No. 23-1275

IN THE

Supreme Court of the United States

EUNICE MEDINA, in her official capacity as 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 FOR *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS *ET AL.* IN SUPPORT OF RESPONDENTS

(Amici Curiae continued on next page)

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AMICI CURIAE (cont.)

**AMERICAN ACADEMY OF FAMILY PHYSICIANS,
AMERICAN ACADEMY OF PEDIATRICS,
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AMERICAN COLLEGE OF PHYSICIANS,
SOCIETY FOR ADOLESCENT
HEALTH AND MEDICINE,
SOCIETY OF FAMILY PLANNING,
SOCIETY OF GYNECOLOGIC ONCOLOGY,
AND SOCIETY OF OB/GYN HOSPITALISTS**

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INTEREST OF AMICI[1]

Amici, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, American College of Nurse-Midwives, American College of Physicians, Society for Adolescent Health and Medicine, Society of Family Planning, Society of Gynecologic Oncology, and Society of OB/GYN Hospitalists, are leading professional medical organizations that serve patients in South Carolina and beyond, work to ensure access to evidence-based health care, advance medical education, further the ethical practice of medicine, and promote health care policy that improves patient health. *Amici* submit this brief to explain the importance of Medicaid in the United States and the potential consequences on the public health system if states are able to indiscriminately exclude qualified and willing providers. *Amici* are uniquely positioned to provide the Court with the insight and perspective of thousands of medical providers and experts.

SUMMARY OF ARGUMENT

As the national health insurance program for persons of limited financial means, Medicaid plays

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[1] No counsel for any party has authored this brief in whole or in part, and no person has made any monetary contribution intended to fund the preparation or submission of this brief.

a vital role in propelling the nation's health care system by offering coverage to a wide segment of this country's population. Protecting Medicaid is an investment in the health, lives, and futures of individuals nationwide. This starts with ensuring that Medicaid continues to offer access to a wide range of qualified health care providers. Choosing a medical provider is a crucial decision that individuals make about their health care. It is fundamental to patient autonomy and can be pivotal in shaping the patient's treatment, overall well-being, and quality of life. Despite this, South Carolina seeks to eliminate Planned Parenthood South Atlantic ("PPSAT"), an affiliate of Planned Parenthood Federation of America ("Planned Parenthood"), as a qualified provider under the State's Medicaid program, thereby limiting patients' choice of providers.

The State's attempt to defund PPSAT contravenes the Medicaid Act's free-choice-of-provider provision, which gives Medicaid beneficiaries the right to choose to receive their medical care from a qualified and willing provider. This provision was added to the Medicaid statute through an amendment in 1967 to improve access to health care for low-income populations and allow patients to choose their care.[2] The amendment was passed in

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[2] Lara Cartwright-Smith & Sara Rosenbaum, *Medicaid's Free-Choice-of-Provider Protections in a Family Planning Context: Planned Parenthood Federation of Indiana v. Commissioner of the Indiana State Department of Health,* 127 Public Health Reports 119, 120 (2012).

response to evidence from Medicaid's early years of existence showing states had acted to limit beneficiaries' access to health care settings of their choosing.[3] Since these practices were contrary to Medicaid's goal of expanding access to health care providers, Congress acted swiftly to codify Medicaid beneficiaries' right to choose.[4]

PPSAT is a qualified and willing provider. The State expressly "agree[s]" that PPSAT is "perfectly competent to provide…health care." Pet. App. 41a. PPSAT and its predecessors have provided health care to low-income residents of South Carolina for four decades. Across two health centers in South Carolina (and several others across North Carolina, Virginia, and West Virginia), PPSAT provides essential medical services, including physical exams, cancer screenings, contraception, pregnancy testing and counseling, and screening for conditions such as diabetes, depression, anemia, thyroid disorders, and high blood pressure. PPSAT also provides abortion services, but Medicaid does not pay for abortion care except in limited circumstances.

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[3] *Id.*

[4] *See id.*; *see also* H.R. Rep. No. 544-90, at 122 (1967) (the right to choose one's medical provider is "a characteristic of our medical care system"); President's Proposals for Revision in the Social Security System, First Session on H.R. 5710: Hearing Before the Committee on Ways and Means, 90th Cong. 1630, 1637-38 (1967) (discussing the importance of the provision to the provider-patient relationship.

Amici strongly oppose political interference in patients' ability to obtain care from qualified providers. The State concedes that PPSAT could receive state Medicaid funding if it stops performing abortions, implying that the State seeks to remove an otherwise qualified and willing medical provider *only* because it disagrees with a safe and effective health care service offered by that provider. Allowing South Carolina to arbitrarily remove PPSAT, a provider of crucial family planning and reproductive care in the State, from the Medicaid program will not only impact the people of South Carolina, but will also have downstream impacts on the health care system and public health nationwide, because other states may take similar action in arbitrarily removing qualified Medicaid providers.

First, Medicaid providers, including PPSAT, ensure access for millions of Americans to a wide range of health care services. This is particularly true for women, low-income individuals, people of color, and people living in rural areas, who depend on Medicaid to receive care and already face difficulties accessing it. Permitting South Carolina to eliminate a qualified Medicaid provider sets a dangerous precedent allowing states to remove otherwise qualified and willing providers from the health care system indiscriminately. The impact will be devastating, undermining patient choice, interfering with the clinician-patient relationship, and creating further barriers to medical care.

Second, if states were to arbitrarily remove qualified providers from their state's Medicaid plan, this would be detrimental to public health across the country. Data shows that other health care providers cannot compensate for the loss of a qualified provider. The exclusion of providers would further overwhelm a system that is already limited in capacity. Reducing access to services will inevitably lead to poorer health outcomes.

Third, focusing on South Carolina specifically, if successful, terminating PPSAT as a Medicaid provider would have a harmful impact on South Carolina residents. Removal of PPSAT from the State's Medicaid program would reduce the number of providers available in South Carolina and create additional barriers to accessing health care in the State. As demonstrated by recent history, and discussed further *infra*, it will increase (rather than decrease) negative health outcomes and consequences for South Carolinians.

Medicaid services should be protected and expanded to provide greater access to the full range of services to support patient health care needs, not restricted by government interference based on ideological objections unrelated to quality of care. The Court should reject the State's attempt to interfere with the provision of health care without any medical or scientific justification. For all these reasons, Court should uphold the Fourth Circuit's decision.

