
IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 11-2464

PLANNED PARENTHOOD OF INDIANA, INC., *et al.*,
Plaintiffs/Appellees,

v.

COMMISSIONER OF THE INDIANA STATE DEPARTMENT OF HEALTH, *et al.*,
Defendants/Appellants.

On Appeal from the United States District Court for the
Southern District of Indiana, No. 1:11-cv-630-TWP-DKL
The Honorable Tanya Walton Pratt, Judge

**BRIEF AND REQUIRED SHORT APPENDIX OF
APPELLANTS INDIANA STATE DEPARTMENT OF HEALTH, *et al.***

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JURISDICTIONAL STATEMENT

On May 10, 2011, Plaintiffs Planned Parenthood of Indiana, Inc. (“PPIN”) filed a complaint in the Southern District of Indiana against several State officials under 42 U.S.C. § 1983 seeking a declaratory judgment and preliminary and permanent injunctions against Defendants with regard to certain provisions of House Enrolled Act 1210 (codified at Indiana Code sections 5-22-17-5.5 and 16-34-2-1.1(a)(1)(E) and (G)) contending that those provisions violate federal rights secured by the Medicaid Act and various provisions of the United States Constitution. [Docket Nos. 1, 9]. The district court has subject-matter jurisdiction over this case under 28 U.S.C. § 1331.

On June 24, 2011, the district court filed its Entry on Motion for Preliminary Injunction, enjoining Defendants from enforcing Indiana Code sections 5-22-17-5.5 and 16-34-2-1.1(a)(1)(G), but refusing to enjoin defendants from enforcing section 16-34-2-1.1(a)(1)(E). [Docket Nos. 76-77]. Defendants filed a notice of appeal on June 28, 2011, seeking review of the district court’s June 24, 2011, Entry. [Docket No. 78]. This Court has jurisdiction over this interlocutory appeal of an injunction pursuant to 28 U.S.C. § 1292(a)(1).

STATEMENT OF THE ISSUES

1. Does either 42 U.S.C. § 1396a(a)(23) or 42 U.S.C. § 247c *et seq.*, which establish criteria for States to receive federal grants, confer an individual right enforceable through 42 U.S.C. § 1983 or the Supremacy Clause?

2. May a State, consistent with 42 U.S.C. § 1396a(a)(23), the Supremacy Clause, the Contract Clause and the Fourteenth Amendment, disqualify abortion clinics from State contracts and grants, including Medicaid and Disease Intervention Services grants?

STATEMENT OF THE CASE

This is an interlocutory appeal from the district court's Entry of June 24, 2011, enjoining two sections of Indiana House Enrolled Act 1210, which was signed into law on May 10, 2011. The portion of the Entry appealed here enjoined a provision of HEA 1210 prohibiting abortion providers from receiving State contracts and grants, including Medicaid funds and federal Disease Intervention Services grants made pursuant to the Preventive Health and Health Services block grant program, 42 U.S.C. § 247c, *et seq.* See Ind. Code § 5-22-17-5.5(b)-(d).

This case is collateral to a related administrative appeal concerning the State contracts qualification provision. To reflect the changes in the State's Medicaid law imposed by HEA 1210, the Indiana Office of Medicaid Policy and Planning (the "State Medicaid office") submitted a State plan amendment to the Centers for Medicare and Medicaid Services ("CMS"), a division of the United States Department of Health and Human Services. See App. 138-41; 42 C.F.R. § 430.12(c)(1) (requiring a participating State to file a plan amendment with CMS whenever the State enacts a "[m]aterial change[] in State law, organization, or policy" respecting Medicaid). CMS responded by disapproving the proposed amendment on the basis that "Medicaid programs may not exclude qualified health

care providers from providing services that are funded under the program because of a provider's scope of practice." App. 142. The State Medicaid office filed a formal request for reconsideration, which has been set for hearing on September 13, 2011. See App. 147; 42 C.F.R. § 430.18(a). A final determination by CMS will be reviewable by this Court. 42 C.F.R. §§ 430.38, 430.102(c).

STATEMENT OF FACTS

1. Although the Supreme Court has held that the Fourteenth Amendment's Due Process Clause protects a limited right to obtain abortions, the Court has also insisted that governments have "a legitimate and substantial interest in preserving and promoting fetal life." *Gonzales v. Carhart*, 550 U.S. 124, 145 (2007). To that end, States are free to enact policies and laws that encourage pregnant women to choose childbirth over abortion, so long as they do not unduly burden women's ability to obtain abortions prior to viability. See *id.* at 146.

One of the constitutionally permissible means of promoting childbirth and discouraging abortion is to withhold taxpayer subsidies for abortions. See *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 511 (1989) ("[T]he State need not commit any resources to facilitating abortions . . ."). Since 1976, abortions have been among the medical services for which federal funding is unavailable (under the Hyde Amendment), except where the pregnancy resulted from rape or incest or when an abortion is necessary to save the life of the mother.¹

¹ The Hyde Amendment is not permanent legislation but rather is part of a budget bill appropriating funds for certain departments of the federal government for a given fiscal

In *Harris v. McRae*, 448 U.S. 297 (1980), the Court directly confronted the constitutionality of the Hyde Amendment. First, however, the Court held that as a matter of statutory interpretation, the Medicaid Act does not require States to fund the cost of medically necessary abortions for which federal funds are unavailable under the Hyde Amendment. *Id.* at 309. Then, reasoning that “a woman’s freedom of choice [does not] carr[y] with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices,” *id.* at 316, the Court upheld the Hyde Amendment. *Id.* at 318.

Indiana has chosen to pay only for those abortions necessary to save the life of the mother and that the federal government reimbursed under the Hyde Amendment, *i.e.*, where the pregnancy resulted from rape or incest. *See* Ind. Code § 12-15-5-1(17) (excepting abortion from the family planning services provided under Medicaid); Ind. Code § 16-34-1-2 (“Neither the state nor any political subdivision of the state may make a payment from any fund under its control for the performance of an abortion unless the abortion is necessary to preserve the life of the pregnant woman.”); 405 Ind. Admin. Code 5-28-7 (“Medicaid reimbursement is available for abortions only if performed to preserve the life of the pregnant woman or in other circumstances if the abortion is required to be covered by Medicaid under federal law.”). In *Humphreys v. Clinic for Women, Inc.*, 796 N.E.2d 247, 250-51 (Ind. 2003), the court held that these laws are facially valid under the Indiana Constitution, but “unconstitutional as applied to Medicaid-eligible women

year. *See* Omnibus Appropriations Act of 2009, Pub. L. No. 111-8, §§ 507-08, 123 Stat. 524, 802-03 (2009) (enacting H.R. 1105).

whose pregnancies create serious risk of substantial and irreversible impairment of a major bodily function.” *Id.* at 259.

Thus, to sum up the current state of the law, Indiana provides Medicaid funding for abortions in the following circumstances: (1) where the pregnancy results from rape or incest; (2) where abortion is necessary to save the life of the mother; and (3) where pregnancy creates a serious risk of substantial and irreversible impairment of a major bodily function. While these restrictions largely prevent direct funding of non-therapeutic abortion through Medicaid, they do *not* prevent Medicaid funds from *indirectly* subsidizing abortion.

That is to say, when an abortion provider also provides other medical services, any Medicaid reimbursement it receives for those non-abortion services may be used to support the operation as a whole—including, among other things, the cost of facilities, staffing, and utilities—which indirectly supports its abortion operation. Because money is fungible, taxpayer money is used to support abortions whenever the State awards grant money to an entity that performs abortions; even when a taxpayer subsidy is designated exclusively for non-abortion services, it frees up resources that would have been used for those non-abortion services and makes them available for abortions.

For example, PPIN’s audited financial statements indicate no restrictions on the use of Medicaid or federal grant funds; nor are there indications that such funds are segregated from other revenues. App. 63. Moreover, the financial statements do not provide a detailing of patient services, making it impossible to establish what

costs are from particular services, whether they be Medicaid or other services, including abortions. App. 64. Accordingly, it is reasonable to conclude from these financial statements that taxpayer money may, indeed, subsidize abortion services through the payment of shared overhead and similar expenses. A broad prohibition on distributing taxpayer money to entities that perform elective abortions is the only way to ensure that public funds are not used to subsidize abortion services. Along these lines, in *Rust v. Sullivan*, 500 U.S. 173, 196-99 (1991), the Court upheld the constitutionality of regulations prohibiting Title X project activities from including abortion services, referrals, or counseling.

In light of these concerns, the Indiana General Assembly passed, and on May 10, 2011, Governor Mitch Daniels signed into law, House Enrolled Act 1210, which disqualifies abortion providers from State contracts and grants, including those which distribute federal funds. Specifically, the law provides that “[a]n agency of the state may not . . . enter into a contract with [] or make a grant to[] any entity that performs abortions or maintains or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state.” Ind. Code § 5-22-17-5.5(b). The law does not apply to hospitals or ambulatory surgical centers licensed under Indiana Code section 16-21-2. Ind. Code § 5-22-17-5.5(a). And organizations such as Planned Parenthood can continue to receive funding through the simple expedient of separating their abortion services into a separate yet affiliated entity; they have already done this in Texas in response to a similar law enacted several years ago. *See Planned*

Parenthood of Houston and Se. Texas v. Sanchez, 403 F.3d 324, 342 (5th Cir. 2005) (upholding a Texas law excluding entities that perform abortions from receiving Title X funds, and noting that “[w]hile creating affiliates might entail some time and expense, and might not be the most convenient arrangement, this extra effort alone would not relegate the state statute to preemption”).

Among other things, this statute in effect prohibits abortion providers from being Medicaid providers. It also disqualifies them from receiving Disease Intervention Services grants. Even with those disqualifications, Medicaid beneficiaries seeking family planning services could choose from among approximately 800 Medicaid providers that have historically billed for family planning services. App. 60-61. Plaintiffs do not claim that HEA 1210 deprives Medicaid beneficiaries of the opportunity to obtain family planning services from an otherwise qualified provider; rather, they claim only that it deprives them from choosing one provider in particular: PPIN.

2. PPIN provides abortions, as well as cancer screenings and comprehensive family planning. [Docket No. 1 at 7-8]. To pay for non-abortion services, PPIN accepts private insurance, as well as federal funds. Federal monies received include Medicaid and funds administered by the Indiana State Department of Health through Disease Intervention Services grants as part of the federal Preventive Health and Health Services block grant program, 42 U.S.C. § 247c *et seq.* [Docket No. 1 at 8-9].

As a Medicaid provider, PPIN executed a provider agreement with the State Medicaid office. App. 1-5. The provider agreement imposes responsibilities on the provider including conditions on preserving patient confidentiality, claims processing, overpayment, and an agreement to “comply with all federal and state statutes and regulations pertaining to the Indiana Health Coverage Programs, as they may be amended from time to time.” App. 2. Failure to comply with any provision allows for immediate termination, and the State Medicaid office may also terminate the agreement without cause with sixty days notice. App. 5.

As a Disease Intervention Services grant recipient, PPIN executed two grant agreements with the Indiana State Department of Health. App. 6-59. Like the Medicaid provider agreement, the disease intervention grants are terminable at will. App. 21, 48. Specifically, Section 18 of the grant agreement states that “[t]his Grant Agreement may be terminated, in whole or in part, by the State whenever, for any reason, the State determines that such termination is in the best interest of the State.” App. 21, 48.

SUMMARY OF THE ARGUMENT

While HEA 1210 affects all Indiana government contracts (and grants) with abortion providers, this case is principally about whether, consistent with the Medicaid Act and various clauses of the U.S. Constitution, Indiana can prevent indirect taxpayer subsidy of abortion by precluding abortion clinics from being Medicaid providers. Other equitable factors are relevant, but the district court’s

preliminary injunction mainly rises or falls based on whether it got the answers to this and related legal questions right.

When Congress enacted Medicaid, it did not create a top-down welfare model where the national government commandeers a State administrative apparatus and instructs it to provide particular benefits through prescribed channels. Rather, it created a cooperative-federalist program offering federal reimbursement to States that choose to establish Medicaid programs that comply with federal criteria. Under this model, States decide what services and segments of the population they want to cover and determine the qualifications and standards of practice for those who seek to provide the covered services. The federal government reimburses States whose Medicaid plans conform to the Medicaid Act and may refuse to issue grants to States with non-compliant plans. But a non-compliant plan, while perhaps ineligible for federal reimbursement, does not “violate” any federal law, let alone violate federal *rights*. Establishing a non-compliant plan is akin to lowering the drinking age to 18 and risking a diminished share of federal highway funds.

Accordingly, PPIN cannot have a right of action to “enforce” 42 U.S.C. § 1396a(a)(23), referred to hereafter as the “free-choice plan requirement.” All concede that the Medicaid Act itself affords no right of action. The question is whether the free-choice plan requirement, and the Preventive Health and Health Services block grant program, 42 U.S.C. § 247c *et seq.* (which authorizes the Disease Intervention Services grant) can be enforced by way of 42 U.S.C. § 1983.

To enforce a federal statute under Section 1983, a plaintiff must assert that a defendant has violated a right “unambiguously conferred” by Congress. The free-choice plan requirement, however, is just that—a plan requirement, *i.e.*, a criterion for reimbursement, not an individual right. It was enacted as part of a section of the Medicaid Act explaining what a State Medicaid plan must provide to be approved by the Secretary of Health and Human Services, and thus to render the State eligible for federal Medicaid matching funds. It serves to guide both the State, which creates its own plan, and the Secretary, whose job is to ensure compliance with the program. By the Act’s terms, a State cannot even “violate” the free-choice plan requirement, much less can it do so in a way that transgresses an “unambiguously conferred” individual right. The only official who can “violate” the Medicaid Act is an HHS Secretary who approves a State plan not in conformance with the Medicaid Act.

Similarly, the Preventive Health and Health Services block grant program creates no rights whatever. It merely outlines the parameters of permissible State grants and leaves it to States to decide what programs and providers are deserving of aid.

Permitting Plaintiffs to proceed with a Section 1983 claim in this case has now overrun the administrative process that Congress provided for the Secretary to enforce Medicaid’s preconditions for federal matching funds. On May 13, three days after HEA 1210 was signed into law, Indiana proposed to CMS a State Plan Amendment that would bring its plan into conformance with HEA 1210’s abortion-

clinic qualification provision. On June 1, CMS rejected that plan amendment. Indiana has now appealed from that determination, which is ultimately subject to judicial review in this Court. If CMS continues to reject Indiana’s plan amendment and is affirmed in doing so, it will likely penalize the State by denying (again subject to judicial review) some portion of federal matching grants. Indiana—meaning the Indiana General Assembly—will then have to decide whether disqualifying abortion clinics from Medicaid is worth whatever price CMS imposes. But now a federal court has, in this collateral proceeding, enjoined State officials from enforcing the provision at all, so while Indiana can appeal the CMS rejection of its plan amendment, it may never learn what price CMS would charge for its non-compliance, and never get to decide whether disqualifying abortion clinics from Medicaid is worth it. The Court should re-focus Medicaid accountability where it belongs—in the CMS administrative review process—by denying Plaintiffs a cause of action here.

