No. 23-1275

IN THE

Supreme Court of the United States

EUNICE MEDINA, 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 *AMICI CURIAE* ORGANIZATIONS ADVANCING REPRODUCTIVE RIGHTS, HEALTH, AND JUSTICE IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

Amici are 18 organizations dedicated to gender justice. They seek to advance reproductive rights, health, and justice as part of a world where all individuals and communities will have the resources and freedom to make decisions about their bodies, health, families, and lives. Amici promote self-determination, equality, and access to dignified health care using expertise in law, policy, advocacy, research, education, community building, and service delivery. Because *Amici* believe that all people should have the power to make decisions about their own bodies and health care without government interference, *Amici* have an interest in this case. *Amici* respectfully urge the Court to rule in favor of the Respondent.

A list of signers appears in the Appendix.[1]

INTRODUCTION AND SUMMARY OF THE ARGUMENT

At issue is a South Carolina measure that would deny Medicaid beneficiaries the right to choose their own provider and bar them from accessing critical reproductive health services at Planned Parenthood. All individuals and communities should have the freedom to make their own decisions about where, how, and from whom they seek health care. For Medicaid recipients, the right to receive care from a qualified, willing, and

1. No counsel for a party authored this brief in whole or in part, and no party or party's counsel made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *Amici*, their members, or their counsel made a monetary contribution to this brief 's preparation or submission.

freely-chosen medical provider is vital to health, dignity and self-determination—especially with respect to sexual and reproductive health care services. Because there is a limited pool of trusted providers who accept Medicaid patients, and because Medicaid beneficiaries frequently experience discrimination and mistreatment in health care settings, it is essential they have the freedom to choose a provider offering high-quality care that meets their individual needs, and with whom they feel comfortable.

South Carolina's actions will impose particularly significant barriers to health care for communities of color, people with disabilities, LGBTQ+ people, and others who have been excluded from social, economic, and political power. Systemic discrimination informs how these individuals interact with the healthcare system, and makes access to a trusted, freely-chosen provider even more essential. Terminating Planned Parenthood from South Carolina's Medicaid program will result in harms to reproductive health that fall most heavily on those who have long been denied the opportunity to exercise decision-making about their bodies, families, and lives.

Further, Medicaid beneficiaries' ability to bring § 1983 actions to enforce their rights under the Medicaid statute ensures that they have access to justice through the courts. If accepted, South Carolina's position could have far-reaching and potentially devastating consequences for Medicaid beneficiaries, their families, and their communities.

ARGUMENT

The Medicaid program has dramatically expanded access to health care through public insurance that

millions of people rely upon to build healthy lives and families. The "free-choice-of-provider provision"—and the access to high-quality, comprehensive sexual and reproductive health care providers that it facilitates—has made Medicaid a crucial resource for people with low incomes across the United States.

Congress created the Medicaid program in 1965 with a central goal of providing individuals with low incomes dignified health care in their communities, free from inappropriate government interference.[2] In 1967, noting that the law did not prevent states from limiting recipients' access to high quality providers—and concerned that Medicaid recipients were unable to visit the sources of medical care that they preferred—Congress added a provision to "assure that any individual eligible for medical assistance will be free to obtain such assistance from the qualified institution, agency, or person of his choice" (the "free-choice-of-provider provision").[3] Despite this clear statutory language, whether or not a Medicaid beneficiary

2. *See*, *e.g.*, 111 Cong. Rec. 505 (1965) (statement of Rep. Pelly) ("[T]he doctors have been fearful—and rightly so—of steps that would eventually lead to government medicine. . . . I think the American people and most Members of Congress want free choice of hospital and doctor.").

3. *See* S. Rep. No. 90-744, at 183 (1967), *as reprinted in* 1967 U.S.C.C.A.N. 2834, 3021 ("Under the current provisions of law, there is no requirement on the State that recipients of medical assistance under a State title XIX program shall have freedom in their choice of medical institution or medical practitioner. In order to provide this freedom, a new provision is included in the law to require States to offer this choice. . . . States are required to permit the individual to obtain his medical care from any institution, agency, or person, qualified to perform the service or services. . . .").

in South Carolina is able to meaningfully exercise the right to choose a provider is now a question before this Court, with significant implications for reproductive health and autonomy.

I. Denying Medicaid Patients their Choice of Provider Will Harm the Many People and Communities that Rely on Medicaid Insurance

Medicaid is the largest source of public health insurance in the United States, covering sexual and reproductive health care and other vital health services for individuals with low incomes, including many women, single parents, people with disabilities, and other groups that may face challenges obtaining private health insurance.[4] Around half of the American people have been covered by Medicaid or had a family member covered at some time.[5] Approximately 40 percent of single mothers are covered by Medicaid, the Children's Health Insurance Program (CHIP), or other means-tested coverage.[6] More

4. Ivette Gomez, et al., *Medicaid Coverage for Women*, KFF (Feb. 17, 2022), https://www.kff.org/womens-health-policy/issue-brief/medicaid-coverage-for-women/; Robin Rudowitz, et al., *Medicaid 101: Who Is Covered by Medicaid?*, KFF (May 28, 2024), https://www.kff.org/health-policy-101-medicaid/?entry=table-of-contents-who-is-covered-by-medicaid.

5. Drew Altman, *The Biggest Health Policy Decisions Now Facing the Trump Administration*, KFF (Feb. 2025), https://www.kff.org/from-drew-altman/the-biggest-health-policy-decisions-now-facing-the-trump-administration/.

6. Isabela Salas-Betsch, *The Economic Status of Single Mothers*, Ctr. for Am. Progress (Aug. 7, 2024), https://www.americanprogress.org/article/the-economic-status-of-single-mothers/.

than 12 million people with disabilities rely on Medicaid for their health insurance,[7] and the program covers more than four in ten nonelderly people with disabilities.[8] Due to workplace discrimination and other systemic barriers, the LGBTQ community faces higher levels of poverty compared with the non-LGBTQ population[9] and the Medicaid program is critical to reducing health disparities in this population.[10] In some states, Medicaid is also a key source of coverage for people experiencing homelessness and those transitioning out of carceral settings.[11]

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7. *Medicaid Enrollees by Enrollment Group: 2021*, KFF, https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/?dataView=0&currentTimeframe=0&selectedDistributions=individuals-with-disabilities&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Mar. 3, 2025).

8. Alice Burns, et al., *10 Things to Know About Medicaid*, KFF (Feb. 18, 2025), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.