ARGUMENT

I. ELIMINATING MEDICAID PROVIDERS LIMITS ACCESS TO HEALTH CARE

Medicaid was designed to expand access to medical care and, as history illustrates, has had a profound impact on access to health care and improved health outcomes. Medicaid providers fulfill a critical need in ensuring access to quality health care for millions of individuals with limited financial means and those living in medically underserved communities. If states were arbitrarily able to remove providers from their state Medicaid programs, then patient choice would be undermined, and potentially even extinguished in certain care deserts, inevitably leading to reduced, or delayed, access to certain health care services.

A. Medicaid Is Critical in Providing Access to Essential Health Care

Medicaid is integral to the American health care safety net. Medicaid provides access to health care for over 20% of the United States population.[5] Last year, Medicaid provided health insurance to 72.1 million individuals nationwide.[6] Notably, Medicaid

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[5] Alice Burns et al., Kaiser Fam. Found., *10 Things to Know About Medicaid*, at Figure 1 (Feb. 18, 2025), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.

[6] *October 2024 Medicaid & CHIP Enrollment Data Highlights*, Medicaid.gov (Oct. 2024), https://www.medicaid.gov/

provides coverage for a significant portion of women across the country, and is the largest single payer of maternity care in the United States.[7] In 2023, nearly one in five women aged 19 to 64 relied on Medicaid for insurance.[8] South Carolina mirrors the national Medicaid statistics, as nearly 1 million South Carolinians were enrolled in Medicaid last year, representing more than 17% of the State's population.[9] In the State, 20% of women aged 15 to 49 relied on Medicaid coverage for access to health care.[10]

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medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[7] Ivette Gomez et al., Kaiser Fam. Found., *Medicaid Coverage for Women*, (Feb. 17, 2022), https://www.kff.org/womens-health-policy/issue-brief/medicaid-coverage-for-women/. Medicaid covered over 40% of all U.S. births in 2023. This figure is even higher for underserved populations; for Black mothers, Medicaid covered approximately 64% of all labor and delivery services in 2022. *See* Michelle Osterman et al., *Births: Final Data for 2022*, 73:2 Nat'l Vital Stat. Repts. 1, 7 (Apr. 4, 2024), https://www.cdc.gov/nchs//data/nvsr/nvsr73/nvsr73-02.pdf.

[8] Kaiser Fam. Found., *Women's Health Insurance Coverage* (Dec. 2024), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/.

[9] *October 2024 Medicaid & CHIP Enrollment Data Highlights*, Medicaid.gov, *supra* note 6.

[10] Kaiser Fam. Found., *Medicaid in South Carolina* (Aug. 2024), https://files.kff.org/attachment/fact-sheet-medicaid-state-SC.

Medicaid providers offer patients a wide range of medical services. Medicaid covers a comprehensive list of essential services to beneficiaries, including a variety of services that states are required to provide under federal law.[11] These include inpatient and outpatient hospital services, laboratory and X-ray services, nursing facility services, physician services, certified pediatric and family nurse practitioner services, rural health clinic services, and more.[12] There are also optional Medicaid benefits, such as dental services, physical therapy, occupational therapy, prescription drugs, and hospice, that states may provide if they add them through the State plan.[13]

Medicaid plays an indispensable role in maternal care, providing both prenatal and postpartum coverage. Medicaid is the largest payer of pregnancy services, financing between 40% and 50% of all births in the United States, and is the largest source of public funding for family planning services, accounting for 75% of all public family planning expenditures.[14] Notably, these statistics do

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[11] *Mandatory & Optional Medicaid Benefits*, Medicaid.gov (last visited Mar. 6, 2025), https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html.

[12] *Id.*

[13] *Id.*

[14] Usha Ranji et al., Kaiser Fam. Found., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey* (Feb. 2022), https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/; American College of Ob-

not capture the months of coverage for essential prenatal care Medicaid provides that enables many patients to have healthy pregnancies and infants, nor do they reflect the coverage provided after delivery. For example, Medicaid ensures that people of reproductive age have access to screening and treatment for diseases that may affect pregnancy, such as diabetes, heart disease, and obesity.[15] In states that expanded Medicaid, mothers are more likely to utilize prenatal and postpartum services, which results in their infants having reduced rates of low birthweight and a decreased likelihood of infant mortality.[16] Moreover, to ensure that there is not a care gap for newborn children, Medicaid provides immediate coverage to infants born to Medicaid enrollees.[17]

Medicaid also limits cost burdens on beneficiaries, thereby increasing access to these services.

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stetricians and Gynecologists ("ACOG"), *Medicaid* (last visited Feb. 24, 2025), https://www.acog.org/practice-management/payment-resources/payer-policies/medicaid.

[15] Wayne Turner et al., *What Makes Medicaid, Medicaid? - Services,* Nat'l Health Law Program, at 4-5 (2023), https://healthlaw.org/wp-content/uploads/2023/04/Protect-Medicaid-series-Services-FINAL-2.pdf.

[16] Madeline Guth & Karen Diep, Kaiser Fam. Found., *What Does the Recent Literature Say About Medicaid Expansion?: Impacts on Sexual and Reproductive Health* (June 29, 2023), https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-impacts-on-sexual-and-reproductive-health/.

[17] 42 U.S.C. § 1396a(e)(4); 42 C.F.R. § 435.117.

When comparing individuals enrolled in Medicaid to those who were privately insured, out-of-pocket spending is ***ten times lower***.[18] Studies show that Medicaid expansion resulted in lower out-of-pocket costs and improved access to primary and preventative care.[19] States with Medicaid expansion also showed better continuity of care and management of chronic disease, an overall decrease in unmet health care needs among low-income adults, and a significant reduction in overall emergency department use.[20] Individuals in Medicaid expansion states are also less likely to skip medications or delay care due to cost.[21]

For women in particular, Medicaid advances economic security, decreasing debt and bankruptcy

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[18] Heidi Allen et al., *Comparison of Utilization, Costs and Quality of Medicaid vs Subsidized Private Health Insurance for Low-Income Adults*, 4:1 JAMA Network Open e2032669, at 1, 2 (Jan. 5 2021).

[19] Benjamin Sommers et al., *Changes in Utilization and Health among Low-Income Adults after Medicaid Expansion or Expanded Private Insurance*, 176:10 Jama Internal Med. 1501, 1507-08 (Oct. 2016).

[20] Amber Sabbatini & Jerome Dugan, *Medicaid Expansion and Avoidable Emergency Department Use-Implications for US National and State Government Spending*, 5:6 Jama Network Open e2216917, at 1 (2022).