On the merits, neither Medicaid’s free-choice plan requirement nor the Preventive Health and Health Services block grant program deprive States of the ability to decide provider or grantee qualifications. The Disease Intervention Services authorization statute is utterly silent as to grantee qualifications and limits on State authority. And 42 U.S.C. § 1396a(p)(1) provides that “[i]n addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation[.]”

Consequently, States have substantial authority to determine provider qualifications under their own medical assistance programs. And there is no Medicaid-relevant distinction between disqualifying a provider to avoid indirect subsidy of abortion and disqualifying one to avoid indirect subsidy of, say, poor patient care, shoddy recordkeeping, improper waste disposal, or any number of other practices of which States disapprove.

On this point, the district court erred by granting a “some level of deference” to the letter from CMS disapproving of Indiana’s proposed State plan amendment. *Chevron*-type deference is only appropriate where there is a gap in the law that Congress intended the agency to fill with its expertise. Here, such a gap does not exist, and instead an interpretive question central to the program is presented—the extent to which States can determine provider qualifications in light of the free-choice plan requirement—which Congress has not left to agency discretion. CMS’s failure even to consider the State’s power to determine provider qualifications renders its initial interpretation of the free-choice plan requirement unreasonable and unworthy of deference in any event.

Finally, Plaintiffs’ Contract Clause and unconstitutional condition claims are unpersuasive. Because the Medicaid provider agreement and Disease Intervention Services grants are terminable at will, PPIN has no vested interests in them and, hence, no claim under the Contract Clause. Moreover, the State has delivered all the contracts have required; the Contract Clause does not require States to hire particular entities to deliver government benefits in perpetuity.

The unconstitutional condition claim is predicated upon a right that has never been recognized to exist: the right to provide abortions. Thus, Plaintiffs are unlikely to succeed on the merits of their constitutional claims.

STANDARD OF REVIEW

“A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, *and* that an injunction is in the public interest.” *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (emphasis added). A district court’s grant of a preliminary injunction is reviewed *de novo* as to its legal conclusions, for abuse of discretion as to its balance of the equities, and for clear error as to its factual findings. *See United Air Lines, Inc. v. Air Line Pilots Ass’n, Int’l*, 563 F.3d 257, 269 (7th Cir. 2009).

In particular, where plaintiffs do not as a matter of law have a likelihood of success on the merits, a district court’s issuance of a preliminary injunction must be reversed and vacated. *See, e.g., Chicago Observer, Inc. v. City of Chicago*, 929 F.2d 325, 329 (7th Cir. 1991) (vacating a preliminary injunction of an ordinance that was constitutionally valid).

ARGUMENT

I. **Plaintiffs Do Not Have a Cause of Action to Enforce the Medicaid Free-Choice Plan Requirement**

As this Court has expressly recognized, the Medicaid Act itself creates no private rights of action. *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456 (7th Cir. 2007). Nevertheless, the district court held that Plaintiffs have a private right of action to enforce 42 U.S.C. § 1396a(a)(23), the Medicaid free-choice plan requirement, under 42 U.S.C. § 1983. This holding is erroneous in view of the text and structure of the Medicaid Act. Medicaid *permits* States to establish non-compliant programs that will not qualify for federal funds. Even after a State accepts federal funds, Section 1396c recognizes the State’s continuing prerogative to alter its Medicaid program. Any State that administers a non-compliant program runs the risk that the Secretary will turn off the funding spigot, but this remains a lawful option for the State under the statute. Plaintiffs cannot possibly have a federally protected “right” to State Medicaid services when the statutes do nothing more than supply criteria for federal reimbursement.

A. The free-choice plan requirement creates no “unambiguously conferred rights” enforceable under 42 U.S.C. § 1983

1. Section 1983 affords a cause of action to enforce federal rights, not federal laws

In order for a federal statute to be enforceable through 42 U.S.C. § 1983, it must create an “unambiguously conferred” right that the defendant has allegedly violated. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 284 (2002). That is, Section 1983

affords relief only when officials violate a plaintiff's federal *rights*; it does not provide a remedy for a mere violation of federal *law*. *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989) (“Section 1983 speaks in terms of ‘rights, privileges, or immunities,’ not violations of federal law.”).

Three factors are relevant to determining whether a statutory provision gives rise to a federal right: (1) Congress must have intended the provision in question to benefit the plaintiff; (2) the right allegedly protected by the statute must not be so “vague and amorphous” that its enforcement would strain judicial competence; and (3) the provision giving rise to the right must be stated in mandatory rather than precatory terms. *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997). Plaintiffs bear the burden of showing that the statute was intended by Congress to create such an enforceable right. *See Gonzaga*, 536 U.S. at 284.

Spending Clause legislation such as Medicaid is particularly unlikely to confer individual rights enforceable through Section 1983. In *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), the Court observed that “[i]n legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.” *Id.* at 28; *see also Ind. Prot. and Advocacy Servs. v. Ind. Family and Soc. Servs. Admin.*, 603 F.3d 365, 376 (7th Cir. 2010) (acknowledging “the need for close attention to the specific language *and structure* of the statute at issue” when determining whether a statute creates a private right of action enforceable through

Section 1983) (emphasis added); *id.* at 389 (Easterbrook, C.J., dissenting) (“What a state anticipates when it accepts a federal grant is that enforcement rests in the hands of the grantor, which can either turn off the spigot or sue in its own name[.]”).

Whether Section 1396a(a)(23) creates rights enforceable through Section 1983 is an issue of first impression for this Court, and remains an open question generally. The court below cited three district court cases and one court of appeals case to support its conclusion that Section 1396a(a)(23) creates a privately enforceable right, *see* Short App. 11 (citing *Harris v. Olszewski*, 442 F.3d 456, 459 (6th Cir. 2006); *G. ex rel. K. v. Haw. Dep’t of Human Servs.*, 2009 WL 1322354, at *12 (D. Haw. May 11, 2009); *Women’s Hosp. Found. v. Townsend*, 2008 WL 2743284, at *8 (M.D. La. July 10, 2008); *Martin v. Taft*, 222 F. Supp. 2d 940, 979 (S.D. Ohio 2002)), while conceding that at least one district court disagreed with these rulings. *See id.* (citing *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003) (concluding that “the freedom of choice provisions do not contain the unambiguous rights-creating language of *Gonzaga*”)).²

Consequently, there is no consensus as to whether Section 1396a(a)(23) confers a private right that can be vindicated by Section 1983. Based upon the statutory language and the detrimental effect that finding a private right in this very case would have on the established remedial scheme, it is apparent that

² One of the district court cases cited by the court below completely failed to address *Gonzaga* at all—despite being decided three months later—making its persuasive value highly suspect. *See Martin v. Taft*, 222 F. Supp. 2d 940 (S.D. Ohio 2002); *see also M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003) (noting *Martin’s* inattention to *Gonzaga*).

Congress did not intend for Section 1396a(a)(23) to confer privately enforceable individual rights.

2. The Medicaid Act does not impose legal duties on States, let alone confer rights on providers and recipients

The Medicaid Act creates a voluntary program enabling States to seek federal matching grants for qualifying State healthcare benefits programs; it is not a civil rights statute imposing duties and restraints on State or local governments. Indiana is free to opt out of eligibility for federal Medicaid funds and is in no way obligated to structure its Medicaid program in accordance with the conditions required for federal funding. *Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003) (“A state’s participation in the Medicaid program is completely voluntary.”). Furthermore, even when a State is participating in Medicaid, it remains free to amend its program, even if that means the Secretary will deny federal funding as a consequence. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c).

By its terms, the Medicaid Act imposes legal obligations *only* on the Secretary, who must ensure that States substantially comply with plan requirements before approving federal matching grants. *Id.* If the Secretary finds that a State plan “has been so changed that it no longer complies” with the requirements of Section 1396a or that “in the administration of the plan there is a failure to comply substantially with any such provision,” then the Secretary “shall notify [the] State . . . that further payments will not be made to the State.” *Id.* Payments will be discontinued “until the Secretary is satisfied that there will no

longer be any such failure to comply.” *Id.* Or, rather than cutting off payments completely, the Secretary may, in her discretion, “limit payments to categories under or parts of the State plan not affected by [the] failure [to comply].” *Id.*

In inferring a private right of action, the court below erred in addressing the language of Section 1396a(a)(23) without reference to its context in the Medicaid Act as a whole, particularly with respect to Section 1396c. Instead, like the court in *Olszewski*, 442 F.3d at 459, upon whose analysis it relied, the court quoted only the beginning language of Section 1396a and the language of Section 1396a(a)(23). *See* Short App. 11. Interpreting statutory language “depends upon reading the whole statutory text, considering the purpose and context of the statute, and consulting any precedents or authorities that inform the analysis.” *Dolan v. U.S. Postal Serv.*, 546 U.S. 481, 486 (2006).

The entirety of Section 1396a(a) establishes conditions under which States may qualify to receive federal funding. It begins “[a] State plan for medical assistance must . . .” and each subsection then delineates what a State plan must provide to qualify for federal matching grants. *See* 42 U.S.C §1396a(a). If a State chooses not to meet the conditions of Section 1396a—which is its prerogative—Section 1396c explicitly dictates the appropriate remedy: rejection or discontinuation of some portion of federal funding. *See* 42 U.S.C. § 1396c. Furthermore, the conditions outlined in Section 1396a serve as instructions to both States choosing to participate in the program *and* the Secretary, who is charged with administering it. Consequently, its focus is on “the person regulated rather

than the individuals protected,” and there is “no implication of an intent to confer rights on a particular class of persons.” *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001) (internal quotation marks omitted).

Admittedly, the Supreme Court has found one (since repealed) provision of the Medicaid Act enforceable under Section 1983. *See Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 524 (1990) (permitting hospitals to sue under Section 1983 to enforce the “Boren Amendment,” which required participating States’ Medicaid programs to reimburse providers at “reasonable and adequate rates”). In *Gonzaga*, however, the Court limited *Wilder’s* holding by explaining that the Boren amendment was exceptional because it “explicitly conferred specific *monetary* entitlements upon the plaintiffs.” *Gonzaga*, 536 U.S. at 280 (emphasis added). “More recent decisions,” the Court observed, “have rejected attempts to infer enforceable rights from Spending Clause statutes.” *Id.* at 281. Because there is no such monetary entitlement provided by Section 1396a(a)(23), *Wilder* is inapposite.

Prior to *Gonzaga*, this Court seems to have taken varying approaches when reviewing private claims under Medicaid. In *West Allis Memorial Hospital v. Bowen*, 852 F.2d 251 (7th Cir. 1988), this Court held that 42 U.S.C. § 1395nn(b)(2)(B) (now recodified at 42 U.S.C. § 1320a-7b(b)(2)(B)) is not privately enforceable because it does not secure federal rights, *id.* at 225, as *Gonzaga* requires for both a stand-alone cause of action and a Section 1983 cause of action. *Gonzaga*, 536 US at 283 (stating that, while enforceability under Section 1983 and the existence of an implied right of action to enforce the statute directly are distinct

inquiries, they “overlap in one meaningful respect—in either case it must first be determined whether Congress *intended to create a federal right*[.]” (emphasis in original)). This Court observed that “[w]here a statute is framed as a general prohibition or command to a federal agency, as it is in the present case, a private right of action will seldom be implied.” *West Allis* 852 F.2d at 255 (internal quotations omitted). But in *Stanton v. Bond*, 504 F.2d 1246 (7th Cir. 1974), this Court held that Medicaid-eligible beneficiaries had a cause of action to enforce 42 U.S.C. § 1396d(a)(4)(B) (and implementing regulations), which address preventive care for young people, though the Court did not inquire whether that statute secured federal rights. *Id.* at 1251; *see also Miller by Miller v. Whitburn*, 10 F.3d 1315, 1319 (7th Cir. 1993) (holding that 42 U.S.C. § 1396d(r)(5) was enforceable under Section 1983 because the plaintiff was an intended beneficiary and the statutes “specify, in copious detail” applicable standards, but not inquiring whether the statute directly secured federal rights); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (holding “that providers of medical care have a private right of action, derived through § 1983, to enforce § 1396a(a)(30),” but not inquiring whether the statute directly secured federal rights).³

As far as the State can find, post-*Gonzaga*, this Court has reviewed only one subsection of the Medicaid Act—1396a(a)(8)—for purposes of determining whether

³ Before *Gonzaga*, this Court also ruled on the merits of Medicaid claims without addressing whether plaintiffs had a private right of enforcement. *See Ind. Ass’n of Homes for the Aging, Inc. v. Ind. Office of Medicaid Policy and Planning*, 60 F.3d 262 (7th Cir. 1995) (Section 1396a(a)(13)(A); Section 1396r); *Michael Reese Physicians & Surgeons v. Quern*, 606 F.2d 732 (7th Cir. 1979) (Section 1396a(a)(32)).

it may be enforced through Section 1983. In *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 910-11 (7th Cir. 2003), the Court assumed without discussion that Section 1396a(a)(8) could be so enforced. Four years later, in *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452 (7th Cir. 2007), the Court made the same assumption, this time expressly declining to decide the issue. *Id.* at 457-58 (“Because the parties have not briefed the question whether § 1983 supplies a private right of action to enforce claims under § 1396a(a)(8) in the context of waiver, we think it best to proceed as in *Bruggeman*: to assume that there is such an entitlement, while leaving resolution to the future.”).

In *Procopio v. Johnson*, 994 F.2d 325, 332 (7th Cir. 1993), this Court revised its Section 1983 right-of-action doctrine in light of *Suter v. Artist M.*, 503 U.S. 347 (1992). Here it should do the same in light of *Gonzaga*, particularly since this Court’s pre-*Gonzaga* decisions did not address the private enforcement of section 1396a(a)(23), and did not consistently hold, or even inquire whether, the Medicaid Act secures federal rights.

3. Permitting PPIN to enforce Medicaid through Section 1983 improperly relieves the HHS Secretary of responsibility for reviewing Indiana’s qualification of abortion providers

The proper method of carrying out Medicaid’s plan requirements is for the federal government to decide, subject to judicial review, whether to fund a State’s plan. Congress specified that the Secretary—not a federal court—determines in the first instance whether a State’s Medicaid program is worthy of federal funds. *See Pharm. Researchers & Mfrs. of Am. v. Walsh (PhRMA)*, 538 U.S. 644, 675 (2003)

(Scalia, J., concurring). The process begins with a State’s proposal of a plan or plan amendment. 42 C.F.R. § 430.12(c)(1). CMS then either approves or disapproves the plan. 42 C.F.R. § 430.15.

