, NAT'L WOMEN'S L. CTR., https://tinyurl.com/5e9zdw9j.

level[35] and where women earn only eighty-one percent of their male counterparts' wages.[36] The gap widens even further for Black and Latina women in the state.[37]

Gendered economic inequality doesn't end with wages earned. Women are also economically disadvantaged with respect to health care, which is significantly more costly to women than men. Recent data shows that women spend roughly eighteen percent more on health care than men, even excluding pregnancy-related expenses.[38] This disparity is driven by several factors, "including early age recommendations for annual checkups, high frequency of gynecological examinations, the relatively high cost of breast cancer imaging compared to other types of cancer, and the effects of menopausal transitions."[39] In other words, women

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[35] *Poverty-Women in South Carolina*, UNITED HEALTH FOUND., https://tinyurl.com/y99f7ber (last visited Mar. 11, 2025).

[36] *The Wage Gap by State for Women Overall–Sept. 2024*, *supra* note 34.

[37] *See The Wage Gap by State for Black Women–February 2025*, NAT'L WOMEN'S L. CTR., https://tinyurl.com/4ky5eypc and *The Wage Gap by State for Latina Women–February 2025*, NAT'L WOMEN'S L. CTR., https://tinyurl.com/3ujyykmy (reporting that Black and Latina women in South Carolina earn fifty-eight percent and fifty-six percent, respectively, of the wages of white, non-Hispanic men).

[38] Charlotte Edmond, *US women are paying billions more for healthcare than men every year*, WORLD ECON. F. (Oct. 18, 2023), https://tinyurl.com/2sw3msbf (analyzing a sample of 16 million people in the US with employer-sponsored healthcare).

[39] *Hiding in plain sight: The health care gender toll* at 4, DELOITTE (2023), https://tinyurl.com/bdduajax.

require more preventive health services than men.[40] But women are still more likely than men to delay needed health care or skip recommended medical testing or treatment because of cost.[41] Women on Medicaid, therefore, face complex economic challenges: They qualify for Medicaid likely because they are among the most economically disadvantaged people in the United States, but even with indispensable Medicaid coverage, they are still likely to spend more out of pocket than men for their health care needs.

***Women's Battle with Time Poverty*:** Time constraints present another significant hurdle to low-income women seeking health care. Women shoulder a disproportionate amount of unpaid domestic work, often functioning as caregivers to children or elderly family members. The time women devote to this unpaid labor leaves them "time poor" with little or no time to tend to their own health well-being.[42] Low-income, working women—like the fifty-nine percent of women enrolled in Medicaid[43]—are at particularly high risk of suffering from time poverty, since their

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[40] Deb Gordon, *Women Pay $15 Billion More Than Men For Medical Costs, New Report Shows*, FORBES (Sept. 26, 2023), https://tinyurl.com/bdcmuddj.

[41] *See id.* (citing KFF study showing that fifty percent of women have put off necessary health care and forty percent have forgone recommended medical tests or treatments due to cost, compared to thirty-five percent and twenty-six percent of men, respectively).

[42] Yana Van Der Meulen Rodgers, *Time Poverty: Conceptualization, Gender Differences, and Policy Solutions*, 40. SOC. PHIL. & POL'Y 79, 79–80 (Feb. 2024).

[43] Ivette Gomez et al., *Medicaid Coverage for Women*, KFF (Feb. 17, 2022), https://tinyurl.com/48kyw9ne.

work outside the home only decreases the time they can devote to their own medical needs. In South Carolina in particular, the number of women at risk of experiencing time poverty is high, since women "are the sole, primary, or co-breadwinners in [more than seventy percent] of families."[44] To time poor women, the limited business hours most doctors' offices make available for patient visits[45] are much more than an inconvenience. These limited appointment times can represent an insurmountable barrier to care, and women are often forced to forgo the health care they require altogether.[46]

***Challenges to Women in Rural Communities*:** The challenges women enrolled in Medicaid face finding providers who accept Medicaid, affording the care they need, and making time to care for themselves impact women across the country in urban, suburban, and rural environments alike. Women enrolled in Medicaid who live in rural communities contend with yet another set of challenges associated with the inadequate health infrastructure in rural America. There are not nearly enough doctors to address rural Americans' health care needs. While about twenty percent of the United

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[44] *Fast Facts: Economic Security for Women and Families in South Carolina*, CTR. FOR AM. PROGRESS (Oct. 19, 2018), https://tinyurl.com/3dz9jjy2.

[45] *See* Ann S. O'Malley et al, *After-Hours Care and its Coordination with Primary Care in the U.S.*, J. GEN. INTERNAL MED. (2012), https://tinyurl.com/yc2uesxr.