9. *See* Bianca D.M. Wilson, et al., *LGBT Poverty in the United States: Trends at the Onset of COVID-19*, UCLA Sch. of L. Williams Inst. (Feb. 2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Poverty-COVID-Feb-2023.pdf.

10. *See* Charly Gilfoil & Michelle Yiu, *Protect Medicaid Funding Issue #12: LGBTQI+ People*, Nat'l Health L. Prog. (May 2023), https://healthlaw.org/resource/protect-medicaid-funding-issue-12-lgbtqi-people/.

11. Madeline Guth & Meghana Ammula, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021*, KFF (May 6, 2021), https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/; Rudowitz, et al., *supra* note 4.

Medicaid is an essential resource for women. Approximately one in five non-elderly women across the United States are enrolled in Medicaid[12] and the program covers more than 13 million women of reproductive age (19-49), including more than 5.5 million white women, 3.6 million Latinas, and 2.5 million Black women.[13] Almost 31 percent of all non-elderly American Indian and Alaska Native (AIAN) women receive Medicaid[14] and 15 percent of Asian American and Pacific Islander (AAPI) women are enrolled.[15] Across all demographic groups, 41 percent of births in the United States were covered by Medicaid in 2022.[16]

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12. *Women's Health Insurance Coverage*, KFF (Dec. 12, 2024), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/.

13. *From Maternal Health to Long-Term Care: Medicaid is Vital for Women's Lifelong Health*, Nat'l P'ship for Women & Families 1 (Dec. 2024), https://nationalpartnership.org/wp-content/uploads/medicaid-vital-for-womens-lifelong-health.pdf.

14. *American Indian and Alaska Native Women Face Pervasive Disparities in Access to Health Insurance*, Nat'l P'ship for Women & Families 2 (Apr. 2019), https://nationalpartnership.org/wp-content/uploads/2023/02/AIAN-health-insurance-coverage.pdf.

15. *Asian Women's Access to Health Insurance Increases but Varies by Subgroup*, Nat'l P'ship for Women & Families 2 (Apr. 2019), https://nationalpartnership.org/wp-content/uploads/2023/02/asian-womens-health-insurance-coverage.pdf.

16. *Medicaid and CHIP Scorecard 2024*, Medicaid.gov, https://www.medicaid.gov/state-overviews/scorecard/main (last visited Mar. 3, 2025).

As it does in other states, Medicaid insures a significant proportion of women in South Carolina.[17] Medicaid covers nearly one in five people in South Carolina and more than 63 percent of recipients are women.[18] Fifty-eight percent of South Carolinians enrolled in Medicaid identify as non-white.[19] Twenty percent of all women of reproductive age in South Carolina are enrolled in Medicaid.[20] Nearly half of all births in South Carolina are covered by Medicaid.[21]

As this data demonstrates, Medicaid is an important resource for a diverse group of people, many of whom face multiple barriers to economic security. Medicaid furthers their ability to access care from trusted providers, and

17. In 2023, South Carolina Medicaid beneficiaries were about 63% female and 42% white. *South Carolina Women's Health Insurance Coverage Data*, KFF, https://www.kff.org/interactive/womens-health-profiles/south-carolina/healthcare-coverage/ (last visited Mar. 3, 2025); *Medicaid in South Carolina*, KFF 1 (Aug. 2024), https://files.kff.org/attachment/fact-sheet-medicaid-state-SC. In 2022, over half of Medicaid beneficiaries nationwide were female (54%) and almost half were under the age of 21 (47%), compared with adults (45%) and senior citizens (7%). *Medicaid and CHIP Scorecard 2024*, MEDICAID.GOV, see *supra* note 16. About one fifth of reproductive age women across the country were insured under Medicaid (13.3 million women aged 19-49) in 2023; a disproportionate number of those beneficiaries were women of color. *From Maternal Health to Long-Term Care*, NAT'L P'SHIP FOR WOMEN & FAMILIES, *see supra* note 13 at 1.

18. *Medicaid in South Carolina*, KFF, *supra* note 17 at 1; *South Carolina Women's Health Insurance Coverage Data*, KFF, *supra* note 17.

19. *Medicaid in South Carolina*, KFF, *supra* note 17 at 1.

20. *Id* at 1–2.

21. *Id* at 2.

is critical to advancing health equity for low-income individuals.

II. Exercising the Right to Choose One's Own Health Care Provider is an Act of Agency Essential to Health

Since the founding of the United States, individuals living in poverty, women, communities of color, people with disabilities, and other groups have been excluded from social, economic, and political power. Laws and policies have helped maintain these inequalities, and in many instances, have authorized reproductive oppression. Forced sterilization,[22] impeded or blocked access to health

22. Forced sterilization, including of incarcerated women, poor women, and women of color, has long been used as a tool of oppression and control. *See* Elena R. Gutiérrez, Fertile Matters: The Politics of Mexican-Origin Women's Reproduction 35-54 (2008) (discussing the forced sterilization of Mexican-origin women in Los Angeles); Alexandra Minna Stern, *Sterilized in the Name of Public Health: Race, Immigration, and Reproductive Control in Modern California*, 95 Am. J. Pub. Health 1128 (2005) (historical account of involuntary, federally-funded sterilization of women of color in California); Sally J. Torpy, *Native American Women and Coerced Sterilization: On the Trail of Tears in the 1970s*, 24 Am. Indian Culture & Res. J. 1 (2000) (documenting the federally-funded sterilization of thousands of Native American women in the 1970s); Kathryn Krase, *History of Forced Sterilization and Current U.S. Abuses*, Our Bodies, Ourselves (Oct. 1, 2014), https://www.ourbodiesourselves.org/book-excerpts/health-article/forced-sterilization/ (describing historical and continued forced sterilizations of women of color and incarcerated women); *Forced Sterilization of Disabled People in the United States*, Nat'l Women's L. Ctr. (Jan. 24, 2022), https://nwlc.org/resource/forced-sterilization-of-disabled-people-in-the-united-states/.

care services and coverage,[23] and other reproductive injustices have constrained bodily autonomy and continue to shape contemporary relationships to health care for many. The Medicaid program—strengthened by its free-choice-of-provider provision and the private right of action that supports the provision's enforcement—represents a crucial step forward in mitigating social and economic inequalities that negatively affect health.