In the event of disapproval, the State may file a request for reconsideration. 42 C.F.R. § 430.18(a). A final determination by CMS is then reviewable by the circuit court of appeals. 42 C.F.R. §§ 430.38, 430.102(c). Affected individuals and groups may participate in the administrative appeal process “if the issues to be considered at the hearing have caused them injury and their interest is within the zone of interests to be protected by the governing Federal statute.” 42 C.F.R. § 430.76(b).

CMS’s disapproval notwithstanding, a State may nonetheless carry out a non-compliant Medicaid plan. But CMS may then decide not to pay the State some or all of the federal matching funds payable with regard to a compliant plan. 42 U.S.C. § 1396c. That decision, too, is subject to judicial review. *See* 42 C.F.R. § 430.38(a).

This is precisely the administrative process in which Indiana and CMS are currently engaged. On June 1, 2011, CMS Administrator Dr. Donald Berwick informed the State that the Agency could not approve Indiana’s State plan amendment—which reflected the changes in HEA 1210—on the basis that it did not comport with the Department’s interpretation of Section 1396a(a)(23). App. 142. In accord with established procedure, Indiana filed its letter requesting a hearing for

reconsideration with CMS on June 23, 2011. App. 147. The State’s request has been set for hearing on September 13, 2011.

In its Entry below, the district court took note of this process, but inexplicably concluded that a preliminary injunction was all the more justified precisely because such an injunction would *undercut* that process. *See* Short App. 30-31. It concluded that “denying the injunction could pit the federal government against the State of Indiana in a high-stakes political impasse. And if dogma trumps pragmatism and neither side budes, Indiana’s most vulnerable citizens could end up paying the price as the collateral damage of a partisan battle.” Short App. 30-31. Thus, the court deemed injunctive relief appropriate precisely because it would prevent the administrative process—the one express remedial procedure recognized by Congress—from proceeding with full effect.

This reasoning and outcome further support Indiana’s contention that permitting Planned Parenthood to enforce the free-choice plan requirement through Section 1983 would contravene Congressional intent. Medicaid involves issues of federal and State cooperation and the political choices and tensions attendant to such cooperation. *See Harris v. McRae*, 448 U.S. at 309 (describing Medicaid as a “cooperative program of shared financial responsibility”). The district court’s decision to enjoin Indiana’s enforcement of its abortion clinic qualification statute improperly vitiates the political accountability that Congress built into the Medicaid Act when it put responsibility on the Secretary of HHS to decide in the

first instance (subject to judicial review) whether to disapprove State plans and refuse Medicaid payments to non-compliant States.

What is more, enjoining noncompliant State action undermines the voluntariness of the program itself. Because conditional funding is optional for a State, the appropriate action in dealing with State noncompliance is to reduce funding, not to enjoin the State from enforcing legislation that fails to meet the conditions of funding.

By way of analogy, some federal highway monies are provided to States on the condition that they maintain their drinking ages at twenty-one. The authority to set the drinking age, however, fully remains within the province of the States. *See South Dakota v. Dole*, 483 U.S. 203, 211-12 (1987). As a result, Indiana has the unfettered right to lower its age of consumption without judicial interference—it just risks losing federal funding that Congress has conditioned if it chooses to do so.

Likewise, assuming that HEA 1210 does not comply with the terms of the Medicaid program, the appropriate remedy is not ordering injunctive relief, but rather following the procedures through the administrative channels established by Congress, which could eventually result in Indiana losing all or part of its federal funding for Medicaid. If there is a finding of noncompliance, the State (through its legislature) may be forced to consider rescinding HEA 1210 in order to maintain federal funding; in any event, it will be Indiana's prerogative through its politically accountable branches. Judicial interference forecloses the State's freedom of choice and effectively commandeers State officials to carry out federal policy.

B. The Supremacy Clause affords no direct right of action to enforce a federal statute that confers no individual rights

PPIN has also argued that it has a private right of action to challenge Medicaid disqualification through a preemption claim. This argument, too, must fail. The Supreme Court has already observed that “the Supremacy Clause, of its own force, does not create rights enforceable under § 1983.” *Golden State Transit*, 493 U.S. at 107. And in *Chapman v. Houston Welfare Rights Organization*, 441 U.S. 600, 615 (1979), it held that “an allegation of incompatibility between federal and state statutes and regulations does not, in itself, give rise to a claim ‘secured by the Constitution’ within the meaning of § 1343(3).” It would seem to follow that the Supremacy Clause does not afford a freestanding right of action to bring preemption claims.

Yet the district court found a free-standing right of action under the Supremacy Clause because *Illinois Association of Mortgage Brokers v. Office of Banks & Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002), said that 28 U.S.C. § 1331 provides federal question jurisdiction over a preemption claim without regard to whether the federal law in question secured individual rights. That doctrine does not work, here, however, because PPIN’s claims cannot properly be cast as preemption claims. Again, Section 1396a(a)(23) merely establishes one criterion for federal reimbursement of State payments. A State Medicaid plan that does not comport with the provision may not qualify for federal reimbursement, but it does

not “conflict” with federal law. States may, consistent with federal law, maintain Medicaid plans that do not qualify for federal reimbursement.

Moreover, the federal statute at issue in *Illinois Association of Mortgage Brokers*, the Alternative Mortgage Transaction Parity Act of 1982, 12 U.S.C. § 3803(c), was enacted under the Commerce Clause, not, as with the Medicaid Act, under the Spending Clause. *See Nat’l Home Equity Mortg. Ass’n v. Face*, 64 F. Supp. 2d 585, 592 (E.D. Va. 1999) (“In enacting the Parity Act, Congress exercised its plenary Commerce Clause powers.”). This is an important distinction. Again, the Spending Clause allows Congress to “hold out incentives to the States as a method of influencing a State’s policy choices.” *New York v. United States*, 505 U.S. 144, 166 (1992). Thus, when it comes to legislation enacted under the Spending Clause, the federal-state relationship is defined not by the supremacy of federal law, but by the terms of the voluntary agreement between the State and federal government. That is to say, it is a State’s voluntary agreement to be bound—not the inherent supremacy of federal law—that obligates a State to comply with federally-imposed conditions.

Accordingly, “the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.” *Pennhurst*, 451 U.S. at 28; *see also* 42 U.S.C. § 1396c (allowing the Secretary to withhold Medicaid funds from noncompliant States). To infer private rights of action under the

Supremacy Clause where Spending Clause legislation does not expressly provide such a right greatly undermines *Pennhurst* and *Gonzaga* both.

As it happens, the Supreme Court is scheduled to consider this very issue during its upcoming October Term. In *Douglas v. Independent Living Center of Southern California, Inc.*, 131 S. Ct. 992 (2011) (granting certiorari *sub nom. Maxwell-Jolly v. Indep. Living Ctr. of S. Cal.*), the issue is whether 42 U.S.C. § 1396a(a)(30)(A) can be enforced under a freestanding Supremacy Clause claim. Petition for Writ of Certiorari at i-ii, *Douglas v. Independent Living Ctr. of S. Cal., Inc.*, 131 S.Ct. 992 (No. 09-958), 2010 WL 599171 at *i-ii. The Court has scheduled oral argument in *Douglas* for its first day back from recess, October 3, 2011. See Supreme Court of the United States, Oral Argument Calendar for the Session Beginning October 3, 2011.

As the United States has pointed out in its amicus brief in *Douglas*, it is undisputed “that there is no statutory private right of action to enforce 42 U.S.C. 1396a(a)(30)(A), either under 42 U.S.C. 1983 or directly under the Medicaid Act.” Brief for the United States as Amicus Curiae Supporting Petitioner at 9, *Douglas v. Independent Living Ctr. of S. Cal., Inc.*, 131 S.Ct. 992 (No. 09-958), 2011 WL 2132705 at *9. Furthermore, says the United States, “the relevant features of the [Medicaid] statutory scheme counsel against recognizing a nonstatutory cause of action for Medicaid providers and beneficiaries to enforce Section 1396a(a)(30)(A).” *Id.* at *10. So too for Section 1396a(a)(23), which like Section (a)(30)(a), merely describes what a Medicaid plan must include for the Secretary to approve it and

does not require States to do anything. In its Statement of Interest to the district court in this case, it is worth observing, the United States did not take a position as to whether PPIN has a right of action to enforce Section (a)(23).

II. The Free-Choice Plan Requirement Does Not Preclude States From Disqualifying Abortion Clinics From Medicaid in Order to Prevent Indirect Taxpayer Subsidy of Abortion

Medicaid “was designed to provide the states with a degree of flexibility in designing plans that meet their individual needs. As such, states are given considerable latitude in formulating the terms of their own medical assistance plans.” *Addis v. Whitburn*, 153 F.3d 836, 840 (7th Cir. 1998); *see also PhRMA*, 538 U.S. at 686 (O’Connor, J., concurring in part and dissenting in part) (“Congress has afforded States broad flexibility in tailoring the scope and coverage of their Medicaid programs[.]”).

Accordingly, a plaintiff arguing that a State law is preempted by the federal Medicaid statute has the burden of showing that the State law does not serve any “Medicaid-related goal or purpose.” *Id* at 662 (plurality opinion). Furthermore, “[t]he fact that a State’s decision to curtail Medicaid benefits may have been motivated by a state policy unrelated to the Medicaid Act does not limit the scope of its broad discretion to define the package of benefits it will finance.” *Id.* at 666.

A. The Medicaid Act expressly embraces State authority to establish provider qualifications

One area where States have broad latitude is with respect to provider qualifications. The Medicaid Act provides that “[i]n addition to any other authority,

a State may exclude any individual or entity [from participating in its Medicaid program] for any reason for which the Secretary [of the Department of Health and Human Services] could exclude the individual or entity from participation in [Medicaid].” 42 U.S.C. § 1396a(p)(1).

Senate Report 100-109 shows that Congress intended to protect the State’s right to exclude providers for reasons other than those granted to the Secretary. It first mentions that Section 1396a(p)(1) affords States the ability to prevent “fraud and abuse” and “to protect the beneficiaries . . . from incompetent practitioners and from inappropriate or inadequate care.” S. Rep. No. 100-109, at 2 (1987). But it unambiguously adds that section 1396a(p)(1) “is not intended to preclude a State from establishing, under State law, *any other bases for excluding individuals or entities* from its Medicaid program.” *Id.* at 20 (emphasis added).

Furthermore, regulations promulgated by the federal government implementing Section 1396a(p)(1) carry forward what the plain text and legislative history of the section already provide—broad State authority over qualifications. The federal government has provided that “[n]othing contained in this part should be construed to limit a State’s own authority to exclude an individual or entity from Medicaid for any reason or period authorized by State law.” 42 C.F.R. § 1002.2.

Unsurprisingly, in *First Medical Health Plan v. Vega-Ramos*, 479 F.3d 46 (1st Cir. 2007), the First Circuit interpreted the qualifications authority provided by 1396a(p)(1) not as a limitation on the power of the State to regulate its Medicaid program, but as a specific delegation of power to the State. The court, citing the

legislative history of Section 1396a(p)(1), held that the provision “was intended to permit a state to exclude an entity from its Medicaid program for *any* reason established by state law.” *Id.* at 53.

Pursuant to this qualifications authority, States have enacted and carried out all manner of provider disqualifications. States disqualify providers who commit fraud (*see Guzman v. Shewry*, 552 F.3d 941, 950 (9th Cir. 2008)), pose financial conflicts-of-interest (*Vega-Ramos*, 479 F.3d at 53), keep poor records (*Triant v. Perales*, 491 N.Y.S.2d 486, 488 (N.Y. App. Div. 1985)), and pollute (*Plaza Health Laboratories, Inc. v. Perales*, 878 F.2d 577, 578-79 (2d Cir. 1989)), among others.

Yet the district court interpreted Section 1396a(p)(1) to permit only those State provider qualifications that relate to “the provider’s quality of services—not its scope of services.” Short App. 14-15. The court concluded that if a “state could exclude a provider for any reason at all, the latter half of this provision—relating to the HHS’ authority—would be entirely superfluous.” Short App. 24.

This is not a fair reading of Section 1396a(p)(1), which does two things: first, it *directly* confers on State administrators authority over qualifications commensurate with that of the Secretary; second, it makes clear that this direct conferral of authority is not exclusive of other authority, but “*in addition to any other authority*” a State administrator might have by virtue of State statutes and regulations. Thus, State law can *expand upon* federally conferred powers that State

plan administrators already have. The HHS secretary’s authority serves as the *floor* of the State administrator’s authority to exclude.⁴

Further, the notion that Medicaid qualifications may relate solely to the provider’s “quality of services” not only is without support in the statutory text, but also is contradicted by federal regulations. Under 42 C.F.R. § 1001.1501, the Office of the Inspector General may disqualify providers from participation in Medicare and Medicaid if they have defaulted on health education loan and scholarship obligations. Such disqualification in no way relates to the provider’s “quality of services,” nor does it relate to any rules broken in the course of providing care. Instead, this rule carries out another important federal policy concern—“[t]here is plainly a connection between requiring a physician who is benefitting from government programs to meet his or her financial obligations to the government, by repayment of loans.” Health Care Programs: Fraud and Abuse; Amendments to OIG Exclusion and CMP Authorities Resulting From Public Law 100-93, 57 Fed. Reg. 3298-01, 3313 (Jan. 29, 1992). Such a policy is directly comparable to Indiana’s disqualification of abortion providers. If the Secretary can disqualify Medicaid providers to avoid indirect financing of particular “non-Medicaid” conduct, why cannot States do the same?

⁴ Granting an agent of the State the authority to enforce federal law even absent State legislation is not uncommon. See, e.g., 12 U.S.C. § 5552(a)(1) (granting the State attorney general the authority to take action to protect consumers); 42 U.S.C. § 1396b(q) (granting State attorneys general authority to establish Medicaid Fraud Control Units to investigate Medicaid fraud and abuse); 42 U.S.C. § 9607(f)(2)(B) (requiring the governor of each State to select agents to assess damages to natural resources for purposes of federal law); 47 U.S.C. § 227(e)(6)(A) (permitting the chief legal officer of the State to file suit on behalf of the State against telephone solicitors who violate federal law).