[21] Sommers et al., *Changes in Utilization and Health among Low-Income Adults after Medicaid Expansion or Expanded Private Insurance*, *supra* note 19, at 1503.

due to medical expenditures.[22] In addition, women with Medicaid coverage use primary care and preventive services at rates that approach those of privately-insured women and are less likely to forego care due to cost than their uninsured counterparts.[23]

B. Medicaid Provides Access to Medical Services for Patients Who Otherwise Face Significant Barriers to Care

Medicaid has played an important role in improving health outcomes through providing access to much-needed care to medically underserved communities, including low-income individuals, communities of color, and rural residents.

First, Medicaid provides access to vital services for people with limited financial means. Coverage extends to 59% of all individuals under 65 years of age that have an income below 100% of the federal poverty level.[24] Medicaid generally prohibits premiums on low-income households below 150% of

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[22] ACOG, *Protecting and Expanding Medicaid to Improve Womens Health*, Committee Opinion 826, e163, e164 (June 2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/06/protecting-and-expanding-medicaid-to-improve-womens-health.

[23] Ivette Gomez et al., *Medicaid Coverage for Women*, *supra* note 7.

[24] Congressional Research Service, *Medicaid: An Overview*, at 2 (Feb. 8, 2023), https://crsreports.congress.gov/product/pdf/R/R43357.

the federal poverty level, as even small premiums can negatively impact enrollment.[25] Medicaid coverage is particularly critical for low-income individuals in South Carolina, where the poverty rate is higher than the national average (13.9% versus 12.5%) and approximately one-third of South Carolinians are classified as low-income, meaning their annual incomes fall below 200% of the federal poverty level.[26] Without Medicaid, low-income individuals can face destructive financial consequences or forego care with potentially serious health outcomes. For example, the lowered out-of-pocket costs of Medicaid protect vulnerable individuals from incurring debilitating medical debt from a single catastrophic event or complication. This reduces obligations to debt collectors and ensures that ac-

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[25] Madeline Guth et al., Kaiser Fam. Found., *Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers* (Sept. 9, 2021), https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/; Betsy Q. Cliff et al., Nat'l Bureau Econ. Rsch., *Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules*, at 5 (May 2021), https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[26] United States Census Bureau, S1701 Poverty Status in the Past 12 Months, https://data.census.gov/table?q=S1701:%20POVERTY%20STATUS%20IN%20THE%20PAST%2012%20MONTHS&g=010XX00US,$0400000&y=2023 (last visited Feb. 7, 2025); Kaiser Fam. Found., *Medicaid in South Carolina*, *supra* page note 10.

cessing health care does not lead to medical bankruptcy.[27]

Second, Medicaid also provides an important source of health care coverage for people of color, who make up 60% of Medicaid beneficiaries under the age of 65.[28] Communities of color represent the majority of beneficiaries of Medicaid in 25 states and significant portions of those covered in most of the remaining states.[29] Black and Latinx Americans are more likely to experience poverty and are less likely to have access to quality care. Communities of color also face higher rates of chronic conditions, which require comprehensive and reliable health care coverage.[30] The expansion of Medicaid under the Affordable Care Act demonstrates the important role Medicaid plays in promoting positive health outcomes across populations. The expansion led to increased access to cancer care and resulted in earlier diagnosis and treatment for

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[27] *See* Luojia Hu et al., *The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing*, 163 J. Public Econ. 99, 100, 117–18 (2018).

[28] Kaiser Fam. Found., *Distribution of the Nonelderly with Medicaid by Race/Ethnicity* (2022), https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/.

[29] Jamila Michener, *Politics, Pandemic and Racial Justice Through the Lens of Medicaid*, 11:4 Am. J. Pub. Health 643, 643 (Apr. 2021).

[30] *See* James Price et al., *Racial/Ethnic Disparities in Chronic Diseases of Youths and Access to Health Care in the United States*, BioMed Rsch. Int'l, Sept. 2013, at 1.

Black patients. It also increased access to care for kidney disease for patients of color.[31]

Third, Medicaid plays an important role in helping to address the unique challenges faced by patients living in rural areas. Rural residents face significant challenges to accessing care because they are more likely to be low-income, often face barriers to accessing care, such as provider shortages and long travel distances to providers, and tend to have worse health outcomes. It is, therefore, not surprising that Medicaid coverage rates are higher in rural areas compared to other areas.[32] Access to Medicaid providers is, thus, crucial for the nearly 14 million individuals in this country that reside in rural areas, including nearly 730,000 individuals that live in rural South Carolina.[33] Moreover, individuals in rural communities tend to have worse health outcomes and face significant barriers to accessing health care because of limited

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[31] *Id.*

[32] *See* Aubrianna Osorio et al., *Medicaid's Coverage Role in Small Towns and Rural Areas*, Georgetown University McCourt School of Public Policy (Aug. 17, 2023), https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas/.

[33] Michelle Yiu & Mara Youdelman, *Medicaid Fast Facts,* Nat'l Health Law Program, at 2 (Sept. 2024), https://health-law.org/wp-content/uploads/2024/09/00-MedicaidFastFacts-2024Update.pdf; Rural Health Info. Hub, *South Carolina*, https://www.ruralhealthinfo.org/states/south-carolina (noting in 2022, the poverty rate for rural South Carolinians was 20.4%).

providers.[34] For example, nationally, more than half of all primary care, mental health, and dental health professional shortage areas are located in rural areas.[35] Medicaid helps address barriers faced by rural residents through: non-emergency medical transportation and telehealth. Medicaid law requires states to ensure all enrollees have access to transportation to and from medical appointments to access services.[36] These are important for rural residents, as access to in-person care can be limited.

Populations that are covered under Medicaid include several medically underserved communities with a range of health needs. Thus, a robust network of providers sufficient in number, diversity, and geographic distribution is essential to provide

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[34] Julia Foutz et al., Kaiser Fam. Found., *The Role of Medicaid in Rural Areas* (April 25, 2017), https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/.

[35] Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Designated Health Professional Shortage Areas: First quarter of fiscal year 2021, designated HPSA quarterly summary* (2020), https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[36] Medicaid & CHIP Payment & Access Comm'n ("MACPAC"), *Medicaid and Rural Health*, at 6 (April 2021), https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf.

comprehensive care that is responsive to the complex needs of Medicaid enrollees.[37]

II. EXCLUDING QUALIFIED PROVIDERS FROM MEDICAID IS DETRIMENTAL TO PUBLIC HEALTH

Medicaid beneficiaries rely on a limited network of providers in their state for essential services and care. Studies show that many states do not have sufficient Medicaid providers and are overwhelmed by the large numbers of Medicaid patients. The exclusion of providers from these states' Medicaid programs would further overwhelm a system already stretched thin. The resulting lack of available quality providers will lead to decreased access to care. As proven by countless studies, a reduction in access to health care leads to significant declines in health outcomes. Medicaid patients will suffer a myriad of adverse health consequences if qualified and willing providers are excluded from the program.

