Health Advocate

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2012 Case Round Up

Prepared by: Jane Perkins

Key Resources

Issue Briefs

- Jane Perkins, *The Supreme Court's National Federation Decision on Medicaid Expansion and the Aftermath Moving Forward*, 47 CLEARINGHOUSE REV. J. ON POV. L. & POL. _ (forthcoming Jan.-Feb. 2012)
- Jane Perkins, *Issue Brief: Update on Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983* (Nov. 14, 2012), here
- Jane Perkins, *Q&A: Responding to Medicaid Coverage Exclusions and Monetary Caps: A Review of Recent Cases* (Nov. 28, 2012), here
- Sarah Somers, *Q&A: Recent Developments in ADA-Medicaid Litigation* (Nov. 28, 2012), here

Coming in January's Health Advocate:

What's next for Medicaid in 2013

As in previous years, 2012 produced a number of important Medicaid decisions. This issue of the *Health Advocate* summarizes the two Medicaid opinions issued by the United States Supreme Court and highlights some of the activity in the federal circuit courts of appeal.

The Supreme Court's Focus on Medicaid

On June 28, 2012, the Supreme Court announced *National Federation of Independent Business v. Shalala* (*NFIB*), 132 S. Ct. 2566 (2012), arguably the most important case of the 2011-2012 term. A 5-4 majority upheld, as a valid exercise of Congress's taxing power, the Affordable Care Act's (ACA) key requirement that individuals maintain health insurance coverage or pay a penalty. On the other hand, "*for the first time ever*" the Supreme Court held Congress had unconstitutionally coerced states when it enacted an ACA provision requiring states to expand Medicaid eligibility to non-disabled, non-elderly, childless individuals with incomes below roughly 133% of the federal poverty level. *Id.* at 2630 (Ginsburg, J., dissenting) (emphasis in original).

Chief Justice Roberts wrote the controlling Medicaid opinion. While not questioning Congress's authority to attach appropriate conditions to federal spending clause programs such as Medicaid, he found that "when such conditions take the form of threats to terminate other significant independent grants," courts must determine whether that pressure is so coercive as to cross the line to compulsion. In the Court's view the ACA Medicaid expansion crossed that line. Chief Justice Roberts viewed the expansion as an independent, new grant program that should not implicate a state's existing Medicaid funding: "The original [Medicaid] program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children." *Id.* at 2605-06. By contrast, he said, the ACA amendment "transformed" Medicaid from a program serving designated population groups to a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty line. He criticized Congress for attempting to induce participation in the new program by threatening states with the authority of the Secretary of HHS to terminate all existing federal funding to a state that is not complying with federal conditions of participation. Noting the significant amount of federal funding at stake—20% of the average state's total Medicaid budget and 10% of its overall budget—Chief Justice Roberts concluded that Congress had engaged in "economic dragooning" by placing a "gun to the head" of the states that left them "with no real option but to acquiesce in the Medicaid expansion." *Id.* at 2604-05.

The next question was how to craft a remedy. The Chief Justice, joined by four other justices, concluded that the constitutional violation is "fully remed[ied]" by prohibiting the Secretary of HHS from terminating the existing federal Medicaid funding of a state that does not implement the expansion. *Id.* at 2607. This full remedy solution to the problem significantly restricts the scope of *NFIB*. The Court did not strike the ACA Medicaid expansion, so states can still implement the expansion and will receive generous federal funding (100% for the first few years and 90% thereafter) if they do. *NFIB* does not limit the Secretary's enforcement authority over the existing Medicaid program, nor does it affect any other Medicaid requirements contained in the ACA. All states participating in Medicaid must adhere to them or risk losing all existing Medicaid funding.

Douglas v. Independent Living Center of Southern California, Inc., 132 S. Ct. 1204 (2012), the Supreme Court's other Medicaid case, initially generated great alarm because the State of California and the Obama Administration were arguing that Medicaid beneficiaries have no right to bring court cases to enjoin state Medicaid payment laws that are inconsistent with (and thus preempted by) the federal Medicaid Act. The lower courts, following decades of established federal court practice, found the Supremacy Clause of the Constitution (which makes federal law the supreme law of the land) authorized the Medicaid beneficiaries' and providers legal action against the state payment provisions. After oral argument, but before the Court issued a decision, the federal Medicaid agency changed its position and specifically approved the challenged California state plan amendments. In a 5-4 opinion, the Court found that this intervening event had changed the nature of the case from one focusing on an alleged violation of a federal statute to one challenging the validity of a federal agency's action. As a result, the majority refused to reach the issue of whether the Supremacy Clause provided a cause of action. Instead, the lower court decisions were vacated and remanded for reconsideration in light of the federal agency action. Chief Justice Roberts issued a blistering dissent, arguing that the Supremacy Clause does not provide a cause of action to Medicaid beneficiaries or providers. This case is already generating new litigation concerning both the ability of individuals to challenge state laws under the Supremacy Clause and the legal effect of the federal Medicaid agency's approval of the state plan amendments.