A. Access to high-quality, respectful health care is already limited for Medicaid beneficiaries

Even with Medicaid coverage, low-income people face significant barriers to quality health care, including biases in health care delivery and mistrust between patients and health care providers. As a preliminary matter, not all health care providers accept Medicaid.[24] Fewer physicians are willing to accept new patients with Medicaid insurance than with Medicare or private insurance, leaving many

23. *See*, *e.g.*, 8 U.S.C. § 1613 (2015) (adding a five-year ban on accessing public benefit programs for "qualified" immigrants); *A Quick Guide to Immigrant Eligibility for ACA and Key Federal Means-Tested Programs*, Nat'l Immigration Law Ctr. (Apr. 2018) https://www.nilc.org/wp-content/uploads/2015/11/imm-eligibility-quickguide-2015-09-21.pdf (noting that certain groups of immigrants are ineligible to access government programs); Jessica Arons & Madina Agénor, *Separate and Unequal: The Hyde Amendment and Women of Color*, Ctr. for Am. Progress (Dec. 2010), https://cdn.americanprogress.org/wp-content/uploads/issues/2010/12/pdf/hyde_amendment.pdf (discussing the Hyde Amendment's targeting of women of color and the harm from banning abortion funding).

24. Xinxin Han, et al., *Reports of Insurance-Based Discrimination in Health Care and Its Association with Access to Care*, 105 Am. J. of Pub. Health S517, S517 (2015).

Medicaid recipients with limited provider options.[25] Furthermore, fewer than 40% of family planning clinics offer extended hours to serve patients juggling work, caregiving, and other commitments.[26] And some providers may not be accessible to members of diverse communities. For example, a study in South Carolina found that language barriers "affected [immigrant] women's confidence to make medical appointments and understand all the information conveyed during a typical visit.'"[27]

Ensuring a broad pool of high-quality providers from which patients can choose is critical given that low-income people report negative experiences with health care providers more frequently than people with higher incomes, and consequently have reduced trust in health institutions.[28] Negative experiences include being treated

25. *Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey*, MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N 2 (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf.

26. Alicia VandeVusse, et al., *Publicly Supported Family Planning Clinics in 2022–2023: Trends in Service Delivery Practices and Protocols*, GUTTMACHER INST. Appendix Table 1 (2024), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-family-planning-clinics-2022-2023.pdf.

27. John S. Luque, et al., *Access to Health Care for Uninsured Latina Immigrants in South Carolina*, BMC HEALTH SERVS. RES. 6 (May 2, 2018), https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-018-3138-2.

28. Chris C. Duke & Christine Stanik, *Overcoming Lower-Income Patients' Concerns About Trust and Respect*

disrespectfully, and having reported symptoms and reactions to treatments ignored by providers.[29] Distrust of health providers and the medical system correlates with patient demographics including having less income and education, and also with features of the health care system such as how physicians communicate, where people get care, and whether they have continuity with their chosen provider.[30] Notably, patients who infrequently visit a doctor, have difficulty accessing health services, report cost barriers to treatment, or have to wait for appointments also tend to report lower trust in their physicians.[31] For all these reasons, restricting the options available to Medicaid beneficiaries is likely to further diminish trust in the health care system, especially among low-income people.

For people of color, structural, institutional, and interpersonal racism impacts health care access and outcomes, influencing whether an individual receives the care they need and whether that care is high-quality. Evidence shows that discrimination and racial bias within and beyond the health care system contributes to poor health outcomes for Black patients and members of other

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from Providers, Health Affairs (Aug. 11, 2016), https://www.healthaffairs.org/content/forefront/overcoming-lower-income-patients-concerns-trust-and-respect-providers.

29. *Id.*

30. Anthony L. Nguyen, et al., *What Matters When It Comes to Trust in One's Physician: Race/Ethnicity, Sociodemographic Factors, and/or Access to and Experiences with Health Care?*, 4 Health Equity 280, 280–89 (June 2020).

31. *Id* at 285.

racial and ethnic minority groups.[32] "Higher levels of implicit bias among clinicians have been directly linked with biased treatment recommendations in the care of Black patients . . . [and] ha[ve] also been associated with poorer quality of patient-physician communication and lower patient ratings of the quality of the medical encounter."[33] Research from across the medical field shows that patients of color are treated with less empathy and urgency than white patients, and receive lower quality care, including during pregnancy and childbirth.[34] Given

32. David R. Williams & Ronald Wyatt, *Racial Bias in Healthcare and Health Challenges and Opportunities*, 314 J. Am. Med. Ass'n 555, 555–56 (2015).

33. *Id.* at 555.

34. *See id.*; Yael Eliner, et al., *Maternal Education and Racial/Ethnic Disparities in Nulliparous, Term, Singleton, Vertex Cesarean Deliveries in the United States*, 2 Am. J. Obstetrics & Gynecology Glob. Reps. 1 (Feb. 2022) (finding that all racial or ethnic minority groups had higher rates of cesarean deliveries than non-Hispanic White women, and higher levels of maternal education unequally mitigated the increased risk for non-Hispanic Black and Hispanic women); Mary Catherine Beech, et al., *Testimonial Injustice: Linguistic Bias in the Medical Records of Black Patients and Women*, 36 J. Gen. Intern. Med. 1708, 1710 (June 2021) (physician medical record notes about Black patients were more likely to include judgment words, and quotes or language suggesting disbelief); Elizabeth Howell, et al., *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 Am. J. Obstetrics & Gynecology 122 (2016) (demonstrating variations in quality of care between facilities that serve mostly Black patients and those that serve mostly white patients, with Black women suffering severe maternal morbidity at higher rates when birthing at hospitals that serve a high proportion of Black patients, even after adjusting for sociodemographic characteristics, clinical factors, and hospital characteristics).

the lingering presence of bias in modern health care, individuals insured by Medicaid may be less likely to trust providers they have not been able to select freely, with negative consequences for their health.

Each of these factors—a dearth of accessible providers who accept Medicaid, diminished trust in the health care system, and racial and ethnic biases in health care that contribute to distrust—make it essential that Medicaid beneficiaries have the freedom to choose a provider with whom they feel comfortable and who is capable of providing them with high-quality care that meets their individual needs. Giving states unfettered power to exclude qualified, committed providers from Medicaid for political reasons unrelated to health care would exacerbate the barriers that low-income people already face, regardless of what type of care they seek.

B. Access to culturally competent, trusted providers is critical for people seeking sexual and reproductive health care services

While the ability to choose a provider without improper state interference benefits all Medicaid beneficiaries, infringement of this right would uniquely impact people seeking sexual and reproductive health services. Sexual and reproductive health services implicate deeply personal preferences and choices about bodies and lives. They may involve disclosing or discussing private information, and often require the patient and provider to navigate the complex influences of culture, stigma, and past traumas. In these circumstances, it is imperative that patients choose from whom they will seek information and care, and who they will allow to touch their bodies.