Even if one were to accept, as a limit on 1396a(p)(1) authority, the interpretation suggested by the United States in the district court—that disqualifications must relate to providers’ “fitness to provide or properly bill for Medicaid services[,]” [Docket No. 66 at 10]—HEA 1210 still survives. Neither the United States nor the District Court has refuted Indiana’s grounds for enacting HEA 1210—to prevent indirect taxpayer subsidy for abortion and carry out the policies behind the Hyde Amendment. *See* Pub. L. No. 111-8, §§ 507-08, 123 Stat. 524, 802-03 (2009); Ind. Code §§ 12-15-5-1(17), 16-34-1-2; 405 Ind. Admin. Code 5-28-7. It is not, as the United States has suggested, the exclusion of a “provider based on an ideological objection to the scope of services the provider offers” [Docket No. 66 at 14]. It is instead a measure designed to ensure that the people’s money does not fund, even indirectly through shared staff salaries or overhead, the practice of abortion. Accordingly, HEA 1210 fits comfortably within the federal government’s non-textual “billing practices” interpretation of 1396a(p)(1), which is also concerned with ensuring that Medicaid reimbursements are issued only for those services properly covered by Medicaid.

The Supreme Court upheld the constitutionality of a similar indirect subsidy prohibition in *Rust v. Sullivan*, 500 U.S. 173 (1991). Although that case involved the expenditure of Title X family planning funding, the Court’s logic is equally apposite here, where “the Government is not denying a benefit to anyone, but is instead simply insisting that public funds be spent for the purposes for which they were authorized.” *Id.* at 196. The Court noted further that the plaintiff grantee

was still free to provide abortion referrals and services, as long as it kept that practice “separate and distinct” from its federally-funded family planning practice. *Id.*

The same is true here; if PPIN wishes to continue participating in the State’s Medicaid program, it is free to do so. It must, however, “conduct those activities through programs that are separate and independent” from its Medicaid-funded practice, just as the Court found permissible for Title X grantees in *Rust. Id.*

B. The free-choice plan requirement does not limit State authority to set provider qualifications

Given the district court’s narrow reading of 1396a(p)(1), it ultimately concluded that the free-choice plan requirement of 42 U.S.C. § 1396a(a)(23) limited any discretion over qualifications that Indiana possessed. *See* Short App. 14-15. Section 1396a(a)(23) provides that a State plan must allow for a beneficiary to receive care from “any institution, agency, community pharmacy, or person qualified to perform the service or services required . . . who undertakes to provide him such services.” But interpreting this section to preclude State provider qualifications that limit patient choice would mean precluding *every* provider qualification, since keeping even one provider outside the Medicaid program inevitably limits some beneficiary’s free choice.

The key to understanding the free-choice plan requirement is to recognize that it presupposes *qualified* providers. That is, a Medicaid plan must allow a beneficiary to receive care from a provider “qualified to perform the service.” 42

U.S.C. § 1396a(a)(23). The Supreme Court has said that the free-choice plan requirement speaks only to providers that “continue[] to be qualified” in the Medicaid program. *O’Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980). *States*, as discussed, determine what it means to be “qualified” as a Medicaid provider.

Based on *O’Bannon*, the Second Circuit in *Kelly Kare, Ltd. v. O’Rourke*, 930 F.2d 170 (2d Cir. 1991), held that, notwithstanding Section 1396a(a)(23), Westchester County, New York’s Medicaid administrator could unilaterally end a contract with a Medicaid provider without cause. *Id.* at 177-78. Regardless of the reason for the county’s refusal to execute a provider agreement (*i.e.*, regardless whether it related to provider “qualifications” or some other barrier to entry), Medicaid recipients were not able to obtain Medicaid-reimbursed services from Kelly Kare. *Id.* Yet, the court ruled, such lost choice was only an “incidental burden on their right to choose” under Section 1396a(a)(23). *Id.* at 178. According to the court, “Medicaid’s freedom of choice provision is not absolute.” *Id.* at 177. It provides at most that a State plan must afford the right to choose among providers who have been able to enter the market. *See id.* at 178.

Continuing with this logic, this Court has held that 1396a(a)(23) is meant “to give the recipient a choice among available facilities, not to require the creation or authorization of new facilities.” *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003) (citing *O’Bannon*, 447 U.S. at 785-86; *Kelly Kare*, 930 F.2d at 177). If the free-choice plan requirement does not “require the . . .

authorization of new facilities,” *id.*, then implicitly it does not require the continuing authorization of existing facilities that fail to meet new qualification requirements.

To be sure, there are circumstances where courts have found violations of the free-choice plan requirement, but only where the State rules eliminated all choice whatever. For instance, the State of Louisiana was not allowed to force school-aged children to seek services at their respective schools, as opposed to an independent provider. *Chisholm v. Hood*, 110 F. Supp. 2d 499, 506 (E.D. La. 2000). In another instance, the City of New York was enjoined from implementing a program by which Medicaid eligible providers bid for *exclusive* contracts to serve a borough of the city. *Bay Ridge Diagnostic Lab. Inc. v. Dumpson*, 400 F. Supp. 1104, 1105, 1108 (E.D.N.Y. 1975). The program would have created only one provider for each borough and prohibited beneficiaries from seeking services from any other provider. *Id.* at 1105.

By stark contrast, HEA 1210 does not limit Medicaid recipients to one or even a few providers. To the contrary, approximately 800 family planning providers across the State who do not perform abortions would remain available for Medicaid beneficiaries. App. 60-61. Moreover, HEA 1210 does not limit options of care *within* the sphere of State Medicaid-qualified providers; the law does nothing to prevent a beneficiary from receiving care from a provider that is eligible to receive Medicaid funds.

The district court acknowledged that these distinctions were “cogent and [have] some appeal,” yet concluded that the State’s argument would deprive the free-choice plan requirement of significance. Short App. 23 n.7, 24. The State’s theory of section 1396a(a)(23), however, *preserves* its significance: a State may not use a qualification to target patient choice as such—for example by eliminating *all* choice in the market—but it may *reduce* patient choice incident to a qualification targeting some legitimate government objective, such as the desire not to subsidize abortion even indirectly.

By contrast, reading Section 1396a(a)(23) to preclude provider qualifications that merely *reduce* the range of provider choices available to beneficiaries would not only render section 1396a(p)(1) meaningless but also suddenly call into question *all* provider qualifications heretofore assumed valid. Only the State’s interpretation gives effect to both Sections 1396a(a)(23) and 1396a(p)(1) and is consistent with case law.

C. The district court erred by deferring to CMS’s initial interpretation of the free-choice plan requirement

As it wrestled with the interplay between Sections 1396a(a)(23) and 1396a(p)(1), the district court afforded “some level of deference” to the CMS disapproval letter. Short App. 21. Based on the circumstances and substance of CMS’s interpretation of Section 1396a(a)(23), it is entitled to no deference whatever.

One basic question in determining whether to defer to a federal agency’s interpretation of law under *Chevron, U.S.A., Inc. v. Natural Resources Defense*

Council, Inc., 467 U.S. 837, 842-43 (1984), is whether the interpretation was of an “interstitial” nature. That is, agency deference is predicated on the existence of statutory interstices that Congress has authorized an agency to fill. *Krzalic v. Republic Tire Co.*, 314 F.3d 875, 879 (7th Cir. 2002) (observing that agency deference is based, among other things, on “the interstitial nature of the legal question”) (quoting *Barnhart v. Walton*, 535 U.S. 212, 222 (2002)). For *Chevron* deference to be appropriate, Congress must have “explicitly left a gap for the agency to fill” such that “there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation.” *Chevron*, 467 U.S. at 843-44.

In addition, the Supreme Court has indicated that when statutory interpretation implicates central aspects of a statutory scheme, *Chevron* is not applicable because Congress likely did not intend to give the agency that degree of authority. See *Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000) (holding that “Congress could not have intended to delegate a decision of such economic and political significance to an agency in so cryptic a fashion”); *MCI Telecomms. Corp. v. AT&T*, 512 U.S. 218, 231 (1994) (finding it “unlikely” that Congress intended for an agency to determine to what extent an industry should be rate-regulated given the magnitude of the issue).

Furthermore, this Court has suggested that, in the context of agency adjudication, *Chevron* applies only where the ruling entails the exercise of permissible policymaking discretion. See *Bob Evans Farms, Inc. v. NLRB*, 163 F.3d

1012, 1017-20 (7th Cir. 1998). The Court in *Bob Evans* recognized that there is not always a clear delineation between agency rulemaking and agency adjudication; indeed, sometimes agencies carry out rulemaking in the course of adjudication. *See id.* at 1018-19 (discussing *International Association of Machinists & Aerospace Workers v. NLRB*, 133 F.3d 1012 (7th Cir. 1998), where the National Labor Relations Board’s “chosen medium for promulgating these rules was a 125-page opinion delivered in response to the complaint of a number of union nonmembers. Thus, the context was clearly adjudicative but the function was legislative in character.”). Accordingly, when agencies engage in this sort of hybrid adjudicatory/rulemaking function, “the prominence or obscurity of a legislative purpose or of policymaking itself is a factor” in deciding whether *Chevron* deference is warranted. *Id.* at 1019.

This case fits none of these models justifying agency deference. Congress has not left an interstice to be filled by CMS, nor has CMS engaged in permissible policymaking in fulfilling its quasi-adjudicatory function—which as of this writing is not yet even final. What is needed here is not new interstitial law—which typifies agency action entitled to deference—but an interpretation of *existing* law. Specifically, what needs to be reconciled is the central relationship between the authority granted States to set provider qualifications under Section 1396a(p)(1) and the free-choice language in Section 1396a(a)(23).

Chevron deference is inappropriate here because Congress has legislated extensively in creating a system of cooperative federalism, and because

harmonizing Sections 1396a(a)(23) and 1396a(p)(1) is central to how Medicaid functions. What constitutes a qualified provider and how the right of States to disqualify providers interacts with freedom of choice are not mere gaps in the law which Congress entrusted CMS to fill. On the contrary, they are questions that implicate a central aspect of the overall Medicaid scheme: the ability of States to determine provider qualifications. Consequently, any interpretation as to the interaction between Sections 1396a(a)(23) and 1396a(p)(1)—which was absent from CMS’s disapproval letter—would exceed the scope of administrative authority intended by Congress.

The absence of any such congressional intent is particularly evident in consideration of the Senate committee report addressed above. The understanding of Congress was that States *would not* be limited in setting provider qualifications, while the Secretary *would*. See S. Rep. No. 100-109, at 20 (1987). States would thus have significant latitude to determine whether providers were qualified, with the clear implication that qualifications have an effect on beneficiaries’ ability to choose providers. If anything, it is the States, not CMS, that Congress expected to harmonize Sections 1396a(a)(23) and 1396a(p)(1). In any event, CMS’s determination is not entitled to deference because resolving the inherent tension between these two sections is of central importance to the administration of Medicaid.

Moreover, even under *Chevron*, courts are not required to defer to agency interpretations that are unreasonable. See *Louisiana Dep’t of Health & Hosp. v.*

Ctrs. for Medicare & Medicaid Servs., 346 F.3d 571, 579 (5th Cir. 2003) (refusing to defer to CMS’s disapproval of a State amendment because “the Administrator’s decision was made without proper consideration of the appropriate facts” and was based on assumptions about statutory meaning, without textual justification). CMS’s interpretation is unreasonable on two independent grounds. First, its conclusion neglects Indiana’s strong justification for amending its State plan: to ensure that taxpayer funds are not being used to subsidize abortion. Second, CMS does not even mention, never mind analyze, Section 1396(p)(1), and inexplicably states its disapproval as if freedom of choice is absolute, which, for reasons explained above, cannot be correct. Indeed, CMS fails to explain how, if the State cannot establish provider qualifications to eliminate indirect taxpayer subsidy of abortions, the State can nonetheless establish provider qualifications to address matters such as self-dealing and toxic waste dumping. *See, e.g., Vega-Ramos*, 479 F.3d at 53; *Plaza Health Labs.*, 878 F.2d at 578-79, 582-83.

What is more, CMS has in recent years approved Indiana Medicaid plan amendments related to provider qualifications that would have the effect of preventing some provider choices for some patients. In 2006, CMS allowed the State to refuse to qualify additional beds for Medicaid in nursing facilities in certain circumstances. *See App.* 149-52. That change did not involve the provider’s ability to perform covered services or billing, and it would undoubtedly force some patients who would otherwise choose the affected nursing facilities to choose another provider, yet CMS approved it anyway. It is hard to understand why Indiana can

restrict recipient choice for the sake of limiting nursing home capacity but not for the sake of preventing indirect Medicaid subsidy of abortions.

III. The Preventative Health and Health Services Block Grant Program Does Not Preclude States From Disqualifying Abortion Clinics

PPIN also contends that other federal funds have been wrongly withheld due to HEA 1210. PPIN receives federal funding for the screening and treatment of sexually transmitted diseases through the Preventive Health and Health Services Block Grant Program, 42 U.S.C. § 247c, *et seq.* See App. 6-59. This funding comes to PPIN via Disease Intervention Services grants administered by the Indiana State Department of Health. PPIN currently has two grant agreements with the State totaling \$150,000 that are set to expire on December 31, 2011. App. 6-59.

A. Plaintiffs do not have a right of action under Section 1983 or the Supremacy Clause to challenge the defunding of Disease Intervention Services grants

The district court, in its Entry below, acknowledged that 42 U.S.C. § 247c does not “unambiguously confer[]” the individual right necessary permit a Section 1983 cause of action. Short App. 26. Yet, as with the Medicaid Act, it found a likelihood of success only by presuming that PPIN could sue directly under the Supremacy Clause. Short App. 27. For the reasons explained above, this conclusion is likely incorrect, and in any event is being addressed by the Supreme Court this term.

B. Plaintiffs are not likely to succeed on their claim that HEA 1210 violates the federal block grant program, which contains no restrictions on State administration

In finding that the Plaintiffs are likely to succeed on their claim that Indiana's disqualification of abortion providers violates (or is preempted by) the Preventive Health and Health Services Block Grant Program, 42 U.S.C. § 247c, *et seq.*, the court below cited to cases that all involve Title X, a statute that expressly sets forth qualifications, unlike the block grant program. *See* Short App. 28. Because the block grant program in no way identifies recipient qualifications or limits State grant administration, it does not preclude States from disqualifying abortion providers in order to prevent indirect taxpayer subsidy of abortions.

Title X sets forth criteria for applicant eligibility. *See* 42 C.F.R. § 59.3 (“Any public or nonprofit private entity in a State may apply for a grant[.]”). 42 U.S.C. § 247c, on the other hand, does not contain such restrictions.

The absence of restrictions favors the conclusion that DIS grants are susceptible to State qualifications because Congress presumably would have used the same language it used in Title X had it wanted to place the same restrictions. Moreover, any presumption runs against preemption. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996); *see also Planned Parenthood of Houston & Se. Texas v. Sanchez*, 403 F.3d 324, 336-37 (5th Cir. 2005) (“We start with ‘a presumption that the state statute is valid, and ask whether petitioner has shouldered the burden of overcoming that presumption.” (quoting *Pharm. Researchers and Mfrs. of Am. v. Walsh (PhRMA)*, 538 U.S. 644, 661-62 (2003)). “[M]ere differences between state

and federal regulation of the same subject are not conclusive of preemption.” *Aux Sable Liquid Prods. v. Murphy*, 526 F.3d 1028, 1034 (7th Cir. 2008) (quoting *Frank Bros., Inc. v. Wisc. Dep’t of Transp.*, 409 F.3d 880, 894 (7th Cir. 2005)).