[46] *See* Kulleni Gebreyes et al., *What's causing US women to skip or delay medical care?*, DELOITTE (Sept. 10, 2024), https://tinyurl.com/4tn8fznt (discussing polling showing some women skip appointments because office hours conflict with work hours).

States population—nearly 50 million people—lives in rural areas, only ten percent of doctors practice there.[47] This rural physician shortage is only expected to worsen. Many doctors in rural communities are aging out of the workforce, and there are relatively few young doctors to replace them.[48] Alarmingly, this shortage is projected to get even worse. The Medicaid and CHIP Payment and Access Commission estimates that by 2033, the United States will have a shortage of between 21,400 and 55,200 primary care physicians overall.[49] The Bureau of Healthcare Workforce ("BHW") anticipates that this projected shortage will be particularly devasting to rural areas. According to BHW, by 2036, metro areas will see a six percent shortage of physicians—while rural areas will experience a *fifty-six* percent shortage.[50]

Because women's health care in rural areas is in especially short supply,[51] women must travel long distances to receive basic care. For low-income patients, the cost and time associated with getting to the doctor can result in delaying needed medical care or forgoing it altogether.[52] Given the lack of primary care in rural America, it is not surprising that women in rural areas are less likely than other women to

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[47] *Rural Health: Addressing Barriers to Care*, NAT'L INST. FOR HEALTH CARE MGMT. (Oct. 25, 2023), https://tinyurl.com/4t6hhtvx.

[48] MACPAC, MEDICAID AND RURAL HEALTH at 3 (Apr. 2021), https://tinyurl.com/47jbktrm.

[49] *Id.*

[50] *Id.*

[51] AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, HEALTH DISPARITIES IN RURAL WOMEN, at 2 (Feb. 2014, Reaffirmed 2024), https://tinyurl.com/3wwnva9v.

[52] MACPAC, *supra* note 48.

receive routine screenings for cervical and breast cancer, and more likely to be diagnosed with these diseases at later stages.[53] Women in rural areas are also more likely to suffer from obesity, and experience death from suicide, cerebrovascular disease, and ischemic heart disease than other American women.[54]

The challenges of rural health care are especially relevant to women in South Carolina, where about one-third of the population lives in rural areas as defined by the U.S. Census Bureau.[55] For example, women who live in rural South Carolina travel long distances to reach birthing hospitals, which greatly increases their risk of pregnancy complications.[56] Recent data shows that women in rural South Carolina were at a seventy percent higher risk of pregnancy-related death than their urban counterparts.[57] Women in South Carolina are also diagnosed with and die from cervical and breast cancer at higher rates than the national average.[58]

***Transportation Barriers Prevent Health Care Access for Urban Women*:** While physical

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[53] *See* AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 51, at 1 (women living in rural areas are thirty percent more likely to have surgery and seventeen percent less likely to receive radiotherapy as first-course treatment for breast cancer than women in urban areas).

[54] *Id.*

[55] *What is Rural?*, S.C. CTR. FOR RURAL AND PRIMARY HEALTHCARE, UNIV. S.C. SCH. OF MED., https://www.scruralhealth.org/rural-101 (last visited Mar. 11, 2025).

[56] *South Carolina State Health Assessment* at 64, S.C. DEP'T PUB. HEALTH (Dec. 2023), https://tinyurl.com/2fddrcx5.

[57] *Id.*

[58] *Id.* at 274, 276.

distance to a provider is not necessarily a barrier to health care access for low-income women in urban areas, lack of reliable transportation often takes its place. An estimated 5.8 million people delay medical care each year because they lack reliable transportation.[59] Like many barriers to health care, transportation difficulties disproportionately affect low-income individuals and people of color, since those populations are "more likely to live in neighborhoods that are poorly served by public transportation and far from high quality health care services."[60] Even women traveling relatively short distances when measured in miles face long travel times to get to the doctor when taking public transportation, as medical trips via public transportation are twice as long as those by private vehicle.[61] Especially for women already struggling with time poverty and financial strain, transportation poses yet another barrier.

***Language Barriers Stifling Health Care Access*:** Finally, some women also face language and cultural barriers to receiving health care. Of course, a provider cannot effectively treat a patient without open communication about the individual's symptoms, treatment options, and necessary follow-up actions. If a provider and patient do not speak the same language, they must rely on an interpreter. But even with the help of an interpreter, word-for-word language translation can "omit[] salient cultural aspects that may be important for physicians to know

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[59] Muhieddine Labban et al., *Disparities in Travel-Related Barriers to Accessing Health Care From the 2017 National Household Travel Survey* at 2, JAMA NETWORK (July 27, 2023), https://tinyurl.com/yj92e6t2.

[60] *Id.* at 10.