Access to sexual and reproductive health services must also be viewed in the context of a long history of reproductive oppression, whereby both states and private parties have sought to control the bodily autonomy of people who they deem unfit for reproduction, or undeserving of the freedom to make decisions for and about themselves and their families. Women, people of color, immigrants, people with disabilities, LGBTQ individuals, and other marginalized groups have been, and continue to be, targets of reproductive coercion, discrimination, and neglect.

The reproductive oppression of women of color manifests as both blocked access to health care services and forced and unconsented medical procedures. For example, key developments in the early field of gynecology were made by medical practitioners who performed brutal surgeries on enslaved Black women, without anesthesia.[35] Not only were enslaved women denied bodily autonomy while being tortured during medical experiments, they were also subjected to sexual violence, forced to bear children, and often deprived of the right to raise those children.[36]

After slavery, certain individuals and communities were targeted for compulsory sterilization. Tied to the eugenics movement, compulsory sterilization efforts sought to control the reproductive autonomy of individuals deemed "undesirable" by society—including people of color, those who were incarcerated, people with

35. Deirdre Cooper Owens, Medical Bondage: Race, Gender, and the Origin of American Gynecology 11 (2017).

36. *Id.*

disabilities, and people with low incomes. In *Buck v. Bell*, 274 U.S. 200 (1927), the Supreme Court upheld Virginia's eugenic sterilization law, which permitted the forcible sterilization of thousands of men and women.

The legacy of sterilization abuse has profoundly affected Black communities across the South. Between 1964 and the mid-1970s, approximately 65 percent of the women sterilized in North Carolina were African American.[37] In a practice so common it came to be known as the "Mississippi appendectomy," medical students in the South developed their surgical skills by performing unnecessary hysterectomies on poor Black women at teaching hospitals, without their informed consent.[38] In *Relf v. Weinberger*, 372 F. Supp. 1196 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977), a legal challenge was brought by Mary Alice and Minnie Relf of Alabama, poor African-American sisters with intellectual disabilities who were sterilized at the ages of 14 and 12. Their mother, who was illiterate, was misled to believe she had given permission for her daughters to receive birth control shots. The lawsuit revealed that 100,000 to 150,000 poor people were being sterilized each year under federally-funded programs. *Id.* at 1199.

Sterilization abuses have been perpetrated against other communities of color as well. During the late 1960s and early 1970s, low-income, immigrant, Mexican women in Los Angeles were coercively sterilized by medical

37. *See* Angela Y. Davis, Women, Race, & Class 217 (1st ed. 1983).

38. Dorothy Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty 90 (2d ed. 2017).

practitioners who believed that "poor minority women in L.A. County were having too many babies."[39] In the 1960s and 70s, the Indian Health Service sterilized approximately one quarter of all Native American women.[40] And between 2006 and 2013, nearly 30 percent of tubal ligations performed on women incarcerated in the California prison system were done without legal consent, many on women of color.[41]

Coercion and discrimination in healthcare settings also occurs during pregnancy and birth. One in six women (of all races and ethnicities) report experiencing mistreatment in maternity care.[42] For women of color, it's nearly one in four.[43] Such mistreatment by healthcare providers includes shouting and scolding, ignoring patient requests for help, violations of privacy, and threatening to

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39. *See* Stern, *supra* note 22, at 1135.

40. *Sterilization Abuse: A Proposed Regulatory Scheme*, 28 DePaul L. Rev. 731, 733 n.14 (1979).

41. Cal. State Auditor, Report 2013-120, Sterilization of Female Inmates: Some Inmates Were Sterilized Unlawfully and Safeguards Designed to Limit Occurrences of the Procedure Failed 1 (2014), https://www.auditor.ca.gov/pdfs/reports/2013-120.pdf (noting that 39 of the 144 inmates who had sterilization procedures from 2005 to 2012 did not provide fully informed consent).

42. Saraswathi Vedam, et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 Reprod. Health (June 2019), https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2.

43. *Id.*

administer or withhold treatment against a patient's will.[44] Mistreatment rates are high when patients are facing complex situations that may need additional support. One in three women experiencing pregnancy complications report mistreatment, and the figure is the same for those with social risks such as substance use, incarceration, and/or intimate partner violence.[45]

Finally, underscoring that Medicaid beneficiaries must be able to choose freely among qualified providers, some health care providers contribute to the surveillance and punishment of patients seeking care, often targeting those who are low-income, pregnant, immigrant, and/or people of color. For example, hospitals that serve a higher proportion of Medicaid patients have been exposed for subjecting pregnant patients to unconsented drug tests.[46] Black families are more likely to be reported to child protective services as a result of these tests and are also more likely to have hospital security called on them.[47]

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44. *Id.*

45. *Id.* at 8.

46. *"Whatever They Do, I'm Her Comfort, I'm Her Protector." How the Foster System Has Become Ground Zero for the U.S. Drug War*, Movement for Family Power 34 (June 2020), https://static1.squarespace.com/static/65e79daddfbda143522ace5d/t/66ed89f8af7a4d5e1edbbfce/1726843386472/Ground-Zero-Report-Full.pdf; *see also* Ferguson v. City of Charleston, 532 U.S. 67 (2001) (holding that state hospital's policy to test obstetrics patients' urine without their consent imposed unreasonable searches).

47. Kayla L. Karvonen, et al., *Structural Racism Operationalized via Adverse Social Events in a Single-Center Neonatal Intensive Care Unit*, 260 J. Pediatrics 1, 5–6 (Sept. 2023).

Health care providers have reported patients seeking care for pregnancy loss to the police[48] and Medicaid patients who are—or are perceived to be—immigrants have increasing reasons to fear that their provider may report them to immigration authorities.[49] In South Carolina, a Black woman who lost a pregnancy faced unjustified homicide charges before being cleared by a grand jury. Her initial interrogation by law enforcement took place in a hospital recovery room.[50]

For these reasons and more, concerns about coercion, discrimination, and trust inform patients' choices about sexual and reproductive health care services and providers. Sexual and reproductive health decisions are deeply personal, and patients often consider their past, present, and future as they make them. While everyone

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48. Julie Carr Smyth, *A Black Woman Was Criminally Charged After a Miscarriage. It Shows the Perils of Pregnancy Post*-Roe, Associated Press, (Dec. 16, 2023), https://apnews.com/article/ohio-miscarriage-prosecution-brittany-watts-b8090abfb5994b8a23457b80cf3f27ce; Purvaja S. Kavattur, et al., *The Rise of Pregnancy Criminalization: A Pregnancy Justice Report*, Pregnancy Justice 46 (Sep. 2023), https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/9-2023-Criminalization-report.pdf.