Because there are no indications that Congress intended to preempt State regulations regarding the Disease Intervention Services funds, Plaintiffs have no viable claim.

IV. Disqualifying Abortion Providers From State Government Contracts Does Not Offend the Contract Clause

Planned Parenthood also argued to the district court that HEA 1210’s government contracts qualification provision substantially impairs its Medicaid and Disease Intervention Services contracts in violation of the Contract Clause. While the district court did not address this issue in its Entry, Plaintiffs presumably will renew this claim as an alternative basis to affirm the decision below.

Neither the Medicaid provider agreements nor the DIS grants at issue in this case are substantially impaired by HEA 1210 because, even prior to the enactment of that legislation, the State enjoyed the right to cancel the agreements for any reason. And even apart from being terminable upon the State’s notice, these agreements do not represent commercial or vendor contracts that implicate Contract Clause concerns. Rather, they are the means of carrying out government programs intended to benefit the poor and disadvantaged, not PPIN. This is a crucial distinction in Contract Clause analysis.

A. PPIN has no “vested interest” in its Medicaid and Disease Intervention Services agreements with the State

“To establish a contractual relationship subject to the Contract Clause, the party must demonstrate that the contract gave her a vested interest, not merely an expectation.” *Allstate Life Ins. Co. v. Hanson*, 200 F. Supp. 2d 1012, 1018 (E.D. Wis. 2002) (citing *Dodge v. Bd. of Educ.*, 302 U.S. 74, 77-78 (1937); *Larsen v. Senate*, 154 F.3d 82, 89-90 (3d Cir. 1998); *Ace Cycle World, Inc. v. Am. Honda Motor Co., Inc.*, 788 F.2d 1225, 1228 (7th Cir. 1986)).

The agreements between PPIN and Indiana were terminable at will and thus PPIN had no vested contractual rights in its Medicaid provider agreements that it can vindicate under a Contract Clause claim. The State’s provider agreement with Planned Parenthood plainly states that it may be ended “[b]y IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.” App. 5. Likewise, the State’s Disease Intervention Services grant agreement with PPIN states that it “may be terminated . . . by the State whenever, for any reason, the State determines that such termination is in the best interest of the State.” App. 21, 48. Because these agreements are terminable at will, PPIN has no vested interests protected by the Contract Clause.

In addition, PPIN could not reasonably have expected its State contract rights and obligations to remain unchanged, or its Medicaid provider status to continue in perpetuity. The language in the Medicaid agreement unequivocally states that PPIN will “comply with all federal and state statutes and regulations

pertaining to the Indiana Health Coverage Programs, as they may be amended from time to time.” App. 2. Obviously, PPIN could expect changes in State law, and that failure to comply with the State law could result in termination of the provider agreement. This is precisely what took place. As a result, PPIN’s claim that it had a vested interest that was substantially impaired is unpersuasive.

In this respect, this case is analogous to *Hanson*, where the court held that an ex-wife—a named beneficiary in her prior husband’s life insurance policy—did not have a vested interest in the policy benefit. *Hanson*, 200 F. Supp. 2d at 1019 (internal quotations and citations omitted). Rather, she only had a “revocable expectancy,” because her husband “expressly reserved the right to change the beneficiary[.]” *Id.* By consequence, she could not “reasonably have expected her beneficiary status to continue.” *Id.* Such a claim was thus not enforceable under the Contract Clause.

B. The Contract Clause permits States to alter the terms of their welfare and regulatory programs

Provider and grant agreements do not create any type of perpetual financial obligations upon the State and, prior agreements notwithstanding, the State retains the police power to protect the general welfare of their people. *See City of El Paso v. Simmons*, 379 U.S. 497, 508 (1965).

The Contract Clause is applicable when a State has created a financial obligation to the holder of some form of security, only to pass a law thereafter that attempts to avoid the obligation. *See Energy Reserves Grp., Inc. v. Kansas Power*

and Light Co., 459 U.S. 400, 412 n.14 (1983) (“When a State itself enters into a contract, it cannot simply walk away from its financial obligations. In almost every case the Court has held a governmental unit to its contractual obligations when it enters financial or other markets.”); *see also W.B. Worthen Co. ex rel. Bd. of Comm’rs of Street Improvement Dist. No. 513 of Little Rock, Ark. v. Kavanaugh*, 295 U.S. 56, 59 (1935) (striking down an Arkansas statute that modified procedures by which municipal bondholder and trustee could collect delinquencies); *State ex rel. S. Bank v. Pilsbury*, 105 U.S. 278, 299-301 (1881) (striking down Louisiana legislation interfering with State bond initiative to fund the consolidation of New Orleans with surrounding areas); *Murray v. City of Charleston*, 96 U.S. 432, 447-48 (1877) (striking down a Charleston ordinance levying a tax upon interest generated by city-issued bonds, finding that the assessment essentially decreased the contractual interest rate).

HEA 1210 does not avoid payment of services that were already rendered prior to the law taking effect; it only affects prospective services, which PPIN knows in advance will not be compensated under the State’s Medicaid plan. Planned Parenthood’s agreements with the State are not the type of “debt contracts” that are routinely enforced against States by the courts. *See U.S. Trust Co. of New York v. New Jersey*, 431 U.S. 1, 24 n.22 (1977) (collecting cases). Indiana is not circumventing any established financial obligation, and thus it cannot be claimed that there is substantial impairment.

Moreover, the State of Indiana does not even enter any “financial or other markets” by entering into a Medicaid provider agreement. Instead, the State enters into these agreements for the purpose of effectuating the welfare scheme created by Congress under the Medicaid Act. By becoming a party to these agreements, the State does not waive any right to continue to make decisions that are in the policy interests of its citizens.

C. There can be no Contract Clause violation because HEA 1210 is supported by a “significant and legitimate purpose”

Additionally, even if it were found that HEA 1210 does create a substantial impairment of contracts, the statute is still valid as long as the State has “a significant and legitimate public purpose behind the regulation[.]” *Energy Reserves Grp.*, 459 U.S. at 411.

As noted, HEA 1210 serves the “significant and legitimate public purpose” of preventing indirect subsidization of abortion through the use of government funds. The Supreme Court has affirmed the State’s interest in protecting fetal life, and so held that States may make public policy that favors childbirth over abortion, so long as the regulations do not impose an undue burden on a woman’s right to an abortion. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 872-73 (1992).

V. There Is No Constitutional Right to Perform Abortions, So Disqualifying Abortion Clinics From Government Contracts Does Not Impose Unconstitutional Conditions on the Clinics

Another argument that Plaintiffs are likely to present as an alternative basis for affirmance is that HEA 1210 imposes an unconstitutional condition on the right

of abortion clinics to provide abortions. Because there is no constitutional right to perform abortions, however, and because in any event Planned Parenthood could establish unsubsidized affiliates to perform abortions while it retains its status as a Medicaid provider, there is no valid “unconstitutional conditions” claim.

While States may not generally condition government benefits on the forfeiture of constitutional rights, *see e.g., Perry v. Sindermann*, 408 U.S. 593, 597 (1972), the Supreme Court has never held that providers or physicians have a constitutional right to perform abortions—or any medical procedure for that matter—independent from the rights of the patient. In fact, the Court has even declined to determine whether a physician has a “constitutional right[] to practice medicine.” *Singleton v. Wulff*, 428 U.S. 106, 113 (1976) (plurality opinion) (citation and internal quotations omitted).

In any event, it is clear that the State may regulate the ability of physicians to practice medicine, including performing abortions. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (plurality opinion); *see also Lambert v. Yellowley*, 272 U.S. 581, 596 (1926) (“[T]here is no right to practice medicine which is not subordinate to the police power of the states[.]”). For example, this Court has previously upheld Indiana’s ability to require physicians to impart specific information to abortion patients, in their presence, at least 18 hours before the abortion. *A Woman’s Choice-East Side Women’s Clinic v. Newman*, 305 F.3d 684, 685-86, 693 (7th Cir. 2002).

Any right that a physician may have to perform abortions is entirely derivative of, and no broader than, the rights of the pregnant woman. *See Casey*, 505 U.S. at 884 (“Whatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman’s position.”); *Harris v. McRae*, 448 U.S. 297, 318 n.21 (1980) (“[T]he constitutional entitlement of a physician who administers medical care to an indigent woman is no broader than that of his patient”) (citing *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977)). As a result, physicians have standing to assert the right to abortion as a barrier to government regulation only to the extent that the governmental action allegedly “interfere[s] with the abortion decision.” *Singleton*, 428 U.S. at 118.

HEA 1210 does not affect a woman’s right to an abortion—it merely ensures that taxpayers are not subsidizing abortion, even indirectly. By consequence, “it “places no obstacles absolute or otherwise in the pregnant woman’s path to an abortion” because she “continues as before to be dependent on private sources for the service she desires.” *Maher v. Roe*, 432 U.S. 464, 474 (1977) (upholding prohibitions on the use of Medicaid to pay for non-therapeutic abortions).

Furthermore, HEA 1210 does not prevent women from procuring abortions from other privately funded facilities, making this case analogous to the regulation against using public hospitals for abortions upheld in *Webster v. Reproductive Health Services*, 492 U.S. 490, 509, 522 (1989). There, the Court reasoned that Missouri’s law prohibiting use of public facilities for abortions “leaves a pregnant woman with the same choices as if the State had chosen not to operate any public

hospitals at all.” *Id.* at 509. Here, similarly, HEA 1210 leaves pregnant women seeking abortions with the same choices as if the State had chosen not to participate in Medicaid at all.

To be sure, the Court in *Webster* speculated that the case “might [] be different if the State barred doctors who performed abortions in private facilities from the use of public facilities for any purpose.” *Id.* at 510, n.8. There is a substantive difference between that hypothetical and HEA 1210, however. Prohibiting abortion doctors from using public facilities for non-abortion services would serve no purpose other than to punish the practice of abortion. By contrast, HEA 1210 disqualifies abortion clinics from government contracts not to punish doctors or clinics for performing abortions, but to prevent even indirect taxpayer subsidy of abortion, such as by helping to finance personnel, capital resources and general overhead that support both abortion and non-abortion practices. The *Webster* hypothetical does not admit of any similar public interest concern, since it presumes all abortion procedures would take place in private facilities with no possibility of indirect subsidization.

Additionally, if PPIN wants to continue to receive Medicaid funds it can maintain affiliation with abortions clinics—so long as there is no cross-subsidy. In *Planned Parenthood of Mid-Missouri and Eastern Kansas v. Dempsey*, 167 F.3d 458, 463 (8th Cir. 1999), the Eighth Circuit held that a Missouri law resembling HEA 1210 did not impose an unconstitutional condition on PPIN’s receipt of Title X family-planning funds because recipients could continue “to exercise their

constitutionally protected rights through independent affiliates.” *Id.* at 463. The *Dempsey* law prohibited family-planning funds from being used to “perform, assist, encourage, or make direct referrals for abortions,” while also prohibiting affiliates of abortion providers from receiving funds. *Id.* at 461. Nevertheless, the court held that “nothing [in the law] expressly prohibits grantees from maintaining an affiliation with an abortion service provider, so long as the affiliated abortion service provider does not directly or indirectly receive State family-planning funds.” *Id.* at 463. While such an allowance is not constitutionally required, its existence under HEA 1210 nevertheless evidences the law’s constitutionality.

The language of HEA 1210 provides that “[a]n agency of the state may not . . . enter into a contract with[] or . . . make a grant to any entity that performs abortions or maintains or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state.” Ind. Code § 5-22-17-5.5(b). Nothing prohibits PPIN from establishing independent affiliates for providing abortion services. Indeed, FSSA is currently engaged in rulemaking that will clarify that HEA 1210’s reference to “any entity that performs abortions or maintains or operates a facility where abortions are performed,” Ind. Code § 5-22-17-5.5(b)(2), “does *not* include a separate affiliate of such entity, if the entity does not benefit, even indirectly, from government contracts or grants awarded to the separate affiliate.” App. 148 (emphasis added).

Such an understanding of the law is consistent with its intent, which was to prevent governmental monies from indirectly funding abortions. Nothing in the

law's language or its intent was to stop PPIN from providing women with abortion services. Instead, the General Assembly was concerned that Medicaid funds were being commingled with other sources. Allowing a system of affiliation wherein cash flows are separate and clearly accounted for adequately resolves the legislature's concern.

VI. The District Court Erred in Finding That the Balance of Equities and the Issue of Irreparable Harm Favor Granting Preliminary Injunctive Relief

To prevail on a motion for a preliminary injunction, a plaintiff must show “that the probability of success on the merits is sufficiently high—or the injury from the enforcement of the order sufficiently great—to warrant a conclusion that the balance of error costs tilts in favor of relief.” *Ill. Bell Tel. Co. v. Worldcom Techs, Inc.*, 157 F.3d 500, 503 (7th Cir. 1998). Injunctive relief is always an “extraordinary and drastic remedy,” *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (citation omitted), and this Court has said that when the party opposing a preliminary injunction is the government, public policy considerations weigh even more heavily against granting relief, as “the court must consider that all judicial interference with a public program has the cost of diminishing the scope of democratic governance.” *Ill. Bell*, 157 F.3d at 503. *See also United States v. Rural Elec. Convenience Co-op. Co.*, 922 F.2d 429, 440 (7th Cir. 1991) (noting that “the government's interest is in large part presumed to be the public's interest”). By consequence, Plaintiffs have a very heavy burden for establishing that the balance of equities weighs in their favor.

The district court supported its conclusion that public policy favors injunctive relief on the possibility that Indiana could lose the entirety of its Medicaid funds. Yet, the court’s injunction completely undermines the public interest in following the established administrative process. While Indiana respectfully disagrees with CMS’s initial disapproval—and is accordingly seeking reconsideration—it believes that the appropriate venue for these issues is not through a collateral judicial proceeding, but through the channels established expressly by Congress. That is the process that is consistent with cooperative federalism. Thus, the district court erred in viewing judicial interference as a virtue.

Furthermore, the district court improperly minimized Indiana’s vital interest in verifying that its Medicaid funds do not indirectly subsidize abortion. By disqualifying abortion providers, the State is able to ensure that it is complying with funding restrictions that both federal and Indiana law mandate. Pub. L. No. 111-8, §§ 507-08, 123 Stat. 524, 802-03 (2009); Ind. Code §§ 12-15-5-1(17), 16-34-1-2; 405 Ind. Admin. Code 5-28-7. HEA 1210 is thus not designed as a punitive measure for abortion providers, but is instead constructed to address a significant public policy issue.