A. Other Health Care Providers Cannot Compensate for the Loss of a Given Provider

A shortage of Medicaid providers already exists in the United States, leading many Medicaid bene-

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[37] 42 C.F.R. § 438.207(a),(b)(2) (requiring states to ensure they have the capacity to serve expected Medicaid enrollment and maintain a network of providers "sufficient in number, mix, and geographic distribution" to meet patient needs).

ficiaries to struggle to find quality care. In a 2023 survey, every state but Nebraska reported shortages for more than one type of provider, and 48 states reported shortages among five or more provider types.[38] Having a sufficient number of providers from which patients can choose is a key challenge for states as they ensure access to care for Medicaid beneficiaries.[39] The majority of states which report challenges to ensuring enough quality care for Medicaid beneficiaries cite a general shortage of providers as a contributing factor.[40] As of 2019, there was an average of 783.4 Medicaid primary care providers[41] per 100,000 Medicaid population in

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[38] Alice Burns et al., Kaiser Fam. Found., *Payment Rates for Medicaid Home- and Community-Based Services: States' Responses to Workforce Challenges* (Oct. 24, 2023), https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/.

[39] Kayla Holgash & Martha Heberlein, Health Affairs, *Physician Acceptance of New Medicaid Patients: What Matters And What Doesn't* (April 10, 2019), https://www.healthaffairs.org/content/forefront/physician-acceptance-new-medicaid-patients-matters-and-doesn-t.

[40] *See* U.S. Gov't Accountability Office, *GAO-13-55, Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, at 18 (Nov. 2012), https://www.gao.gov/assets/650/649788.pdf.

[41] Medicaid primary care providers include Family Medicine, Internal Medicine, Pediatrics, OB/GYN, Advanced Practice, Registered Nurses, and Physician Assistants.

the United States.[42] The average Medicaid provider in America is therefore responsible for providing care to roughly 128 Medicaid patients at any given time.[43] Eliminating even one qualified provider from this already limited pool has a serious impact on remaining providers and further exacerbates existing barriers to beneficiaries' access to quality care.

Health care provided to Medicaid patients is often highly concentrated, with a small group of providers responsible for the bulk of care. One study showed that, among Medicaid managed care plans in several states, 25% of primary care physicians provided 86% of the care.[44] Adults and children whose primary coverage is Medicaid are more likely to report having a difficult time reaching their usual medical provider after hours for urgent medical needs compared to those with private insurance.[45] The exclusion of qualified providers from

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[42] George Washington Univ. Fitzhugh Mullan Inst. for Health Workforce Equity, *U.S. Medicaid Primary Care Workforce Tracker*, https://www.gwhwi.org/medicaid-primary-care-workforce-tracker.html (last visited Mar. 10, 2025).

[43] *See id.*

[44] Avital Ludomirsky, et al., *In Medicaid Managed Care Networks, Care Is Highly Concentrated Among a Small Percentage of Physicians*, 41:5 Telemedicine, Disparities, Pharmaceuticals & More 760, 760 (May 2022).

[45] MACPAC, *MACStats: Medicaid and CHIP Data Book*, at 10 (Dec. 2023), https://www.macpac.gov/wp-content/uploads/2023/12/MACSTATS_Dec2023_WEB-508.pdf.

Medicaid exacerbates care deserts, leaving Medicaid patients vulnerable.

Further, not all providers accept Medicaid. Medicaid provider participation has been shown to vary across states, and studies consistently show providers are less likely to accept patients with Medicaid than those with private insurance or Medicare.[46] For instance, a recent Medicaid and Children's Health Insurance Program ("CHIP") Payment & Access Commission ("MACPAC") study found that, as of 2017, physicians were significantly less likely to accept new patients insured by Medicaid (74.3%) than those with Medicare (87.8%) or private insurance (96.1%).[47] National surveys demonstrate similar findings, with only 68% of family physicians and 36% of psychiatrists reporting they accept new Medicaid patients.[48] Addition-

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[46] *See* George Washington Univ. Fitzhugh Mullan Inst. for Health Workforce Equity, *U.S. Medicaid Primary Care Workforce Tracker: Why This Matters*, https://www.gwhwi.org/medicaid-why-this-matters.html (last visited Mar. 10, 2025).

[47] MACPAC, *Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey* at 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.

[48] Candice Chen et al., Health Affairs, *Tracking the Elusive Medicaid Workforce to Improve Access* (Aug. 2, 2023), https://www.healthaffairs.org/content/forefront/tracking-elusive-medicaid-workforce-improve-access.

ally, studies show that health care providers are less likely to accept new patients with Medicaid compared to private insurance or Medicare.[49] It is estimated that up to one-third of all physicians are unable to accept new Medicaid patients, and these percentages have not changed significantly during the past decade.[50] Finally, providers in urban areas who have access to a large enough patient base outside of Medicaid are often less willing to accept Medicaid.[51]

As a result of only a limited number of providers participating in Medicaid, beneficiaries are more likely to experience difficulty in finding a new Medicaid provider.[52] For instance, Medicaid beneficiaries often struggle to find physicians willing to see them, and their wait times for appointments are longer than those of private insurance beneficiaries.[53] Thus, Medicaid patients are already limited in their choice of provider from the start. The ex-

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[49] *Id.*

[50] Steven Spivack, Health Affairs, *Avoiding Medicaid: Characteristics of Primary Care Practices with No Medicaid Revenue* (Jan. 2021), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00100.

[51] *See id.*

[52] *See* George Washington Univ. Fitzhugh Mullan Inst., *Why This Matters*, *supra* note 46.

[53] Mandar Bodas et al., *Association of Primary Care Physicians' Individual- and Community-Level Characteristics With Contraceptive Service Provision to Medicaid Beneficiaries*, 4:3 JAMA Health Forum 1, 2 (March 2023).

clusion of qualified providers would further narrow the options available, and would likely overwhelm remaining Medicaid providers.

Medicaid also makes up a large and growing share of revenue for the providers that accept Medicaid, which enables them to continue to serve disproportionate numbers of low-income people.[54] These providers rely on Medicaid revenue to continue operating and providing vital health care services to vulnerable populations, and removing these providers' ability to access Medicaid revenue will cause some to close, further restricting patients' access to care. To illustrate, since 2014, states that expanded Medicaid saw a substantial decline in the number of uninsured hospital admissions and, as a result, reduced uncompensated care costs by $5 billion.[55] Moreover, rural and safety net hospitals that disproportionately serve uninsured patients rely on payments for care provided to Medicaid patients to keep their doors open.[56] In contrast, "[n]early 75% of the rural hospitals that closed between 2010 and 2021 were in states that

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[54] Rachel Nuzum et al., *Why the U.S. Needs Medicaid*, The Commonwealth Fund Blog (Sept. 23, 2016), https://www.commonwealthfund.org/blog/2016/why-us-needs-medicaid.