49. *See* Lucie Arvallo, et al., *Deepening the Divide: Abortion Bans Further Harm Immigrant Communities*, Nat'l Latina Inst. for Reprod. Just. & Ctr. for L. & Soc. Pol'y (Sept. 17, 2024), https://www.clasp.org/wp-content/uploads/2024/09/Deepening-the-Divide-2024-Factsheet_Final_English.pdf.

50. Lauren Sausser, *She Was Accused of Murder After Losing Her Pregnancy. She's Now Telling Her Story*, La. Illuminator, (Sept. 23, 2024), https://lailluminator.com/2024/09/23/murder-pregnancy/.

deserves access to quality health care, women who have been excluded from the benefits of reproductive health advances, exploited during their development, coerced into certain reproductive choices, or mistreated while seeking care may be especially concerned about choosing a health care provider on their own terms. In this context, the patient must have a meaningful opportunity to choose the provider they trust to deliver comprehensive information, options, and services in an atmosphere of respect and non-judgment.

III. Access to Qualified Reproductive Health Providers Like Planned Parenthood is Crucial to South Carolinians' Public Health

Maintaining access to qualified sexual and reproductive health care providers and respecting patients' choice of provider promotes public health. South Carolinians already struggle with adverse outcomes across a range of health indicators, including preventable pregnancy-related deaths, and these have been exacerbated by the state's health laws and policies. Planned Parenthood provides a multitude of essential health services that address South Carolinians immediate health concerns, while also improving health outcomes over the long term by allowing individuals to enter, experience, and recover from pregnancy in better health. South Carolina asserts that permission to discriminate against qualified providers will allow it to better manage Medicaid resources—but as Texas has already demonstrated, this approach will instead likely lead to immense strain on South Carolina's health care system and reproductive health outcomes.

A. Denying Medicaid patients access to Planned Parenthood goes against the public interest, putting the health of South Carolinians at risk, and potentially exacerbating disparities

South Carolinian women face myriad health challenges and a dearth of supportive policies that might alleviate them. In 2024, South Carolina ranked 38th in the country on maternal mortality, with Black women dying at rates four times higher than white women in the State, and far above the national average.[51] South Carolina also ranked poorly on preterm birth (44th),[52] low birthweight (45th),[53] and prevalence of chlamydia among women (47th).[54] Benchmarked against national averages that are already considered poor compared to other wealthy countries, South Carolina was ranked 38th overall on women's and children's health and well-being.[55] The rates

51. *Maternal Mortality in South Carolina*, Am. Health Rankings, https://www.americashealthrankings.org/explore/measures/maternal_mortality_c/SC (last visited Mar. 3, 2025); *Pregnancy and Postpartum Health*, S.C. Dep't of Pub. Health, https://dph.sc.gov/health-wellness/family-planning/pregnancy/pregnancy-and-postpartum-health/ (last visited Mar. 3, 2025).

52. *2024 March of Dimes Report Card for South Carolina*, March of Dimes (2024), https://www.marchofdimes.org/peristats/reports/south-carolina/report-card.

53. *Low Birthweight in South Carolina*, Am. Health Rankings, https://www.americashealthrankings.org/explore/measures/birthweight/SC (last visited Mar. 3, 2025).

54. *Chlamydia—Women in South Carolina*, Am. Health Rankings, https://www.americashealthrankings.org/explore/measures/chlamydia_women/SC (last visited Mar. 3, 2025).

55. *2024 Health of Women and Children Report—State Summaries*, Am. Health Rankings 83 (2024), https://assets.

of infant mortality, child mortality, and teen mortality in South Carolina are all above the national average,[56] and communities of color and people with low incomes routinely bear a disproportionate burden of these adverse health outcomes.[57]

South Carolina lawmakers have spent substantial time and energy restricting reproductive health care in the state. In the wake of *Dobbs*, South Carolina began enforcing a ban on abortion at six weeks of pregnancy.[58]

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americashealthrankings.org/app/uploads/ahr_2024hwc_statesummaries-all.pdf.

56. *Id.* at 84.

57. In South Carolina, 23% of Black and Hispanic women reported having fair or poor health status in 2023, compared to 19% of white women. *South Carolina Women's Health Status Data*, https://www.kff.org/interactive/womens-health-profiles/south-carolina/health-status/ (last visited Mar. 3, 2025). Black women in South Carolina have a slightly lower rate of getting breast cancer than white women, but are more likely to die of the disease than white women. *Breast Cancer in South Carolina*, S.C. Dep't of Pub. Health 1 (2020), https://dph.sc.gov/sites/scdph/files/media/document/2020-Breast-Cancer-Fact-Sheet.pdf. Similarly, because of socioeconomic, cultural, and gender barriers, and lack of access to comprehensive sex education, STIs, including HIV, disproportionately impact women of color. In South Carolina, Black women have nearly seven times the rate of HIV diagnosis than white women. *South Carolina Women's Sexual Health Data*, KFF, https://www.kff.org/interactive/womens-health-profiles/south-carolina/sexual-health/ (last visited Mar. 3, 2025). Latinas have four times the rate of HIV diagnosis while Asian women have double the rate. *Id.*

58. *See After* Roe *Fell: Abortion Laws by State: South Carolina*, Ctr. for Reprod. Rights, https://reproductiverights.org/maps/state/south-carolina/ (last visited Mar. 3, 2025).

After the South Carolina Supreme Court found the ban violated the state constitutional right to privacy, *Planned Parenthood S. Atl. v. State*, 438 S.C. 188, 197, 882 S.E.2d 770, 775 (2023), *reh'g denied* (Feb. 8, 2023), the legislature enacted a virtually identical ban which the South Carolina Supreme Court then upheld. *Planned Parenthood S. Atl. v. State*, 440 S.C. 465, 472, 892 S.E.2d 121, 125 (2023), *reh'g denied* (Aug. 29, 2023). A concurring justice explicitly noted that the new ban sought to promote and increase access to contraceptives and early pregnancy testing, which in his view made the ban's intrusion on privacy more "reasonable." *Id.* at 491–94 (Few, J., concurring). The state's ongoing attempts to prevent people with Medicaid insurance from obtaining contraceptives, testing, and other non-abortion family planning services at their provider of choice flies in the face of that excuse for banning abortion before many people even realize they are pregnant.