Plaintiffs must also establish that a denial of the issuance of a preliminary injunction will result in irreparable harm. “‘Irreparable’ in the injunction context means not rectifiable by the entry of a final judgment.” *Walgreen Co. v. Sara Creek Prop. Co.*, 966 F.2d 273, 275 (7th Cir. 1992) (citations omitted). The court erred in finding that Plaintiffs satisfied this burden as to the defunding provision.

The patients themselves are only incidentally harmed—as in *Kelly Kare*—because only one provider has been disqualified, while beneficiaries continue to have an extensive choice of approximately 800 providers from whom they may receive their Medicaid services. App. 60-61. Consequently, any injury that they may experience is far from meeting the requisite irreparability standard. PPIN claims that it is also irreparably harmed by the fact that it ceases to receive funds. However, PPIN continues to have a full year from the date of services rendered to submit claims with the Medicaid office for repayment. 405 Ind. Admin. Code 1-1-3(a). Accordingly, PPIN maintains adequate monetary remedies should HEA 1210 ultimately be invalidated.

VII. Any Injunctive Relief Must Be Tailored to the Limits of PPIN’s Successful Claims

When a plaintiff mounts a facial challenge to a Legislative act, “the challenger must establish that no set of circumstances exists under which the Act would be valid.” *United States v. Salerno*, 481 U.S. 739, 745 (1987). “The fact that the [statute] might operate unconstitutionally under some conceivable set of circumstances is insufficient to render it wholly invalid[.]” *Id.* HEA 1210 refers to contracts generally while making no mention of Medicaid, DIS, or any other specific funding source. *See* Ind. Code § 5-22-17-5.5(b)-(d). So, even if HEA 1210 is invalid with respect to Medicaid funding or Disease Intervention Services grants, Plaintiffs would not be entitled to facial invalidation, but only to relief for Medicaid and Health Services block grants. *See* App. 24-25.

CONCLUSION

The preliminary injunction should be REVERSED and VACATED.

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

I verify that this brief, including footnotes and issues presented, but excluding certificates, contains 13,890 words according to the word-count function of Microsoft Word, the word-processing program used to prepare this brief.

By: s/ Thomas M. Fisher
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CIRCUIT RULE 31(e) CERTIFICATION

The undersigned hereby certifies that I have filed electronically, pursuant to Circuit Rule 31(e), versions of the brief and all of the appendix items that are available in non-scanned PDF format.

By: s/ Thomas M. Fisher
Thomas M. Fisher
Solicitor General

CERTIFICATE OF SERVICE

I hereby certify that on August 1, 2011, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system.

Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

I further certify that some of the participants in the case are not CM/ECF users. I have served the foregoing document by First-Class United States Mail, postage prepaid, on the following CM/ECF non-participants:

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REQUIRED SHORT APPENDIX

Pursuant to Circuit Rule 30, Appellants submit the following as their Required Short Appendix. Appellants' Short Appendix contains all of the materials required under Circuit Rule 30(a).

By: s/ Thomas M. Fisher
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**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION**

PLANNED PARENTHOOD OF INDIANA, INC.,)
MICHAEL KING M.D., CARLA CLEARY C.N.M.,)
LETITIA CLEMONS, and DEJIONA JACKSON,)

Plaintiffs,)

v.)

Case No. 1:11-cv-630-TWP-TAB

COMMISSIONER OF THE INDIANA STATE)
DEPARTMENT OF HEALTH, DIRECTOR OF THE)
INDIANA STATE BUDGET AGENCY,)
COMMISSIONER OF THE INDIANA DEPARTMENT)
OF ADMINISTRATION, SECRETARY OF THE)
INDIANA FAMILY AND SOCIAL SERVICES)
ADMINISTRATION, THE PROSECUTOR OF MARION)
COUNTY, THE PROSECUTOR OF MONROE COUNTY,)
THE PROSECUTOR OF TIPPECANOE COUNTY,)
INDIANA GENERAL ASSEMBLY, and the)
UNITED STATES OF AMERICA,)

Defendants.)

ENTRY ON MOTION FOR PRELIMINARY INJUNCTION

Following a vigorous and often contentious legislative debate, Governor Mitch Daniels signed House Enrolled Act 1210 (“HEA 1210”) into law on May 10, 2011. The new law accomplishes two objectives. First, HEA 1210 prohibits certain entities that perform abortions from receiving any state funding for health services unrelated to abortion – including for cervical PAP smears, cancer screenings, sexually transmitted disease testing and notification, and family planning services (the “defunding provision”). This portion of the law – codified at Ind. Code § 5-22-17-5.5(b) through (d) – went into effect immediately. Second, HEA 1210 modifies the informed consent information that abortion providers must give patients prior to receiving

abortion services (the “informed consent provision”). This portion of the law – codified at Ind. Code § 16-34-2-1.1(a)(1) – goes into effect July 1, 2011.

Within minutes of HEA 1210 being signed into law, Plaintiffs – Planned Parenthood of Indiana, Inc. (“PPIN”), Michael King, M.D., Carla Cleary, C.N.M., Letitia Clemons, and Dejiona Jackson, (collectively, “Plaintiffs”) – filed a lawsuit against the Commissioner of the Indiana State Department of Health, *et al.* (collectively, “Commissioner”), challenging the legality of both the defunding provision and the informed consent provision. That same day, this Court heard oral arguments on Plaintiffs’ Motion for a Temporary Restraining Order (“TRO”), which related only to the defunding provision. The next day, on May 11, 2011, the Court denied Plaintiffs’ Motion. In doing so, the Court cited the exacting standard required for a TRO, PPIN’s limited evidence supporting immediate and irreparable harm, and the fact that the Commissioner had not yet had the opportunity to brief the relevant issues.

Now, this matter is before the Court on Plaintiffs Motion for Preliminary Injunction (Dkt. 9). The parties have fully briefed the issues and the Court heard oral arguments on this matter on June 6, 2011. For the reasons set forth below, Plaintiffs Motion is **GRANTED** in part and **DENIED** in part.

I. THE DEFUNDING PROVISION

A. Background

The defunding provision of HEA 1210 generally prohibits Indiana agencies from contracting with or making grants to any entities that perform abortion services. It also immediately canceled past state appropriations to pay for contracts with or grants made to entities that perform abortions. The defunding provision reads as follows:

(b) An agency of the state may not:

2

(1) enter into a contract with; or
(2) make a grant to;
any entity that performs abortions or maintains or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state.

(c) Any appropriations by the state:
(1) in a budget bill;
(2) under IC § 5-19-1-3.5; or
(3) in any other law of the state;
to pay for a contract with or grant made to any entity that performs abortions or maintains or operates a facility where abortions are performed is canceled, and the money appropriated is not available for payment of any contract with or grant made to the entity that performs abortions or maintains or operates a facility where abortions are performed.

(d) For any contract with or grant made to an entity that performs abortions or maintains or operates a facility where abortions are performed covered under subsection (b), the budget agency shall make a determination that funds are not available, and the contract or the grant shall be terminated under section 5 of this chapter.

Ind. Code § 5-22-17-5.5. The defunding provision does not apply to hospitals licensed under Ind. Code § 16-21-2 or ambulatory surgical centers licensed under Ind. Code § 16-21-2. Ind. Code § 5-22-17-5.5(a).

PPIN is an Indiana not-for-profit corporation that provides comprehensive reproductive healthcare services throughout Indiana. With 28 health centers in Indiana, PPIN has provided approximately 76,229 patients with health care services, including cervical smears, cancer screening, sexually transmitted disease (STD) testing, self-examination instructions, and a variety of family planning and birth control options. Only a small percentage of PPIN's services involve abortion. For abortion services, PPIN uses funds from private sources and takes steps to ensure no commingling of private and taxpayer dollars. PPIN is audited annually by an

independent auditing firm and routinely by the Indiana Family Health Council. To date, no audit has uncovered inappropriate commingling.¹

B. PPIN's Enrollment in Medicaid

Significant to this dispute, PPIN is a Medicaid provider. To that end, PPIN has executed a provider agreement ("Provider Agreement") with the Indiana Family and Social Services Administration ("FSSA"), which administers Indiana's Medicaid program. Under the Provider Agreement, PPIN provides Medicaid-approved services and is then reimbursed by federal and state funds, paid through FSSA and the Indiana State Budget Agency. Reimbursable services include, among other things, the diagnosis and treatment of STD's, health education and counseling, pregnancy testing and counseling, the provision of contraceptives, and cervical smears.

In the past year, PPIN provided Medicaid services to more than 9,300 patients throughout Indiana and, in turn, received \$1,360,437.00 in funds as a Medicaid provider. Plaintiffs Letitia Clemons and Dejiona Jackson are two such Medicaid recipients who receive annual examinations and other health services at their local PPIN health centers. Both wish to continue using PPIN as their provider for various Medicaid-funded services, and PPIN remains a competent provider of these services.

C. PPIN's Receipt of Other Federally Funded Grants

PPIN also receives reimbursement for other services from funds originating from federal

¹ The Commissioner, however, contends that PPIN's audited financial statements for 2009 and 2010 "give rise to a reasonable inference that it commingles Medicaid reimbursements with other revenues it receives." (Dkt. 28 at 1). In particular, the Commissioner alleges that Medicaid reimbursements "help pay for total operational costs, such as management, personnel, facilities, equipment and other overhead." (Dkt. 28 at 2).

grants and programs that pass through the State of Indiana in various ways. For instance, PPIN has entered into two contracts with the Indiana State Department of Health. The contracts, which total \$150,000, are for Disease Intervention Services (“DIS”) and are designed to ensure that individuals diagnosed with or exposed to STD’s are provided notification and testing. PPIN investigates and intervenes in approximately 3,500 STD infection cases each year. The funds for the DIS grants are made through the federal Preventative Health Services Block Grant Program, 42 U.S.C. § 247c, *et seq.*, and utilize entirely federal monies.

D. The Effect of HEA 1210 on PPIN

HEA 1210 will exact a devastating financial toll on PPIN and hinder its ability to continue serving patients’ general health needs. Despite a large influx of donations following HEA 1210’s passage and the Court’s ruling denying Plaintiffs’ request for a TRO, the law has already affected PPIN in tangible ways. Specifically, PPIN has ceased performing services under the DIS grant and has stopped taking new Medicaid patients. As of June 20, 2011, PPIN stopped treating its Medicaid patients and has laid off two of its three STD specialists. PPIN estimates that the new law will force it to close seven health centers and eliminate roughly 37 employees. According to PPIN, thousands of patients have lost or will lose their healthcare provider of choice. Additional facts are added below as needed.

II. LEGAL STANDARD

A preliminary injunction is “an exercise of a very far-reaching power, never to be indulged in except in a case clearly demanding it.” *Roland Mach. Co. v. Dresser Indus., Inc.*, 749 F.2d 380, 389 (7th Cir. 1984) (citation and internal quotations omitted). When a court is presented with a request for preliminary injunction, it considers multiple factors. As the Seventh Circuit has recognized, a party seeking to obtain a preliminary injunction must demonstrate: (1)

“a likelihood of success on the merits,” (2) “a lack of an adequate remedy at law,” and (3) “a future irreparable harm if the injunction is not granted.” *Reid L. v. Ill. State Bd. of Educ.*, 289 F.3d 1009, 1021 (7th Cir. 2002). The court must then balance, on a sliding scale, the irreparable harm to the moving party with the harm an injunction would cause to the opposing party. *See Girl Scouts of Manitou Council, Inc. v. Girl Scouts of U.S. of America, Inc.*, 549 F.3d 1079, 1086 (7th Cir. 2008). The greater the likelihood of success, the less harm the moving party needs to show to obtain an injunction, and vice versa. *Id.* Finally, the court must consider the interest of and harm to nonparties that would result from a denial or grant of the injunction. *See Storck USA, L.P. v. Farley Candy Co.*, 14 F.3d 311, 314 (7th Cir. 1994).

III. DISCUSSION OF DEFUNDING PROVISION

A. Likelihood of Success on the Merits

Plaintiffs make four separate arguments challenging the legality of the defunding provision. First, the law violates the “freedom of choice” provision of the Medicaid statute. Second, along similar lines, the defunding provision is preempted by federal law. Third, the defunding provision violates the Contract Clause of the United States Constitution. Fourth, the defunding provision imposes an “unconstitutional condition” on PPIN’s receipt of state and federal funds. Given the nature of its ruling, the Court only needs to address Plaintiffs’ arguments relating to “freedom of choice” and preemption. Specifically, the Court finds that Plaintiffs have established: (1) a reasonable likelihood of success on the merits of their “freedom of choice” argument; and (2) a reasonable likelihood of success on their preemption argument as it relates to the DIS grants.

B. Does the defunding provision violate federal law relating to Medicaid?

This dispute can be distilled into a single question: Can the State of Indiana exclude PPIN as a qualified Medicaid provider because PPIN performs abortion services that are unrelated to its Medicaid services? The Commissioner argues that Indiana is free to exclude PPIN as a Medicaid provider because states have the authority to determine what constitutes a “qualified” provider. PPIN sharply disagrees, arguing that the defunding provision illegally limits a Medicaid recipient’s choice of providers. Before the Court reaches the merits of this very difficult question, however, some background is instructive.

1. Background

The Medicaid program, jointly funded by the states and federal government, pays for medical services to low-income persons pursuant to state plans approved by the Secretary of the Department of Health and Human Services (hereinafter, “HHS”). *See* 42 U.S.C. § 1396a(a)-(b). As the Supreme Court has noted, Medicaid is a federal-state program that is “designed to advance cooperative federalism.” *Wisconsin Dep’t of Health & Family Servs. v. Blumer*, 534 U.S. 473, 495 (2002).

State participation in Medicaid is voluntary. But if a state opts to participate, and thus receive federal assistance, it must conform its Medicaid program to federal law. *See Blanchard v. Forrest*, 71 F.3d 1163, 1166 (5th Cir. 1996). A state electing to participate in Medicaid must submit a plan detailing how it will expend its funds. *Community Health Center v. Wilson-Coker*, 311 F.3d 132, 134 (2d Cir. 2002); *see also S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 586 (5th Cir. 2004) (“a state must submit to the [federal government] and have approved a ‘state plan’ for ‘medical assistance’ . . . that contains a comprehensive statement describing the nature and scope of the state’s Medicaid program.”) (citations omitted). From there, the Secretary of HHS

reviews each plan to ensure that it complies with a long list of federal statutory and regulatory requirements. *See Wilson-Coker*, 311 F.3d at 134; 42 C.F.R. § 430.15(a). The Secretary of HHS delegates power to review and approve plans to Regional Administrators of the Centers for Medicare and Medicaid Services (“CMS”). *See Wilson-Coker*, 311 F.3d at 134; 42 C.F.R. § 430.15(b).