Developments in Federal Circuit Courts of Appeal

Private enforcement under § 1983

During 2012, the federal circuits issued five opinions discussing whether Medicaid beneficiaries could enforce provisions of the Medicaid Act. In all instances, the courts allowed the individuals to enforce the Medicaid provision, thus allowing them to challenge the ongoing state actions that were harming them. The following chart summarizes the circuit level activity in 2012:

Medicaid Provision (42 U.S.C.)	Enforceable	Case Citation
Opportunity for a hearing when claims denied or delayed (1396a(a)(3))	Yes	*Shaknes v. Berlin*, 689 F.3d 244 (3d Cir. 2012)
Individuals listed in the Medicaid Act must be covered (1396a(a)(10)(A))	Yes	*Bontrager v. Indiana Family & Social Services Admin.*, 697 F.3d 604 (7th Cir. 2012)
Medicaid beneficiaries must have free choice of provider (1396a(a)(23)(A))	Yes	*Planned Parenthood of Ind. v. Cmm'r of Ind. State Dep't of Health*, _ F.3d _, 2012 WL 5205533 (7th Cir. Oct. 23, 2012)
Allowing individuals with disabilities to maintain certain trusts and qualify for Medicaid (1396p(d)(4)(C))	Yes	*Center for Special Needs Trust Administration v. Olson*, 676 F.3d 688 (8th Cir. 2012) *Lewis v. Alexander*, 685 F.3d 325 (3d Cir.2012)

Attacks on women's access to reproductive health

During 2012, two federal circuits decided cases involving the ability of health care provider Planned Parenthood to render reproductive health services to individuals in their service areas. The decisions reached different conclusions.

The Seventh Circuit Court of Appeals upheld a lower court injunction blocking a new Indiana law that would prohibit state agencies from providing Medicaid funds to entities that use non-federal funds to perform abortions or that maintain or operate facilities where abortions are performed. The decision was based in part on a longstanding provision in the Medicaid Act that guarantees beneficiaries the right to obtain medical care from the qualified provider of their choice. As part of its analysis, the Court noted that while a state has broad authority to exclude unqualified providers from its Medicaid program, it does not have plenary authority to exclude a class of providers for *any* reason, particularly for a reason unrelated to provider qualifications. *See Planned Parenthood of Ind., et al. vs. Comm'r of the Ind. State Dep't of Health, et al.*, _ F.3d _, 2012 WL 5205533 (7th Cir. Oct. 23, 2012).

On the other hand, *Planned Parenthood Ass'n of Hildalgo Co. Tex. v. Suehs*, 692 F.3d 343 (5th Cir. 2012), vacated a lower court ruling that had enjoined a new Texas regulation that prohibited Women's Health Program funding of health care providers who perform or promote elective abortions or affiliate with entities that perform or promote elective abortions. The Fifth Circuit panel concluded that the Texas law did not abridge constitutionally protected free speech. According to the court, the restriction on promoting elective abortion directly regulated the WHP and reflected state policy to limit its funding to subsidizing non-abortion family planning speech. The Court also upheld that regulation's restriction on affiliating with entities that promote elective abortions; regulations define affiliation to include the use of identifying marks (such as the Planned Parenthood mark). The Court found the State's authority to directly regulate the content of its program necessarily includes the power to limit the identifying marks, because "[i]dentifying marks represent messages." *Id.* at 350.

Annual monetary cap on Medicaid services rejected

Bontrager v. Indiana Family & Social Services Admin., 697 F.3d 604, 609 (7th Cir. 2012) assessed Sandra Bontrager's rights to obtain Medicaid coverage of significant dental work. The Indiana Medicaid agency acknowledged that it covers adult dental services and that Ms. Bontrager's requested treatments were medically necessary, but it denied her request for any Medicaid coverage because the requested treatments exceeded its $1,000 annual cap on dental services for adults. Indiana argued that the cap was appropriate because it operated as an appropriate utilization control device. The Seventh Circuit rejected this argument, stating, "This is a bizarro-world notion of insurance coverage: once the insurance provider (the State) meets the initial deductible ($1,000), the insured is left covering all the remaining costs." The Court explained the problem with this notion of "some coverage" noting that if a needed procedure costs $1,200, the cap prevents reimbursement to the provider altogether because the indigent individual will be unable to pay the remaining $200. The Court rejected the State's classification of the cap as a utilization control procedure because it "serves to exclude medically necessary treatment," in contrast to accepted utilization controls that assure medical necessity and fraud prevention. *Id.*

Conclusion

When state and federal Medicaid programs do not adhere to the requirements of federal law, beneficiaries may be forced to go to court in an effort to halt the offenses. This was certainly the case in 2012, and it will be true in 2013 as well. Already, the Supreme Court has announced it will review another Medicaid case, this one involving the ability of states to place liens on medical malpractice awards received by program beneficiaries. *See E.M.A. ex rel. Johnson v. Cansler*, 674 F.3d 290 (4th Cir. 2012), *cert. granted sub nom. Delia v. E.M.A.*, 133 S. Ct. 99 (2012). Meanwhile, lawyers continue to challenge provisions of the Affordable Care Act in federal courts across the country, including over 35 cases challenging ACA requirements for insurers to offer preventive reproductive health services without cost sharing. Please monitor forthcoming *Health Advocates* and on our website, www.healthlaw.org for news about these and other cases.

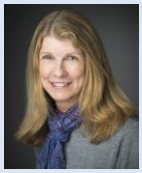
About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

Author

The following NHeLP attorney contributed to this month's *Health Advocate*:

Jane Perkins
Legal Director,
North Carolina office



Offices

Washington, DC
1444 I Street NW, Suite 1105
Washington, DC 20005
(202) 289-7661
nhelpdc@healthlaw.org

Los Angeles
3701 Wilshire Blvd, Suite 750
Los Angeles, CA 90010
(310) 204-6010
nhelp@healthlaw.org

North Carolina
101 East Weaver Street, Suite G-7
Carrboro, NC 27510
(919) 968-6308
nhelpnc@healthlaw.org

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