Notably, even while banning abortion, South Carolina has been slower to implement evidence-based policies known to support women's and children's health and well-being.[59] For instance, the state has rejected expansion of Medicaid under the Affordable Care Act, imposes stringent Medicaid income limits for pregnant women, and does not require insurers or Medicaid plans to cover some forms of over the counter contraception without

59. *Evaluating Priorities: Evaluating Abortion Restrictions and Supportive Policy Across the United States*, Ibis Reprod. Health & Ctr. for Reprod. Rights, https://evaluatingpriorities.org/ (last visited Mar. 3, 2025) (showing that South Carolina has the third highest number of abortion restrictions in the country, along with three other states, but has passed only nine of 25 evidence-based supportive policies).

a prescription.[60] Now that abortion is almost banned in the state, and Planned Parenthood continues to provide crucial preventive services to people who may lack other high-quality, accessible providers, it is even more clear that the State's attacks on Planned Parenthood are unrelated to the care provided, and will harm people who need services the most.

Maintaining access to qualified health care providers like Planned Parenthood is critical to addressing health disparities and the gaps in South Carolina's safety net.[61] Family planning providers help to reduce unintended pregnancies, preterm and low birthweight births, sexually transmitted infections, and cases of cervical cancer.[62] Limiting access to health care and preventing women from choosing providers that they trust is counterproductive to any interest in advancing public health in South Carolina.

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60. *South Carolina Women's Health Insurance Coverage Data*, KFF, *supra* note 17.

61. Anti-poverty programs and government resources that assist people facing economic hardship are often referred to as a "safety net." Such programs may include nutrition assistance, health care, childcare, and more.

62. For example, Title X (a federal program that covers family planning services) improves people's health beyond helping them plan their pregnancies. In 2023, the Title X network provided cervical cancer screening for more than 460,000 patients, STI testing for more than 1.5 million patients, and HIV testing for more than 984,000 patients. Phillip Killewald, et al., *Family Planning Annual Report: 2023 National Summary*, Off. of Population Affs., U.S. Dep't of Health and Hum. Serv. 16 (Sept. 2024), https://opa.hhs.gov/sites/default/files/2024-10/2023-FPAR-National-Summary-Report.pdf.

B. Planned Parenthood is a highly qualified provider of reproductive health care services upon which people with low incomes depend

Planned Parenthood plays a uniquely crucial role in safeguarding the health of South Carolinians, many of whom rely on Planned Parenthood for essential services that enable them to plan their pregnancies, maintain their health, and self-determine a future for themselves and their families. Nationally, Planned Parenthood provides around 9.13 million clinical services to approximately 2.05 million patients a year,[63] more than one third of whom are women of color.[64] Planned Parenthood South Atlantic, the affiliate that serves South Carolina, provides a full range of reproductive health and women's health care services at their Charleston and Columbia locations. In addition to contraceptive care and STI screening and treatment, the Charleston and Columbia health centers provide breast exams, cervical cancer screenings, fibroid evaluation, prenatal care referrals, HPV vaccines, and mental health services.[65] The Columbia health center also

63. *Above & Beyond: Annual Report 2022-2023*, Planned Parenthood 7 (2024), https://www.plannedparenthood.org/uploads/filer_public/ce/f6/cef6efdb-919a-4211-bb5c-ce0d61fda7f5/2024-ppfa-annualreport-c3-digital.pdf.

64. *This is Who We Are*, Planned Parenthood 1 (2021), https://www.plannedparenthood.org/uploads/filer_public/2d/e1/2de1e14c-9bce-46b8-94f5-d57de80f1a3d/210210-fact-sheet-who-we-are-p01.pdf.

65. *Charleston Health Center of Charleston, SC*, Planned Parenthood, https://www.plannedparenthood.org/health-center/south-carolina/charleston/29407/charleston-health-center-4288-90860 (last visited Mar. 3, 2025); *Columbia Health Center of Columbia, SC*, Planned Parenthood, https://

provides general health care including physicals, diabetes screening, flu vaccinations, and a range of additional services.[66]

A provider's expertise in sexual and reproductive health and ability to provide a safe, accepting environment is highly valued by patients considering family planning services.[67] As a result, many women seeking contraception choose specialized family planning providers like Planned Parenthood. The primary reasons patients cite for selecting such facilities include being treated respectfully by staff, confidential services, free or low-cost services, and staff knowledge about women's health care.[68] Compared to many family planning providers, Planned Parenthood provides care that accommodates a

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www.plannedparenthood.org/health-center/south-carolina/columbia/29204/columbia-health-center-2646-90860 (last visited Mar. 3, 2025).

66. *Wellness and Preventive Care in Columbia, SC*, Planned Parenthood, https://www.plannedparenthood.org/health-center/south-carolina/columbia/29204/columbia-health-center-2646-90860/general-health (last visited Mar. 3, 2025).

67. For example, a study of clients at family planning clinics serving rural communities found that "clients viewed their interactions with providers as positive when providers were warm, non-judgmental, and knowledgeable." Bianca Faccio, et al., *Family Planning Clients' Experiences with Providers Can Inform Patient-Centered Care*, Child Trends (Jan. 18, 2023), https://www.childtrends.org/publications/family-planning-clients-experiences-with-providers-can-inform-patient-centered-care.

68. Jennifer J. Frost, et al., *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 Women's Health Issues e519, e523 (2012).

wide range of patient preferences. For example, 98 percent of Planned Parenthoods use a prescription protocol that allows a patient to start oral contraception on the day of their visit, while overall just over 60 percent of clinics do that same.[69] And 92 percent of Planned Parenthood clinics prescribe a supply of oral contraceptive pills that lasts 12 or more months, while overall just over a third of all clinics do.[70] For many LGBTQ individuals seeking respectful sexual and reproductive health care, Planned Parenthood offers a comprehensive range of services specifically addressing LGBTQ medical needs, including gender-affirming care.[71] The expansive set of services offered can be especially important to people who use Planned Parenthood as their primary source of sexual and reproductive health care, and, like respondent Julie Edwards, rely on Planned Parenthood referrals for additional health needs. Decl. of Julie Edwards ¶¶ 12–13, J.A.29. In these instances, Planned Parenthood serves as an important entry point into the health care system for individuals and their families.[72]

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69. VandeVusse, et al., *supra* note 26, at Appendix Table 3.

70. *Id.*

71. *See Gender Affirming Care*, Planned Parenthood, https://www.plannedparenthood.org/get-care/our-services/gender-affirming-care (last visited Mar. 3, 2025).