[61] *Id.* at 6.

in order to provide the best care to the patient."[62] These communication challenges are further exacerbated by the fact that receiving quality medical care often requires a patient to disclose sensitive information. It is understandable that a woman would be hesitant to share personal information if she cannot confidently communicate with her provider.

A person encountering just one of these barriers faces significant hardship in accessing necessary primary care. But women enrolled in Medicaid often encounter many of these barriers at once. As low-income women, they are at high risk to face time poverty; the two are "mutually reinforcing."[63] Similarly, adults with limited English proficiency are more likely to be low-income.[64] Rural women on Medicaid are the most poorly situated, being low-income, likely time-poor, and without basic medical infrastructure.

III. Gutting the "Free Choice of Provider" Provision in the Medicaid Act Would Significantly Impact Women in Underserved Areas

If this Court were to hold that the Medicaid Act's free-choice-of-provider provision does not unambiguously confer a private right upon a Medicaid beneficiary to choose a specific provider, the significant hurdles medically underserved women

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[62] Derek Soled, *Language and Cultural Discordance: Barriers to Improved Patient Care and Understanding*, 7 J. PATIENT EXPERIENCE 830, 831 (July 2020).

[63] Rodgers, *supra* note 42, at 80.

[64] Ana Gonzalez-Barrera et al., *Language Barriers in Health Care: Findings from the KFF Survey on Racism, Discrimination, and Health*, KFF (May 16, 2024), https://tinyurl.com/4arex4er.

already face in accessing quality health care would be seriously exacerbated. Indeed, a decision in favor of South Carolina would effectively reduce the number and change the nature of qualified providers available to women on Medicaid by allowing states to dictate who is and is not a "qualified provider" based solely on whether it agrees with all the services the provider offers. These implications will be far-reaching, intensifying the already challenging health care landscape that these women face.

As this case illustrates, a physician or clinic that offers abortion care may provide numerous other primary care services completely unrelated to abortions. In fact, abortion services account for less than five percent of all services Planned Parenthood offers.[65] According to its most recent annual report, Planned Parenthood delivered more than 9.13 million services to the 2.05 million patients it saw in 2022.[66] Testing and treatment for sexually transmitted infections accounted for roughly fifty percent of the services Planned Parenthood administered.[67] Planned Parenthood also offered more than 464,000 cancer screening and prevention treatments and more than 70,000 primary health care visits.[68] If states are permitted to exclude Planned Parenthood from Medicaid, millions of women who rely on it for primary health services will be forced to look elsewhere.

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[65] PLANNED PARENTHOOD, 2022-2023 ANNUAL REPORT at 24, https://tinyurl.com/yckecjy3 (last visited Mar. 11, 2025).

[66] *Id.*

[67] *Id.*

[68] *Id.*

Yet, finding another provider is not guaranteed. And for the women of South Carolina and across the country who are enrolled in Medicaid, the search for a new provider would add yet another hurdle to overcome in accessing basic health care. These women would likely face challenges similar to those experienced in Texas, where in 2013, the state restricted Medicaid recipients' access to Planned Parenthood. This led to unintended consequences.

In 2013, Texas replaced the federally funded Medicaid program with a nearly identical 100 percent state-funded program, the Texas Women's Health Program, which effectively prohibited Planned Parenthood as a provider by excluding facilities affiliated with abortion services.[69] After excluding Planned Parenthood, Texas "added 3,695 providers to the Women's Health Program and successor programs."[70] However, at the same time, "36,375 fewer women received health care services."[71] More providers did not equate to more patient services. Instead, "for each nominal provider added to the program, [ten] women lost health care services."[72]

Texas did not account for private providers' capacities or willingness to treat a high volume of patients. For example, in Midland, Texas, a local Planned Parenthood facility transferred 2,000 active

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[69] Amanda Jean Stevenson et al., *The impact of removing Planned Parenthood from Texas Women's Health Program* at 2, N. ENG. J. MED. (Nov. 30, 2016), https://tinyurl.com/48xrfvd3.

[70] STACEY POGUE, CTR. FOR PUB. POL'Y PRIORITIES, EXCLUDING PLANNED PARENTHOOD HAS BEEN TERRIBLE FOR TEXAS WOMEN at 5 (Aug. 2017), https://tinyurl.com/4p92vyyk.

[71] *Id.*

[72] *Id.*

patient records to a nearby federally qualified health center, but that clinic could not absorb the surge in patients.[73] Three years later, the local health center reported that less than 200 former Planned Parenthood patients had been seen.[74] This example shows that finding a qualified provider is far from simple for women in the current health care landscape, and removing the limited providers willing to provide sought-after care will only make it worse.