[55] *Id.*

[56] *See* Dan Jones et al., Am. Heart Assoc., *Health and Hope for Everyone, Everywhere, Starts With Access to Health Care: The Role of Medicaid Expansion* (July 1, 2024), https://www.ahajournals.org/doi/full/10.1161/CIRCULATIONAHA.124.070084.

either had not expanded Medicaid or had done so less than a year previously."[57] Providers that rely on Medicaid for revenue face significant financial harm and can be forced to close if excluded from the program, undermining the provision of comprehensive health care.

B. Reduction in Access to Services Leads to Poor Health Outcomes

A reduction in access to health care services due to constrained Medicaid provider networks directly contributes to poorer health outcomes for beneficiaries, with individuals less likely to receive preventative care, manage chronic conditions effectively, and seek timely treatment when needed.[58] Numerous studies have shown that interruptions in Medicaid beneficiaries' access to health services contribute to damaging health consequences.[59] For instance, studies show that gaps in

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[57] *Id.*

[58] *See* U.S. Dep't of Health & Human Servs., *Access to Health Services,* Healthy People 2030, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services#cit15.

[59] Alicia Emanuel & Jules Lutaba, Nat'l Health Law Program, *Protect Medicaid Funding Issue #3: Enrollment and Continuity* (Sept. 2024), https://healthlaw.org/wp-content/uploads/2024/09/03-PMF-Enrollment-and-continuity.pdf; *see also* Andrew Bindman et al., *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149:12 Annals of Internal Med. 854, 858 (Dec. 2008) (interruption in Medicaid coverage associated

Medicaid coverage, which interrupt beneficiaries' access to care, lead to negative health outcomes. Both temporary and long-term gaps in coverage can hinder beneficiaries from accessing preventive care, other needed care and treatment, and prescription drugs that are necessary for managing and treating their health conditions.[60] To illustrate, a recent study found that people with serious health conditions who experienced a gap in coverage more than doubled their emergency department visits and hospitalizations related to these conditions in the month after they reenrolled in

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with higher hospitalization rates); Walter Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis*, 56 Inquiry: J. Med. Care Org., Provision & Fin. 1, 1 (2019) (Medicaid insurance associated with a 1.6 fold lower likelihood in successfully scheduling a primary care appointment and a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private insurance); Amanda Stevenson, et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374:9 New Eng. J. Med. 853, 853 (Mar. 2016) (exclusion of Planned Parenthood from the Texas Medicaid family-planning program resulted in estimated reductions in the number of claims from 1042 to 672 for long-acting, reversible contraceptives and from 6832 to 4708 for injectable contraceptives); Betsy Cliff et al., *Enrollee Premiums in Medicaid—Insights from Michigan*, 386:25 New Eng. J. Med. 2352, 2353 (June 2022).

[60] MACPAC, *Effects of Churn on Potentially Preventable Hospital Use* at 1 (July 2022), https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf.

Medicaid compared to their baseline rates.[61] Similar to gaps in coverage, interruptions in care due to provider shortages will inevitably produce harmful health impacts.

Furthermore, a lack of Medicaid providers can have dire impacts on health outcomes for patients with chronic diseases and disabilities who rely on Medicaid for long-term care and treatment. For instance, Alabama's refusal to expand Medicaid, resulting in the closure of 14 hospitals since 2010, has contributed to a rising mortality rate for Alabama women who develop cervical cancer and lack access to providers and essential services such as screenings and treatments.[62] The harms stemming from gaps in Medicaid access is especially visible in the recent cessation of automatic re-enrollment in the program, resulting in nearly two-thirds of disenrolled patients experiencing significant disruptions in care, including access to managed care, specialty, hospital, and other care.[63]

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[61] *Id.*

[62] *See* Equal Justice Initiative, *Women Are Dying as Alabama Refuses to Expand Medicaid* (Apr. 6, 2020), https://eji.org/news/women-are-dying-as-alabama-refuses-to-expand-medicaid/; Eyal Press, *A Preventable Cancer Is on the Rise in Alabama*, The New Yorker (Mar. 30 2020), https://www.newyorker.com/magazine/2020/04/06/a-preventable-cancer-is-on-the-rise-in-alabama.

[63] Peter Shin et al., Geiger Gibson Program in Cmty. Health, Milk Inst. Sch. Of Pub. Health, *One Year After Medicaid Unwinding Began, Community Health Centers, Their Patients, and Their Communities are Feeling the Impact*

A reduction in access to health care options would have especially significant impacts to patient health for those residing in rural areas nationwide. Studies show that rural residents tend to have poorer health compared to their urban counterparts, due, in part, to a scarcity of services, a lack of trained physicians, and insufficient public transport.[64] One study found that rural women had a nine percent greater probability of severe maternal morbidity and mortality compared to urban residents.[65] These health problems are compounded by a shortage of providers and recent hospital closures, with more than half of all primary care, mental health, and dental health professional shortage areas nationally being located in rural areas.[66] Another study found that following rural hospital closures, low-income and elderly patients were more likely than others to report delaying or forgoing needed care because of transportation challenges.[67]

(Apr. 2024), https://geigergibson.publichealth.gwu.edu/one-year-after-medicaid-unwinding-began-community-health-centers-their-patients-and-their.

[64] Nathan Douthit et al., *Exposing some important barriers to health care access in the rural USA*, 129:6 Pub. Health 611 (June 2015).

[65] MACPAC, *Medicaid and Rural Health*, *supra* note 36.

[66] *See id.*

[67] Jane Wishner et al., *Medicaid, A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*, Kaiser Fam. Found. (July 7, 2016), https://www.kff.org/

Threats to Medicaid are threats to the health and lives of people. Stripping away access to qualified Medicaid providers creates barriers and delays care, thus worsening patient outcomes and increasing health care costs. The resulting harm will reverberate through underserved communities and will also adversely affect hospitals, health systems, and physical practices already struggling to provide care.

III. REMOVAL OF PPSAT FROM SOUTH CAROLINA'S MEDICAID PROGRAM REDUCES ACCESS TO CARE AND INCREASES RISKS TO PATIENT HEALTH

Access to care covered by Medicaid insurance is particularly important in South Carolina and PPSAT helps to fill that need. South Carolinians heavily rely on providers who accept Medicaid insurance; one in five South Carolinians receive health insurance through Medicaid, and the State faces a poverty rate higher than the national average.[68] PPSAT helps to ensure access to covered health care in the State by operating health centers in Charleston and Columbia. Those centers serve

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medicaid/issue-brief/a-look-at-rural-hospital-closures-and-implications-for-access-to-care/.