72. A study of women's reasons for seeking care at specialized family planning clinics found that for four out of ten respondents it was their only source of health care. Frost, et al., *supra* note 68, at e524.

C. Other states that have targeted Planned Parenthood for removal from Medicaid have caused serious and inequitable harms to reproductive and maternal health

As South Carolina seeks to cut Medicaid patients off from their trusted health care providers, Texas offers an alarming example of the harm that will ensue. Texas' sustained attempts to exclude Planned Parenthood from the state's family planning programs, culminating with terminating Planned Parenthood's ability to serve Medicaid patients, has inflicted lasting harm to public health.

Beginning in 2011, Texas took multiple actions that gutted its reproductive health safety net. After implementing a family planning expansion project under Medicaid that, according to the State's own data, improved access to contraception, reduced unintended pregnancies, and lowered the number of Medicaid-funded births,[73] Texas changed course and applied for a waiver to exclude abortion providers and affiliates from this project.[74] The federal government denied the waiver, finding, among other things, that it "would eliminate Medicaid beneficiaries' ability to receive family planning services

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73. *See generally 2010 Annual Savings and Performance Report for the Women's Health Program*, Tex. Health & Human Servs. Comm'n (Aug. 2011), https://web.archive.org/web/20170305221530/https://hhs.texas.gov/sites/hhs/files//rider64-womens-health-0811.pdf.

74. *See* Letter from Cindy Mann, Dir. Dep't. of Health & Hum. Services., Ctrs. for Medicare & Medicaid Servs., to Billy Millwee, Assoc. Comm'r Tex. Health & Human Servs. Comm'n (Dec. 12, 2011), http://www.lrl.state.tx.us/scanned/archive/2011/17104.pdf.

from specific providers for reasons not related to their qualifications to provide such services."[75] The State then chose to run its family planning program entirely with state dollars, and excluded from that program "many of the very safety-net providers most able to provide high-quality contraceptive care to large numbers of women," including Planned Parenthood.[76] During this same period, the Texas legislature also slashed family-planning grants by 66 percent.[77]

Texas's exclusion of Planned Parenthood from the state's family planning program led to widespread clinic closures, straining capacity at the remaining clinics and limiting the state's ability to deliver quality preventive care. In 2012, the state served 63 percent fewer women at an average cost per patient of 15 percent more than in 2011.[78] As public health researchers put it: "By excluding

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75. *See id.*

76. Kinsey Hasstedt & Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health*, HEALTH AFFS., (July 18, 2017), http://healthaffairs.org/blog/2017/07/18/atit-again-texas-continues-to-undercut-access-to-reproductive-health-care/.

77. Amanda J. Stevenson, et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEW ENG. J. OF MED. 853, 854 (2016).

78. Jordan Smith, *Texas Women's Health Care: Costs More, Does Less*, AUSTIN CHRONICLE (Nov. 30, 2012), http://www.austinchronicle.com/blogs/news/2012-11-30/texas-womens-health-care-costs-more-does-less/ (reporting based on documents filed with the State Health Services Council). The State's data also show a precipitous decline in contraceptive use among women enrolled in the state program. *See* Stevenson, et al., *supra* note 77, at 858 (describing more than a 30 percent decline in pharmacy and medical claims for long-term contraceptives).

numerous safety-net health centers and relying primarily on private doctors, the state developed a provider network incapable of serving high volumes of family planning clients."[79] Without access to Planned Parenthood clinics that many low-income communities depended on, fewer people in those counties obtained long-acting reversible contraception, people lost access to injectable contraception on which they relied, and births covered by Medicaid increased.[80] These changes suggest life-altering impacts on low-income Texans stemming from Planned Parenthood's exclusion, including interruptions in care and unintended pregnancies.

Despite these outcomes, Texas moved to terminate Planned Parenthood from the state's Medicaid program in 2015.[81] When the termination took effect in 2021, thousands of Medicaid patients lost access to their chosen health care provider.[82] Patients forced to find a new provider had difficulty identifying alternative health care professionals willing to accept Medicaid.[83] These patients found that, unlike Planned Parenthood, other providers were less available to deliver time-sensitive care and

79. Hasstedt & Sonfield, *supra* note 76.

80. Stevenson, et al., *supra* note 77, at 856–58.

81. Press Release, Off. of Tex. Gov., Texas Eliminates Taxpayer Funding to Planned Parenthood Providers (Oct. 19, 2015), https://gov.texas.gov/news/post/texas_eliminates_taxpayer_funding_to_planned_parenthood_providers.

82. Anna Chatillon, et al., *Access to Care Following Planned Parenthood's Termination from Texas' Medicaid Network: A Qualitative Study*, 128 Contraception 110141, 2 (2023).

83. *Id.* at 2–3.

were less willing to help patients navigate structural barriers, such as transportation, childcare, and inflexible or unpredictable work schedules.[84] Former Planned Parenthood patients reported missed or delayed care and emotional distress.[85]

Patients affected by Texas's decision to exclude Planned Parenthood from Medicaid also noted the importance of choosing a provider they trust and spoke to the role that Planned Parenthood plays as an entry point to the broader health care system.[86] One woman, in treatment for colon cancer that a Planned Parenthood clinician had identified, described her chosen provider this way: "Planned Parenthood are the ones that really make a difference. If you've never been to the doctor before, and you start getting regular care, and you have an open environment to talk. It's also easy to get in there. Those are the things that make a difference."[87]

Barring low-income patients from accessing care offered by Planned Parenthood exacerbates already immense gaps in the health safety net and undermines efforts to improve maternal health. Globally, maternal health outcomes are used as health indicators because they reveal whether government commitments to safeguard women's and children's health are serious

84. *Id.* at 3–4.

85. *Id.* at 4.

86. *Id.*

87. *Id.* (cleaned up).

and effective.[88] In the United States, maternal mortality and morbidity are unacceptably high, and Black and Indigenous women are disproportionately affected.[89] South Carolina's most recent data (2020) indicates that 94.4 percent of pregnancy-related deaths in the state are preventable and that 74 percent of the women that died had Medicaid insurance.[90]

Access to contraception, screenings for chronic health conditions, and treatment for infections can enable individuals to enter pregnancy in better health, at a time that is right for them, thereby reducing the risk of adverse outcomes. Indeed, the Texas Maternal Mortality and Morbidity Review Committee recommends that Texas "improve access to comprehensive health services for all women of child-bearing age, including preconception, pregnancy, postpartum, and interpregnancy periods; facilitate continuity of care; implement effective care

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88. For instance, the Millennium Development Goals and Sustainable Development Goals use maternal mortality ratios as a benchmark for measuring progress on development. *See* Nicholas J. Kassebaum, et al., *Global, Regional, and National Levels of Maternal Mortality, 1990-2015: A Systematic Analysis for the Global Burden of Disease Study 2015*, 388 The Lancet 1775, 1775–76 (2016).