Even when alternative providers are available, women confronted with the loss of their preferred provider may completely forgo the care to which they are entitled. A 2024 survey showed that women are already thirty-five percent more likely than men to skip or delay medical care.[75] A third of the women in the same survey reported delaying or skipping women's health visits,[76] the core of Planned Parenthood's services. As explained above, many common reasons women skip care include cost, access, and negative experiences. Having the freedom to choose *any* qualified provider, including Planned Parenthood, helps to alleviate such barriers influencing women to forgo care.

First, because of the time and transportation barriers low-income women face in receiving quality health care, *see*, *supra*, Section II, women enrolled in Medicaid must have access to health clinics that offer care where and when they need it. Seventy-six percent of Planned Parenthood health centers are

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[73] *Id.* at 7–8.

[74] *Id.*

[75] Gebreyes, *supra* note 46.

[76] *Id.*

located in rural or medically underserved areas.[77] These health centers provide care close to home where the supply of health care providers, including primary care physicians and obstetricians, is otherwise low[78] and where residents are more likely to rely on Medicaid.[79] The hypothetical elimination of Planned Parenthood in these areas is foreboding, especially when the shortage of primary care physicians is projected to grow to up to 55,200 nationally by 2033.[80] Further, many Planned Parenthood locations, like its clinic in Little Rock, Arkansas, are open on weekends,[81] and others, like its clinic in Springfield, Missouri, stay open into the evening until seven p.m.[82] Planned Parenthood's non-traditional hours accommodate the demanding schedules of working women, mothers, and young adults, who might otherwise forgo care due to the inability to attend appointments during regular working hours.[83]

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[77] PLANNED PARENTHOOD, THE IRREPLACEABLE ROLE OF PLANNED PARENTHOOD HEALTH CENTERS at 1 (Apr. 2024), https://tinyurl.com/27pe4zp2.

[78] MACPAC, *supra* note 48, at 2–3.

[79] AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 51, at 2.

[80] MACPAC, *supra* note 48, at 3.

[81] *Little Rock Aldersgate Road Health Center of Little Rock, AR*, PLANNED PARENTHOOD, https://tinyurl.com/yckw4zrr (last visited Mar. 11, 2025).

[82] *Springfield Health Center of Springfield, MO*, PLANNED PARENTHOOD, https://tinyurl.com/2xxakcfk (last visited Mar. 11, 2025).

[83] *See* Elizabeth Hyde et al., *Time poverty: Obstacle to women's human rights, health and sustainable development* at 2, J. GLOB. HEALTH (Dec. 2020), https://tinyurl.com/23znf7ud ("One study in

Second, women on Medicaid must be empowered to choose a qualified provider that they trust. If not, they'll be disincentivized to seek care. Many women skip or avoid care because of negative interactions with health care providers and staff.[84] In contrast, a 2017 study found that patients who trusted their health care team report healthier behaviors, fewer symptoms, higher quality of life and greater satisfaction with their treatment.[85] Trust is built in a variety of ways to improve health outcomes, including by compensating for a language barrier in a patient-physician relationship.[86] Clinics that offer translation services, like Planned Parenthood,[87] are an important option for non-English speaking women. Ultimately, trust and comfort are subjective to a particular patient. So long as the provider is qualified, the patients—including all underserved women on

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the United States found that almost one-quarter of American women reported delaying or not seeking health care due to insufficient time.").

[84] *See, e.g.*, Leslie Read et al., *Rebuilding trust in health care*, DELOITTE INSIGHTS (Aug. 5, 2021), https://tinyurl.com/yc7mbeuc (describing focus group in which thirty-six percent of participants identifying as Black, Hispanic, Asian, or Native American reported skipping or avoiding care "because they did not like the way the health care provider or their staff treated them").

[85] Johanna Birkhauer et al., *Trust in the health care professional and health outcome: A meta-analysis*, PLOS ONE (Feb. 7, 2017), https://tinyurl.com/3yffwddy.

[86] *See, e.g.*, Soled, *supra* note 62, at 831.

[87] *See, e.g.*, *Language Services*, PLANNED PARENTHOOD OF SW. OR., https://tinyurl.com/294w2wyf (last visited Mar. 11, 2025) ("At several of our Health Centers, we have staff who speak Spanish. We also offer free telephone interpretation service in more than 100 languages.").

Medicaid—must be able to make their choice to ensure the best health outcomes possible.

CONCLUSION

The Court should affirm the Fourth Circuit's holding that Medicaid enrollees have a private right of action to enforce the free-choice-of-provider provision in the Medicaid Act. In addition to the many legal reasons why South Carolina's reading of the free-choice-of-provider provision in the Medicaid Act is wrong, the impact of gutting the provision will have a severe detrimental effect on women enrolled in Medicaid who already face numerous challenges in seeking access to health care, and primary and preventive care in particular.

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