[68] *See* Kaiser Fam. Found., *Health Care in South Carolina* (2024), https://www.kff.org/statedata/election-state-fact-sheets/south-carolina/; Kaiser Fam. Found., *Medicaid in South Carolina*, *supra* note 10.

hundreds of Medicaid patients each year. Both are in medically underserved communities.

The State justifies its attempt to eliminate PPSAT because of one service it offers: abortion. This ignores that PPSAT provides a range of critical reproductive health care and family planning services. If the State successfully removes PPSAT from its Medicaid program, it will have a devastating impact on South Carolinians. Decreased access to PPSAT's services, including contraception methods, counseling, and cancer and disease screening, will result in more unintended pregnancies, undetected cancers and diseases, and poor health outcomes for an already vulnerable population. Coupled with the inability of other Medicaid providers in the State to absorb impacted individuals, South Carolinians, and especially South Carolinian women, may be forced to forego these health care services all together. Recent cautionary tales illustrate the serious consequences when individuals cannot receive needed care. In light of Planned Parenthood operating nearly 600 health centers across the country, serving 2.1 million patients annually,[69] if other states likewise take similar action by removing Planned Parenthood affiliates from their respective Medicaid programs, it would exacerbate existing barriers to care and intensify the nation's public health crisis.

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[69] Planned Parenthood, *Mission*, https://www.plannedparenthood.org/about-us/who-we-are/mission (last visited Mar. 10, 2025).

A. PPSAT Helps Ensure Access to a Wide Range of Health Care Services

Planned Parenthood plays an irreplaceable role in providing access to health care services, including life-saving health care to millions of Americans, and PPSAT does its part by delivering such care in South Carolina (and other nearby states). Planned Parenthood, and its affiliates, provide an extensive range of family planning and reproductive health care services to millions of Americans. Sexually transmitted infection ("STI") testing and treatment, contraceptive care, cancer screenings, reproductive health services other than abortion care, such as pregnancy tests and prenatal services, and other services including primary care, comprise more than 95% of Planned Parenthood's health care services.[70] To illustrate how widely utilized Planned Parenthood's services are, between 2022 and 2023, Planned Parenthood health centers provided approximately 4.6 million tests or treatment for STIs, including more than 738,000 HIV tests, as well as 464,000 cervical, breast, and other cancer screenings, and nearly 926,000 pregnancy tests.[71] Publicly funded family planning clinics like Planned Parenthood lead the field; 71% of women

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[70] Planned Parenthood, *2022-2023 Annual Report*, at 7, 23-24 (2024), https://www.plannedparenthood.org/uploads/filer_public/ce/f6/cef6efdb-919a-4211-bb5c-ce0d61fda7f5/2024-ppfa-annualreport-c3-digital.pdf.

[71] *Id.*

with Medicaid coverage who receive contraceptive care at family planning clinics consider them to be their usual source of health care and approximately four in ten women nationally consider them their *only* source of health care.[72]

Planned Parenthood clinics are more likely to provide a wide variety of birth control methods than other family-planning clinics, and are more likely to provide a 12-month supply of oral contraception.[73] Planned Parenthood is also significantly more likely than all other clinics to provide a long-acting reversible contraceptive ("LARC") method to

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[72] *See* Jennifer Frost et al., Guttmacher Inst., *Trends and Differentials in Receipt of Sexual and Reproductive Health Services in the United States: Services Received and Sources of Care, 2006-2019*, at 18, 20 (June 2021), https://www.guttmacher.org/sites/default/files/report_pdf/sexual-reproductive-health-services-in-us-sources-care-2006-2019.pdf; Jennifer Frost, Guttmacher Inst., *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use*, 1995-2010, at 43 (May 2013), http://www.guttmacher.org/pubs/sources-of-care-2013.pdf.

[73] *See* Alicia VandeVusse et al., Guttmacher Inst., *Publicly Supported Family Planning Clinics in 2022-2023: Trends in Service Delivery Practices and Protocols*, at 14-15, Guttmacher Inst. (Nov. 2024), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-family-planning-clinics-2022-2023.pdf; Kinsey Hasstedt, *Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net*, 20 Guttmacher Pol'y Rev. 12, 13 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2001216.pdf.

its patients, with nearly all centers offering same-day insertion.[74] LARCs, which include intrauterine devices and contraceptive implants, are widely viewed as the most medically effective and cost-effective forms of contraception.[75] Overall, Planned Parenthood clinics are most likely to have met the Centers for Disease Control and Prevention's goal to provide the full range of FDA-approved contraceptive methods.[76]

B. PPSAT, and Other Planned Parenthood Affiliates, Fill Gaps in the Public Health System

As discussed in *supra* Section IIB, because individuals covered by Medicaid are already limited in

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[74] VandeVusse et al, *supra* note 73, at 14-15.

[75] *See, e.g.*, ACOG, Committee on Health Care for Underserved Women and Contraceptive Equity Expert Work Group, *Increasing Access to Intrauterine Devices and Contraceptive Implants*, Committee Statement No. 5, 141:4 Obstetrics & Gynecology 866, 867, 868 (Apr. 2023); Am. Acad. of Pediatrics, *Policy Statement: Contraception for Adolescents*, 134:4 Pediatrics e1244, e1251 (Oct. 2014) "Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents".

[76] *See* VandeVusse et al., *supra* note 73, at 9, 14; *see also* Loretta Gavin, et al, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, 63:RR-04 Morbidity & Mortality Weekly Report Recommendations & Reps. (Apr. 25, 2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf (recommending that providers of contraceptive services offer the full range of FDA-approved contraceptive methods).

their choice of provider, many rely on publicly funded health care centers, like Planned Parenthood. With respect to family planning, of about 25 million women who receive contraceptive services each year, nearly one in five (18%) receive that care at publicly funded clinics.[77] In 21% of counties with a Planned Parenthood health center, Planned Parenthood is the *only* safety-net family planning provider, meaning it is the only available provider of family planning services for low-income and underserved populations.[78] In 68% of counties, Planned Parenthood serves at least half of all safety net family planning patients.[79] In South Carolina specifically, hundreds of individuals rely on PPSAT's services.[80]

Other South Carolina health centers simply cannot fill the gap created if PPSAT loses its status as a qualified Medicaid provider. For example, PPSAT ensures access to contraception, a preventative health care service that is already challenging to

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[77] *See* VandeVusse et al., *supra* note 73, at 2.