These restrictions notwithstanding, states do enjoy some autonomy and flexibility in devising Medicaid plans. Specifically, a state may establish “reasonable standards relating to the qualifications of providers...”. 42 C.F.R. § 431.51(c)(2). As the Supreme Court has recognized, the Medicaid statute “gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in the best interests of recipients.” *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (citation and internal quotations omitted). Indiana participates in the Medicaid program and is therefore bound by its requirements. Ind. Code § 12-15-1-1, *et seq.* Indiana’s Medicaid program provides virtually all non-experimental, medically necessary healthcare services to low-income Hoosiers.²³

Central to the present dispute, a state plan must provide that “any individual eligible for medical assistance . . . may obtain such assistance *from any* institution, agency, community pharmacy, or person, *qualified to perform the service or services required . . . who undertakes to provide him such services...*”. 42 U.S.C. § 1396a(a)(23) (emphasis added) (hereinafter, “‘freedom of choice’ provision”). This “freedom of choice” provision has been interpreted by the Supreme Court as giving Medicaid recipients the right to choose among a range of qualified

² It is worth noting that the federal government reimburses roughly 90% of family planning services provided through the Medicaid program. *See* U.S. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., Data Compendium: Findings: Table VIII.1, available at http://www.cms.gov/DataCompendium/14_2010_Data_Compendium.asp#TopofPage (last visited June 22, 2011).

providers, without government interference. *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980).

As enacted, the defunding provision of HEA 1210 prohibits PPIN from receiving reimbursement from Medicaid for services that would otherwise be reimbursable. Plaintiffs argue that, as a result, Medicaid patients like Letitia Clemons and Dejjona Jackson will be prohibited from obtaining care and treatment through their preferred Medicaid provider, in violation of the “freedom of choice” provision.

2. Do Plaintiffs have a right to sue under 42 U.S.C. § 1983?

As a threshold matter, the Court must determine if Plaintiffs can use 42 U.S.C. § 1983 as a vehicle to pursue their claim that the defunding provision violates the “freedom of choice” provision. Under § 1983, a plaintiff may sue a person who, acting under color of state law, deprived him or her “of any rights, privileges, or immunities secured by the Constitution and laws” of the United States. 42 U.S.C. § 1983. To sue under § 1983, a plaintiff must first allege a violation of a federal statutory or constitutional *right* – not merely a violation of a federal *law*. See *Blessing v. Freestone*, 520 U.S. 329, 340 (1997). Moreover, Plaintiffs bear the burden of showing that the statute at issue was intended to create an enforceable right. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283-84 (2002).

The Supreme Court has emphasized that “it is *rights*, not the broader or vaguer ‘benefits’ or ‘interests’ that may be enforced under the authority of [§ 1983].” *Id.* at 283 (emphasis in original). Further, the Supreme Court has “reject[ed] the notion that [its] cases permit *anything short of an unambiguously conferred right* to support a cause of action brought under § 1983.” *Id.* (emphasis added). The framework set out in *Blessing* explains how courts should determine whether a statute creates an enforceable right. Specifically, it directs courts to consider whether:

(1) “Congress intended that the provision in question benefit the plaintiff”; (2) the plaintiff has “demonstrated that the right assertedly protected by the statute is not so ‘vague and amorphous’ that its enforcement would strain judicial competence”; and (3) “the statute unambiguously imposes a binding obligation on the States,” such that “the provision giving rise to the asserted right is couched in mandatory, rather than precatory terms.”

Ball v. Rodgers, 492 F.3d 1094, 1104 (9th Cir. 2007) (quoting *Blessing*, 520 U.S. at 340-341). If all three elements are satisfied, a federal right is “presumptively enforceable by § 1983, subject only to a showing by the state that Congress specifically foreclosed a remedy under § 1983.” *Id.* at 1116 (citation and internal quotations omitted).

The Commissioner argues that the Medicaid statutes relied upon by Plaintiffs do not unambiguously confer federal *rights*. Instead, they merely impose legal obligations on the Secretary of HHS to determine if a state is substantially complying with its Medicaid plans, and to withhold federal funds if it is not. *See* 42 U.S.C. § 1396c. According to Defendants, it is the province of the Secretary of HHS – not a federal court – to ascertain if a state’s program complies with Medicaid. Thus, the remedy for a state’s non-compliance with the Medicaid statutes is the federal government’s termination of funding, meaning a private right of action is an inappropriate enforcement mechanism. Stated differently, because the applicable statutes only describe the mechanics and criteria for federal reimbursement under Medicaid, they do not provide a source of substantive rights for Plaintiffs.

The Court respectfully disagrees, and finds that a private right of action exists under § 1983 in order to enforce the “freedom of choice” provision. Tracking the *Blessing* framework, the Court first turns to the language of the “freedom of choice” provision, which provides in relevant part:

A state plan for medical assistance must...provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services ...

42 U.S.C. § 1396a(a)(23) (emphasis added).

As to the first *Blessing* prong, the plain language of the “freedom of choice” provision evinces a clear intent to benefit *individuals* by providing them with a choice in their Medicaid provider. This is the sort of “individual-focused terminology” that “unambiguously confer[s]” an individual right under the law. *Gonzaga*, 536 U.S. at 283, 287. Almost uniformly, other federal courts have agreed with this interpretation. *See, e.g., Harris v. Olszewski*, 442 F.3d 456, 459 (6th Cir. 2006) (§ 1396a(a)(23) confers a right enforceable by § 1983); *G. ex. rel. K v. Hawaii Dept. of Human Servs.*, 2009 WL 1322354, at *12 (D. Hawaii May 11, 2009) (same); *Women’s Hosp. Foundation v. Townsend*, 2008 WL 2743284, at *8 (M.D. La. July 10, 2008) (same); *Martin v. Taft*, 222 F. Supp. 2d 940, 979 (S.D. Ohio 2002) (same).

The Court would be remiss not to mention that at least one other federal court has disagreed with this analysis. *See M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003) (“the freedom of choice provisions do not contain the unambiguous language rights-creating language of *Gonzaga*”). That said, the Court believes that the robust analysis found in *Harris* is sound and persuasive. Accordingly, Plaintiffs have satisfied the first *Blessing* prong.

With respect to the second *Blessing* prong, the Court finds that the right is not so “vague and amorphous” that it would strain judicial competence. To the contrary, “while there may be legitimate debates about the medical care covered by or exempted from the freedom-of-choice provision, the mandate itself does not contain the kind of vagueness that would push the limits of judicial enforcement.” *Harris*, 442 F.3d at 462.

As to the third prong, by using the language “must...provide,” the right is framed in mandatory, rather than advisory, terms. *Id.* Finally, there is no indication that Congress sought to foreclose this remedy. As the *Harris* court noted, the other provisions of the Medicaid Act do not “explicitly or implicitly foreclose the private enforcement of [the ‘freedom of choice’ provision] through § 1983 actions.” *Id.*³ In short, as *Harris* recognized, “[t]hat the Federal Government may withhold federal funds to non-complying States is not inconsistent with private enforcement.” *Id.* at 463.

3. Merits

Having determined that a right to sue exists under § 1983, the Court must now turn to the merits of Plaintiffs’ contention that HEA 1210 violates the “freedom of choice” provision. Unquestionably, states have authority to exclude medical providers from participating in Medicaid under some circumstances. The question then becomes whether this is one of those circumstances.

The Court begins its analysis with the Supreme Court’s decision in *O’Bannon*, cited above, which recognized that the “freedom of choice” provision “confers an absolute right to be free from government interference with the choice to [receive services from a provider] that continues to be qualified.” 447 U.S. at 785. However, this right is not limitless. It applies only to the extent that the provider “continues to be qualified,” as the Medicaid Act “clearly does not confer a right on a recipient to enter an unqualified [provider] and demand a hearing to certify it,

³ The Seventh Circuit has not directly addressed this issue but has previously assumed, without deciding, that a private right of action existed under 42 U.S.C. § 1396a(a)(8), which provides that: “A state plan for medical assistance must ... provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals...”. *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 457-58 (7th Cir. 2007).

nor does it confer a right on a recipient to continue to receive benefits for care [from a provider] that has been decertified.” *Id.*

Applying these principles, *O’Bannon* held that Medicaid-eligible nursing home patients did not have a vested right to choose a nursing home that was being decertified as a healthcare provider due to the home’s failure to comply with certain health and safety requirements. In a similar vein, the Seventh Circuit has recognized that the “freedom of choice” provision is meant “to give the recipient a choice among available facilities, not to require the creation or authorization of new facilities.” *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003). Thus, it is well-settled that the “freedom of choice” provision does not give Medicaid recipients an absolutely unfettered right to choose their healthcare provider. For instance, a Medicaid recipient certainly does not have a right to receive services from an incompetent provider with inadequate services.

The defunding provision, however, renders PPIN “unqualified” to serve as a Medicaid provider because, separate and apart from its basic health care services, PPIN also performs abortions. Thus, the question arises: Can Indiana pick and choose Medicaid providers based on the range of medical services they provide?

a. Commissioner’s arguments

The Commissioner argues that the answer is “Yes” – and its position is backed by some notable authority. Significantly, the Medicaid Act itself provides that “in addition to any other authority, a State may exclude any individual or entity [from participating in its Medicaid program] for any reason for which the Secretary [of HHS] could exclude the individual or entity from participation [in Medicaid].” 42 U.S.C. § 1396a(p)(1) (emphasis added). Thus, in addition to excluding an entity for the same reasons as the Secretary of HHS, a state may also exclude an

entity from participating under “any other authority.” *First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46, 53 (1st Cir. 2007).

To flesh out what this means, *Vega-Ramos* – a case that did not involve the “freedom of choice” provision – reviewed the legislative history of § 1396a(p)(1), ultimately holding that the “any other authority” language means that a state is permitted “to exclude an entity from its Medicaid program for *any* reason established by state law.” *Id.* (emphasis in original); see also 42 C.F.R. §1002.2(b). According to the Commissioner, nothing supports the view that a state’s decision to disqualify a single Medicaid provider amounts to a violation of a Medicaid recipient’s “freedom of choice.” See *id.*; see also *Kelly Kare, Ltd. v. O’Rourke*, 930 F.2d 170, 178 (2d Cir. 1991) (New York had the right to unilaterally end a contract with Medicaid provider without cause and provider’s patients had no constitutionally protected property or liberty interest in choosing that provider).⁴

The Commissioner’s arguments are well-taken. That said, the Court also recognizes that the Commissioner may be reading the legislative history relied upon in *Vega-Ramos* too expansively. After all, the introductory paragraph of the operative Senate Report states that “[t]he basic purpose of the Committee bill is to improve the ability of the Secretary ... to protect ... Medicaid ... programs from *fraud and abuse*, and to protect the beneficiaries of those programs from *incompetent practitioners and from inappropriate or inadequate care.*” S. Rep. 100-109, at 1-2 (1987) (emphasis added). This history clarifies that the overarching purpose of the statutory subsection generally relates to the provider’s quality of services – not its scope of

⁴ It is worth noting that the Seventh Circuit cited *Kelly Kare* in its *Bruggeman* decision. However, the citation was only used to support the non-controversial proposition that the aim of the “freedom of choice” provision is “to give the recipient a choice among available facilities, not to require the creation or authorization of new facilities.” *Bruggeman*, 324 F.3d at 911. The *Bruggeman* decision did not delve into whether or not a state can exclude an entity from Medicaid for *any* reason.

services. On this point, there are no allegations that PPIN is incompetent or that it provides inappropriate or inadequate care. PPIN is, by all accounts, “qualified” as the word is used in common vernacular. The overall legislative history casts, at the very least, some doubt on the Commissioner’s contention that it had virtually unfettered discretion to disqualify otherwise competent Medicaid providers.

Moreover, it is important to remain mindful that this case is presently before the Court on a preliminary injunction request, meaning the Court is not tasked with determining who will ultimately prevail. Instead, the Court’s inquiry is limited to whether PPIN has a “reasonable likelihood of success on the merits.” *St. John’s United Church of Christ v. City of Chicago*, 502 F.3d 616, 625 (7th Cir. 2007) (citation and internal quotations omitted). Thus, while it remains to be seen who will ultimately prevail on the merits, the Court is persuaded that PPIN has met its burden of establishing a reasonable likelihood of success. Three considerations support this conclusion: (1) the federal government’s recent rejection of Indiana’s proposed amendment to its Medicaid plan; (2) the language of various provisions in the Medicaid statutes; and (3) case law.

b. HHS’ recent decision

Recently, HHS, the federal department overseeing the administration of the Medicaid program, denied Indiana’s proposed amendment to its Medicaid plan incorporating the defunding provision. By doing so, HHS effectively rejected Indiana’s interpretation of the “freedom of choice” provision.

As an initial matter, a review of the administrative enforcement mechanisms found in Medicaid law is instructive. A state participating in Medicaid must file a plan amendment with CMS whenever it enacts a “[m]aterial change [] in State law, organization, or policy” respecting Medicaid. 42 C.F.R. § 430.12(c)(1)(ii). HHS, through CMS, reviews the plan and determines

whether it complies with statutory and regulatory requirements. *See* 42 U.S.C. § 1316(a)(1) and (b). HHS' disapproval of a plan is final absent further action by the state if its proposed amendment is denied. Under the Medicaid statute, a state can seek reconsideration within 60 days of an adverse ruling. 42 U.S.C. § 1316(a)(2). When this occurs, the Secretary of HHS is required to hold a hearing and shall then "affirm, modify, or reverse" the prior decision. *Id.* This decision constitutes a "final agency action" because it is the "final decision of the Secretary [of HHS]." 42 C.F.R. § 430.102(c). If the state remains dissatisfied with the Secretary's determination, the state may seek judicial review. 42 U.S.C. § 1316(a)(5).

If the state does not act in compliance with an approved plan, or if an approved plan no longer complies with the requirements of the Medicaid Act, the Secretary of HHS may initiate a compliance action. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.35. When this occurs, the Secretary of HHS notifies the state that "no further payments will be made to the State (or that payments will be made only for those portions or aspects of the program that are not affected by the noncompliance)" and that "the total or partial withholding will continue until the Administrator is satisfied that the State's plan and practice are, and will continue to be, in compliance with Federal requirements." 42 C.F.R. § 430.35(d)(1)(i)-(ii). Funding may resume only when the "Secretary is satisfied that there will no longer be [a] failure to comply" with the requirements imposed by the Medicaid Act. 42 U.S.C. § 1396c.