89. *Pregnancy Mortality Surveillance System*, Ctr. for Disease Prevention (Jan. 31, 2025), https://web.archive.org/web/20250131105754/https:/www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance/index.html.

90. *2024 Legislative Brief*, S.C. Maternal Morbidity & Mortality Rev. Comm. 3–4 (2024), https://dph.sc.gov/sites/scdph/files/media/document/New%20PDFs/2024-SC-MMMRC-Legislative-Brief.pdf.

transitions; and promote safe birth spacing."[91] Amici agree that increasing health care access is essential to reversing poor and inequitable maternal health outcomes. Yet, by barring Medicaid patients from choosing Planned Parenthood, South Carolina seeks to deny them access to the very clinics that help safeguard their maternal health.

As Texas has regrettably demonstrated over the last decade, excluding qualified health care providers harms both patients and the health care infrastructure. Planned Parenthood provides critical preventative health services in states across the country that are grappling with provider shortages, facility closures, and maternity care deserts.[92] Terminating Planned Parenthood will only make essential health services less available and accessible—not just for those with Medicaid insurance, but for anyone needing such care.

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91. *Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2024*, Texas Dep't of State Health Servs. 2 (Sept. 2024), https://www.dshs.texas.gov/sites/default/files/legislative/2024-Reports/MMMRC-DSHS-Joint-Biennial-Report-2024.pdf.

92. *See Health Workforce Shortage Areas*, Health Resources & Servs. Admin. (Mar. 2, 2025), https://data.hrsa.gov/topics/health-workforce/shortage-areas; Tina Reed, *Gulf Widens Between Rich and Poor Hospitals*, Axios (Aug. 6, 2024), https://www.axios.com/2024/08/06/hospitals-risk-closing-operating-margins; *Nowhere to Go: Maternity Care Deserts Across the US: 2024 Report*, March of Dimes (2024), https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf.

IV. Access to Justice and Remedies for Rights Violations Are Essential to People Who Depend on Medicaid for Their Health Care and Must be Preserved

South Carolina contends that none of the provisions of the federal Medicaid Act, including the 83 provisions under § 1396a(a), confer private rights that patients may sue to enforce under 42 U.S.C. § 1983. For decades, Medicaid beneficiaries have enforced their rights under the Medicaid statute through § 1983 actions in the courts. If the State's arguments are accepted, the harm to Medicaid beneficiaries could be far-reaching.

What is at stake for Medicaid beneficiaries cannot be overstated. People with Medicaid insurance rely on their benefits to obtain essential yet otherwise unavailable medical care. *See Mem'l Hosp. v. Maricopa Cnty.*, 415 U.S. 250, 269 (1974) (recognizing that restrictions on "eligibility for nonemergency free medical care . . . deny[] [the] basic necessities of life"); *Goldberg v. Kelly*, 397 U.S. 254, 264 (1970) ("For qualified recipients, welfare provides the means to obtain essential food, clothing, housing, and medical care."). States like South Carolina that violate these rights jeopardize Medicaid beneficiaries' access to medically necessary health care. Individually enforceable rights are vital to ensuring that Medicaid beneficiaries can access such care from qualified providers that they trust.

Moreover, enforcement mechanisms provide a critical avenue for communities of color and populations that have been systematically disenfranchised by political and legal systems to seek redress in the courts. This aligns with the broader purpose and history of § 1983, which was

intended to enforce the Fourteenth Amendment to the U.S. Constitution and provide a federal remedy to African Americans subjected to state deprivations of their rights. In the face of state actions and laws that have intentionally targeted and discriminated against them, communities of color and other marginalized groups have long relied on the courts to seek justice when no other recourse was available. Courts have played a necessary role in protecting basic civil and human rights and the need for such protection is ongoing.

In the context of enforcement of the Medicaid Act, § 1983 actions have ensured that people experiencing poverty are able to seek justice in court and have their voices heard. Thus, the private right of action has served the very purpose of § 1983, which "was to interpose the federal courts between the States and the people, as guardians of the people's federal rights." *Mitchum v. Foster*, 407 U.S. 225, 242 (1972); *see also id.* at 239 ("Section 1983 opened the federal courts to private citizens, offering a uniquely federal remedy against incursions under the claimed authority of state law upon rights secured by the Constitution and laws of the Nation").

A private right of action has been—and continues to be—integral to providing an actual and meaningful avenue for individuals to vindicate rights related to the health care they need. Stripping away an individual's right to sue would injure the legal agency and dignity of low-income people seeking to safeguard their own well-being, adding to the injuries the State will inflict by denying Medicaid patients access to respectful care from their provider of choice.

CONCLUSION

Medicaid insurance serves as a critical access point for people seeking a variety of essential health services, especially those related to sexual and reproductive health. People with low incomes in South Carolina already face significant barriers to health care that fall most heavily on communities of color, people with disabilities, LGBTQ+ people, and others who may have experienced mistreatment in health settings and been denied opportunities to make decisions about their bodies, lives, and families. Depriving Medicaid beneficiaries of their right to choose a trusted, willing, and qualified provider will further limit access to high-quality, comprehensive sexual and reproductive health care, and worsen health inequities. One need only look to Texas to preview the harms that result. Moreover, a private right of action has been critical in ensuring that states comply with their duties under the Medicaid Act to afford beneficiaries the opportunity to choose a qualified provider. For the reasons set forth above, this Court should affirm.

Respectfully submitted,

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APPENDIX

TABLE OF APPENDICES

APPENDIX — LIST OF *AMICI*

Center for Reproductive Rights

Access Reproductive Care-Southeast

Elephant Circle

Guttmacher Institute

If/When/How: Lawyering for Reproductive Justice

Ipas US

In Our Own Voice: National Black Women's Reproductive Justice Agenda

The Lawyering Project

National Abortion Federation

National Asian Pacific American Women's Forum

National Latina Institute for Reproductive Justice

National Partnership for Women & Families

National Women's Law Center

Power to Decide

US Gender and Disability Justice Alliance

WAWC Healthcare

Women Enabled International

Women's Law Project