[78] Planned Parenthood, *The Urgent Need for Planned Parenthood Health Centers*, at 2 (Dec. 7, 2016), https://www.plannedparenthood.org/files/4314/8183/5009/20161207_Defunding_fs_d01_1.pdf.

[79] *Id.*

[80] HHS Office of Population Affairs, *Planned Parenthood South Atlantic*, https://opa.hhs.gov/sites/default/files/2024-01/TitleXGranteeProfile-SC-PPSAT.pdf (PPSAT is responsible for nearly 400 family planning encounters and 350 STD according to a 2022 national survey).

access within the State. As of 2023, there are more than one million women of reproductive age (ages 15-44) living in South Carolina.[81] Over 300,000 reproductive-age women live in contraceptive deserts within South Carolina, meaning they lack reasonable access in their county to a health center offering the full range of contraceptive methods, putting them at increased risk of a mistimed or unintended pregnancy.[82] And, in 2014, approximately 323,000 women in South Carolina were identified as in need of publicly funded contraceptive services and supplies, yet only about 100,000 women actually received these services.[83] PPSAT narrows this gap by including contraception as part of the reproductive health care available at their South Carolina clinics. In addition, PPSAT provides nearly 4,000 people annually in South Carolina with breast and cervical cancer screenings, pregnancy testing, fami-

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[81] March of Dimes, *Population Data for South Carolina* (last updated Feb. 2024), https://www.marchofdimes.org/peristats/data?reg=99&top=14&stop=128&lev=1&slev=4&obj=19&sreg=45.

[82] Power to Decide, *Contraceptive Deserts*, https://powertodecide.org/what-we-do/contraceptive-deserts (last visited Mar. 10, 2025).

[83] Jennifer Frost et al., *Contraceptive Needs and Services, 2014 Update*, at 22, 28, Guttmacher Inst. (Sept. 2016), https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

ly planning services, and other preventive care, including vaccinations.[84]

Moreover, PPSAT helps to ensure people living in underserved areas can access health care. In South Carolina, 30% of the population live in areas in which there is a shortage of primary care, and PPSAT's clinics in South Carolina are both located in underserved areas.[85] As a 2016 study found, "an increase in distance to the nearest clinic result[ed] in decreased preventive care utilization," particularly among low-income individuals.[86]

All told, the Congressional Budget Office estimates that excluding Planned Parenthood clinics

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[84] *See* Planned Parenthood, *South Carolina Governor Targets Planned Parenthood Patients* (Aug. 25, 2017), https://www.plannedparenthood.org/about-us/newsroom/press-releases/south-carolina-governor-targets-planned-parenthood-patients; Planned Parenthood, *2022-2023 Annual Report*, *supra* note 70, at 24.

[85] Robin Rudowitz et al., Kaiser Family Found., *Factors Affecting States' Ability to Respond to Federal Medicaid Cuts and Caps: Which States Are Most At Risk?*, at 22 (June 2017), http://files.kff.org/attachment/Issue-Brief-Factors-Affecting-States-Ability-to-Respond-to-Federal-Medicaid-Cuts-and-Caps-Which-States-Are-Most-At-Risk; *see also* Health Res. & Servs. Admin., *MUA Find*, https://data.hrsa.gov/tools/shortage-area/mua-find, (last visited June 2, 2021) (under Select a State/Territory, select South Carolina; then under Select County(s), select Charleston County and Richland County).

[86] Yao Lu & David Slusky, *The Impact of Women's Health Clinic Closures on Preventive Care*, 8 Am. Econ. J.: Applied Econ. 100, 120 (July 2016).

from Medicaid nationwide would cause 390,000 women to lose access to family planning services and as many as 650,000 women to face reduced access to preventive care services.[87] History supports this concerning statistic. As of 2015, in 238 of the 415 counties in which Planned Parenthood clinics operated, Planned Parenthood provided care for at least half of the women who depended on publicly funded family planning services from health care safety-net providers, which deliver contraceptive care at reduced or no cost through federal, state, and local funding.[88]

Although other types of federally funded health centers exist, such as Federally Qualified Health Centers ("FQHCs"), they cannot fill the void. For example, although FQHCs outnumber Planned Parenthood clinics at a rate of 15 to 1, Planned Parenthood provided more than twice as many contraceptive services compared to FQHCs in fiscal

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[87] Sara Rosenbaum, *Medicaid Coverage for Family Planning—Can the Courts Stop the States from Excluding Planned Parenthood?*, 377 New Eng. J. Med 2205, 2205 (Dec. 2017).

[88] Hasstedt, *Understanding Planned Parenthood's Critical Role*, *supra* note 73, at 14; *see also* Kinsey Hasstedt, *Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net*, 20 Guttmacher Pol'y Rev. 67, 67 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2006717_0.pdf.

year 2014 (2.9 million versus 1.4 million).[89] Additionally, although FQHCs may provide family planning and related services, they do not specialize in these services in the way that Planned Parenthood clinics do or meet the comprehensive needs of patients.[90] For example, FQHCs vary widely in the range of family planning services offered: those that do not receive Title X funding are less likely than family planning centers that do receive Title X funding, like Planned Parenthood, to have on-site availability of contraceptive methods, particularly when those methods require additional training, such as IUD placement and removal procedures.[91]

C. Removal of PPSAT Increases Likelihood of Negative Health Consequences

The State's desire to terminate PPSAT as a qualified Medicaid provider will subject South Carolinians to unnecessary, and avoidable, harm—which is

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[89] Congressional Rsch Serv., *Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FHQCs)*, at i (May 18, 2017), https://crsreports.congress.gov/product/pdf/R/R44295/15.

[90] *See id.* at 3.

[91] Liane Ventura et al., *Contraceptive Access at Federally Qualified Health Centers During the South Carolina Choose Well Initiative: A Qualitative Analysis of Staff Perceptions and Experiences*, 2:1 Women's Health Reports 608, 609 (2021).

illustrative of the impact that would occur if states across the country eliminated Planned Parenthood health centers from their states' Medicaid programs. Planned Parenthood is crucial in a state like South Carolina where nearly 40% of all pregnancies are mistimed or unintended, as of 2010, almost 79% of unintended pregnancies were publicly funded.[92] Unintended and closely spaced pregnancies are correlated with negative maternal and childhood health outcomes and may present a variety of social and economic challenges.[93] Publicly funded family planning centers like PPSAT in South Carolina helped avert 23,000 unintended pregnancies in 2013, which would have likely resulted in 11,400 unplanned births, and 7,800 abortions.[94]

But, reducing PPSAT services in South Carolina will have other health consequences beyond unintended pregnancies. For example, reduced access to contraception can lead to avoidable negative health

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[92] *See* Kathryn Kost et al., Guttmacher Inst., *Pregnancies and Pregnancy Desires at the State Level: Estimates for 2017 and Trends Since 2012*, at Fig. 2 (Sept. 2021), https://www.guttmacher.org/report/pregnancy-desires-and-pregnancies-state-level-estimates-2017 (data for women aged 15-44); Guttmacher Inst., *State Facts about Unintended Pregnancy: South Carolina*, at 1-2 (2016), https://www.guttmacher.org/sites/default/files/factsheet/sc_8_0.pdf.

[93] *See* Guttmacher Inst., *State Facts about Unintended Pregnancy*, *supra* note 92, at 1.

[94] *See id.* at 2.

consequences. Contraception protects those for whom pregnancy can be hazardous or life-threatening, in addition to having scientifically recognized non-contraceptive uses and health benefits, including treating severe menstrual pain, endometriosis, and acne, and decreasing the risk of endometrial and ovarian cancer.[95]

As discussed *supra*, PPSAT also provides critical screening services for patients with cancer and HIV. Early testing and detection are crucial for optimizing treatment for these patients.[96] Detecting and treating STIs in their early stages can help prevent serious complications and long-term health effects, such as infertility, chronic pain, or in-

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[95] *See, e.g.,* Megan Kavanaugh & Ragnar Anderson, Guttmacher Inst., *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, at 7, 11–13 (July 2013), https://www.guttmacher.org/sites/default/files/report_pdf/health-benefits.pdf.

[96] *See* Am. Cancer Soc'y, *Cancer Prevention & Early Detection Facts & Figures 2017-2018* (2018), at 52, 64, https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-prevention-and-early-detection-facts-and-figures/cancer-prevention-and-early-detection-facts-and-figures-2017.pdf ("Early detection of cancer through screening reduces mortality from cancers of the colon and rectum, breast, uterine cervix, and lung."); INSIGHT START Study Grp., *Initiation of antiretroviral therapy in early asymptomatic HIV infection*, 373 New Eng. J. Med. 795, 803-05 (Aug. 2015) (finding "significant benefit in the immediate initiation of antiretroviral therapy in patients with HIV infection regardless of" the disease's progress as measured by white blood cell count).

creased risk of certain cancers.[97] Timely detection also enables providers to offer appropriate treatment plans, reducing the risk of recurrence and promoting long-term sexual health.[98] Diagnosis is even more important in light of studies showing that an estimated 15% of people with HIV in the United States are unaware they have HIV, and it is estimated that 40% of new diagnoses of HIV are transmitted by those who are not aware of their HIV diagnosis.[99] Thus, early identification of HIV allows for patients to receive treatment sooner, which is important to reduce related illnesses and improve mortality rates.[100] The risks of delayed care are readily apparent: the longer patients go without knowing they have cancer or HIV, the

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[97] Roxanne Barrow et al., Ctrs. for Disease Control & Prevention, *Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020*, at 1 (Jan. 3, 2020), https://www.cdc.gov/mmwr/volumes/68/rr/pdfs/ rr6805a1-H.pdf; Kaitlin Hufstetler et al., *Clinical Updates in Sexually Transmitted Infections, 2024*, 33:6 J. Womens Health 827, 827 (June 2024).

[98] Aspen Med. Ctr., *The Importance of Early STD Detection and Testing: A Comprehensive Guide* (Apr. 11, 2024), https://aspenmedicalcenter.com/importance-early-std-detection-and-testing/; *see also* Barrow et al., *supra* note 97, at 9 (describing the importance of screening for early detection and prevention of STDs).

[99] Nat'l Insts. of Health, *HIV Testing* (May 24, 2024), https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-testing.

[100] *Id.*

greater the chance they will be unable to receive effective treatment. Many South Carolinians depend on PPSAT for these diagnoses.

These harms are not academic estimation. Other states such as Indiana and Texas have removed Planned Parenthood as a Medicaid provider and experienced the resulting negative health outcomes. The closure of Scott County, Indiana's sole Planned Parenthood clinic in 2013 provides an illustrative example. Prior to the clinic's closing, the county had an average of just five HIV diagnoses per year.[101] However, between November 2014 and November 2015 following the closing, there were 181 HIV diagnoses in the county.[102] The HIV outbreak was unprecedented and caused former governor and vice president, Mike Pence, to declare a

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[101] Jeffrey Crowley & Gregorio Millett, *Preventing HIV and Hepatitis Infections Among People Who Inject Drugs: Leveraging an Indiana Outbreak Response to Break the Impasse*, 21 AIDS & Behav. 968, 969 (Feb. 2017).

[102] *Id.* Because of the closure, it became "hard, if not impossible, for people even to learn they were infected[,]" leading to increased spread of the disease. Gregg Gonsalves & Forrest Crawford, *How Mike Pence Made Indiana's HIV Outbreak Worse*, Politico (Mar. 2, 2020), https://www.politico.com/news/magazine/2020/03/02/how-mike-pence-made-indianas-hiv-outbreak-worse-118648. Early screening and diagnosis allow individuals to access treatment and reduce their risk of further transmitting HIV. Ctrs. for Disease Control & Prevention, *HIV Screening and Testing* (Dec. 20, 2022), https://www.cdc.gov/high-impact-prevention/php/case-studies/hiv-screening-testing.html.

public health emergency.[103] Notably, the Planned Parenthood clinic had been providing free HIV testing, but no comparable testing was available to the community following its closure and prior to the outbreak.[104] As another example, following the defunding of women's health care and associated clinic closures, maternal mortality in Texas rose twofold to 36 maternal deaths per 100,000 live births during 2011–2014.[105] These examples underscore the detrimental impact that the loss of even one health care provider can have on the health of Medicaid beneficiaries.

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[103] Planned Parenthood, *IPM: "Defunding" Planned Parenthood Would Have Devastating Consequences for Communities Across the Country* (Feb. 3, 2025), https://www.plannedparenthood.org/about-us/newsroom/press-releases/ipm-defunding-planned-parenthood-would-have-devastating-consequences-for-communities-across-the-country.

[104] Philip Peters et al, *HIV Infection Linked to Injection Use of Oxymorphone in Indiana*, 2014-2015, 375:3 New Eng. J. Med. 229, 230 (2016).

[105] David Boulware, *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues*, 129:2 Obstetrics and Gynecology 385, 385 (Feb. 2017).

CONCLUSION

For the foregoing reasons, the Court should affirm the decision of the Fourth Circuit.

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