With that backdrop in mind, the Court turns to recent administrative events involving this case. On May 13, 2011, FSSA submitted a Medicaid plan amendment to account for the defunding provision – to "make changes to Indiana's State Plan in order to conform to Indiana State Law." On June 1, 2011, CMS Administrator, Donald M. Berwick, M.D., responded by

informing FSSA that he was “unable to approve” the defunding provision amendment. In relevant part, Berwick wrote:

Section 1902(a)(23)(A) of the [Medicaid] Act provides that beneficiaries may obtain covered services from any qualified provider that undertakes to provide such services. This [amendment] would eliminate the ability of Medicaid beneficiaries to receive services from specific providers for reasons not related to their qualifications to provide such services. As you know, federal Medicaid funding of abortion services is not permitted under federal law except in extraordinary circumstances. At the same time, Medicaid programs may not exclude qualified health care providers from providing services that are funded under the program because of a provider’s scope of practice. Such a restriction would have a particular effect on beneficiaries’ ability to access family planning providers, who are subject to additional protections under section 1902(a)(23)(B) of the Act.... Therefore, we cannot determine that the proposed amendment complies with section 1902(a)(23) of the Act.

(Emphasis added; internal parenthetical omitted). CMS also staked out this position in an informational bulletin published on June 1, 2011.⁵ *See* (Dkt. 48-4 at 1-2) (“States are not ... permitted to exclude providers from the [Medicaid] program solely on the basis of the range of medical services they provide ... Medicaid programs may not exclude qualified health care providers ... from providing services under the program because they separately provide abortion services as part of their scope of practice.”) (internal parenthetical omitted).⁶

HHS’ recent decision generates significant questions that potentially bear on the outcome of the present motion: Namely, at this stage, is HHS’ position entitled to any deference? And, if so, how much? After all, it is well-settled that, under certain circumstances, “considerable weight” should be given to an executive department’s construction of a statutory scheme that it is entrusted to administer. *See Chevron, U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 844-45 (1984).

⁵ Because HHS acts through CMS, the Court, at times, uses the two entities interchangeably.

⁶ On June 23, 2011 the Defendants filed a formal request for reconsideration with CMS (Dkt. 74-1).

Even so, the Commissioner argues that HHS' interpretation should be accorded no deference whatsoever. To support this position, the Commissioner highlights that the CMS letter was not a final, authoritative agency action. Instead, the letter was merely the first step in a fluid administrative process. Indeed, HHS could still reverse course, as its position is still subject to additional administrative review. The Commissioner further argues that *Chevron* deference only applies when "Congress has explicitly left a gap for the agency to fill," meaning "there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation." *Id.* at 843-44. According to the Commissioner, Congress has left no such gap. Finally, setting aside *Chevron*, an agency interpretation can still have persuasive authority, depending "upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). However, CMS' letter lacks persuasive authority, the Commissioner argues, because it is essentially devoid of reasoning and did not address Section 1396a(p)(1), described above, head-on.

The Court respectfully disagrees with the Commissioner's argument. Even if the CMS letter is not entitled to full *Chevron*-style deference, some measure of deference is warranted. And, given the procedural posture of this case, the Court sees no reason to spell out this measure of deference with categorical exactitude. To reiterate, the current motion before the Court is one for a preliminary injunction, where Plaintiffs only must show a "reasonable likelihood of success on the merits." With this somewhat amorphous standard in mind, the Court believes that it would be more academic than pragmatic to assign a precise measure of the appropriate level of deference.

More importantly, ascribing deference to the CMS letter is, in the Court's view, squarely in line with a thorough body of case law. Here, the refusal to approve the proposed amendment to Indiana's Medicaid plan is tantamount to a denial, even though additional mechanisms for reevaluation are still available. Courts have routinely "applied *Chevron* deference to HHS' approval or denial of state Medicaid plans." *Harris*, 442 F.3d at 470 (emphasis added) (citing *Rosen v. Goetz*, 410 F.3d 919, 927 (6th Cir. 2005); *PhRMA v. Thompson*, 362 F.3d 817, 821 (D.C. Cir. 2004); *S.D. v. Hood*, 391 F.3d 581, 596 (5th Cir. 2004); *Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 939 (9th Cir. 2005); *Georgia, Dep't of Med. Assistance ex rel. Toal v. Shalala*, 8 F.3d 1565, 1572-73 (11th Cir.1993)); see also *West Virginia v. Thompson*, 475 F.3d 204, 212-13 (4th Cir. 2007) ("Courts, therefore, have rightly granted *Chevron* deference to agency interpretations of statutes in the context of *state plan amendment disapprovals*.")) (emphasis added). Moreover, as the Second Circuit has noted, "even relatively informal [CMS] interpretations, such as letters from regional administrators, 'warrant[] respectful consideration' due to the complexity of the statute and the considerable expertise of the administering agency." *Wilson-Coker*, 311 F.3d at 138 (quoting *Blumer*, 534 U.S. at 479). As the Seventh Circuit has noted, "the absence of notice-and-comment procedures is not dispositive to the finding of *Chevron* deference." *Beard v. C.I.R.*, 633 F.3d 616, 623 (7th Cir. 2011) (citation omitted).

In reaching these decisions, courts have emphasized that Congress expressly gave the Secretary of HHS "authority to review and approve Medicaid plans as a condition to disbursing federal Medicaid payments." *PhRMA*, 362 F.3d at 822 (citation omitted). "In carrying out this duty, the Secretary [of HHS] is charged with ensuring that each state plan complies with a vast network of specific statutory requirements." *Id.* "Through this express delegation of specific

interpretive authority ... the Congress manifested its intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, *should have the force of law.*" *Id.* (emphasis added; citations and internal quotations omitted). Plainly stated, the Court finds that this is precisely the type of congressional authorization needed to invoke *Chevron* deference.

From a practical standpoint, ascribing some deference to HHS' determination makes sense. HHS has singular competence in administering the Medicaid program and is thus well-suited to interpret the technical intricacies of Medicaid law. As the Second Circuit colorfully noted, "We take care not lightly to disrupt the informed judgments of those who must labor daily in the minefield of often arcane policy, especially given the substantive complexities of the Medicaid statute." *Wilson-Coker*, 311 F.3d at 138; *see also West Virginia*, 475 F.3d at 212 ("The Medicaid statute is a prototypical 'complex and highly technical regulatory program' benefitting from expert administration, which makes deference particularly warranted.") (citations and internal quotations omitted). Tracking this general reasoning, the Court finds that HHS' determination must be entitled to some deference, in light of the expertise and institutional knowledge required to administer a complex program governed by a labyrinth of complex laws.

The Commissioner likens HHS' interpretation to a mere non-binding opinion letter, which would not be entitled to *Chevron* deference. *See U.S. v. Mead Corp.*, 533 U.S. 218, 234 (2001) ("interpretations contained in policy statements, agency manuals, and enforcement guidelines ... [are] beyond the *Chevron* pale.") (citation and internal quotations omitted). The Court, however, is not persuaded. Even though CMS' letter was only the opening salvo in a potentially longer battle, it is still *binding* in the sense that it remains the position of the federal government. As it stands, the federal government has refused to approve the proposed amendment to Indiana's Medicaid plan, meaning the proposed amendment remains denied. *See*

42 U.S.C. 1316(c) (“Action pursuant to an initial determination of the Secretary described in subsection (a) shall not be stayed pending reconsideration.”). And if Indiana does not seek reconsideration – of course, this is an unlikely scenario – the initial decision carries the force of law. The Court believes that Commissioner’s position ignores the context of the CMS letter. Significantly, the letter was written by the head of CMS after consulting with the Secretary of HHS. 42 C.F.R. § 430.15(c)(2) (*denial* of a plan amendment requires consultation with the Secretary of HHS). In short, CMS’ letter is different than a mere “opinion letter.”

The Court acknowledges that further administrative review is available and that this is a potentially evolving process. *See* 42 C.F.R. § 430.18. While this fact perhaps reduces the deference owed HHS’ decision, it does not extinguish it altogether, particularly given the early procedural posture of this case. To use a sports metaphor, just because the final buzzer has not yet sounded does not mean the Court must avert its eyes from the scoreboard. For the reasons explained above, *some* level of deference is warranted. *See Estate of Landers v. Leavitt*, 545 F.3d 98, 107 (2d Cir. 2008) (“in cases such as those involving Medicare or Medicaid, in which CMS, a highly expert agency, administers a large complex regulatory scheme in cooperation with many other institutional actors, the various possible standards for deference – namely, *Chevron* and *Skidmore* begin to converge.”) (citation and internal quotations omitted).

c. Other considerations

The Court finds HHS’ interpretation to be a reasonable reading of a somewhat unclear statute. *See Chevron*, 467 U.S. at 843 (court should determine if Secretary’s interpretation is a permissible and reasonable construction of the statute); *Dep’t of the Treasury v. Fed. Labor Relations Auth.*, 494 U.S. 922, 928 (1990) (agency’s view was unreasonable because it was “flatly contradicted” by plain language of the statute). Thus, even stripping HHS’ decision from

the equation, PPIN would still likely have a reasonable chance of prevailing, as the Medicaid statute itself supports the view that states do not have carte blanche to expel otherwise competent Medicaid providers. In the Court's view, two specific considerations support this position: (1) the actual language of the "freedom of choice" provision; and (2) the fact that the Commissioner's interpretation would render other provisions of the Medicaid Act redundant or meaningless.

First, the actual language of the "freedom of choice" provision supports the view that the defunding provision unlawfully narrows Medicaid recipients' choice of qualified providers. To reiterate, the "freedom of choice" provision provides that "any individual eligible for medical assistance ... may obtain such assistance *from any* institution, agency, community pharmacy, or person, *qualified to perform the service or services required ... who undertakes to provide him such services.*" 42 U.S.C. § 1396a(a)(23) (emphasis added). Further, the regulations clarify that "recipients may obtain services from *any qualified Medicaid provider that undertakes to provide the services to them.*" 42 C.F.R. § 431.51(a)(1) (emphasis added). If the Commissioner's interpretation were adopted, it would undoubtedly restrict the rights of Medicaid patients to obtain services from "any qualified Medicaid provider." This would arguably rob the "freedom of choice" provision of any real meaning. In sum, a strong argument exists that Plaintiffs' interpretation is superior in terms of giving effect to every word of the "freedom of choice" provision. *See Moskal v. U.S.*, 498 U.S. 103, 109 (1990) ("a court should give effect, if possible, to every clause and word of a statute.") (citations and internal quotations omitted).

This overall position is backed by at least two analogous district court cases. In *Chisholm v. Hood*, 110 F. Supp. 2d 499 (E.D. La. 2000), a state Medicaid agency sought to require certain Medicaid-eligible disabled children to obtain occupational, speech, and audiological services

provided by their resident school boards. The district court held that this requirement violated a patient's freedom of choice, recognizing that "[s]tates must allow *all* qualified providers to participate in Medicaid" and "[r]estricting Medicaid recipients to schools and EICs for therapy services that are traditionally included in their educational or family service plans violates their statutory right to obtain these services from other qualified providers." *Id.* at 506.

Similarly, in *Bay Ridge Diagnostic Lab., Inc. v. Dumpson*, 400 F. Supp. 1104 (E.D.N.Y. 1975), the district court granted a preliminary injunction against a New York City program due in part to restrictions in medical services created by the program's limiting of laboratory services to those which had a contract with the state. *Id.* at 1108. In doing so, the district court reviewed the legislative history applicable to the "freedom of choice" provision, recognizing that the provision was meant "to assure freedom of choice as to all qualified providers of medical services willing to render services in accordance with the fee schedules established by the state." *Id.* at 1107-08.⁷ At bottom, the language of the "freedom of choice" provision suggests that PPIN – an otherwise competent Medicaid provider – cannot be rendered "unqualified" solely because Indiana unilaterally says so.

Second, if the Commissioner's interpretation was adopted, certain provisions of the Medicaid Act would arguably be rendered redundant or meaningless. Most notably, §1396a(p)(1), which the Commissioner relies on to support the view that it can exclude PPIN as a Medicaid provider, states, "in addition to any other authority, a State may exclude any individual or entity [from participating in its Medicaid program] for any reason for which the

⁷ The Commissioner counters that these cases are inapposite because they involve instances in which the state *forced* a beneficiary "to utilize the services of one provider over another provider *within* the universe of accepted providers." (Dkt. 28 At 12) (emphasis in original). This point is cogent and has some appeal. Nonetheless, the Court still believes that these cases bolster PPIN's argument that they have a reasonable likelihood of success on the merits.

Secretary [of the Department of HHS] could exclude the individual or entity from participation [in Medicaid].” 42 U.S.C. § 1396a(p)(1). If a state could exclude a provider for any reason at all, the latter half of this provision – relating to the HHS’ authority – would be entirely superfluous. For the above reasons, the Court finds that Plaintiffs have a reasonable likelihood of succeeding on the merits of their “freedom of choice” argument.

C. The DIS Grants

As mentioned earlier, the defunding provision affects more than just Medicaid dollars – DIS funding has also been cut. To reiterate, PPIN has entered into two DIS grant agreements with the Indiana State Department of Health for \$150,000.00. These grants are designed to ensure that individuals diagnosed with or exposed to STDs are tracked down and promptly tested. These grants allow PPIN to investigate and intervene in approximately 3,500 STD infection cases each year. Further, PPIN is the only entity that provides such DIS services in 22 Indiana counties. The DIS grants come from the federal government, which makes grants to states and other entities for STD screening and treatment activities, referrals for necessary medical services, and studies or demonstrations to evaluate or test STD prevention and control strategies and activities through the Preventive Health Services Block Grant Program. 42 U.S.C. § 247c(c).

With this background in mind, the question arises: Medicaid issues aside, is the defunding provision unlawful as applied to the DIS grants? It is somewhat unclear if the Court must address this issue. Assuming for the moment that the defunding provision is invalid with respect to Medicaid dollars, that fact may be enough to render it invalid as a whole. The Seventh Circuit has recognized, “[w]hether invalid provisions in a state law can be severed from the whole to preserve the rest is a question of state law.” *Burlington Northern & Santa Fe Ry. Co. v.*

Doyle, 186 F.3d 790, 804 (7th Cir. 1999) (citations omitted). Indiana has adopted the following test for severability:

A statute bad in part is not necessarily void in its entirety. Provisions within the legislative power may stand if separable from the bad. But a provision, inherently unobjectionable, cannot be deemed separable unless it appears both that, standing alone, legal effect can be given to it and that the legislature intended the provision to stand, in case others included in the act and held bad should fall.

State v. Barker, 809 N.E.2d 312, 317 (Ind. 2004) (quoting *Dorchy v. Kansas*, 264 U.S. 286, 289-90 (1924)). More concisely, “[t]he key question is whether the legislature would have passed the statute had it been presented without the invalid features.” *Id.* (citation and internal quotations omitted). Here, the Court has no real indication, one way or the other, whether the Indiana legislature would have passed a defunding provision that only applied to the DIS grants. Although, in the Court’s view, common sense suggests that Medicaid dollars were probably the legislature’s primary consideration. Moreover, the Commissioner has not expressly argued that even if an injunction is granted with respect to Medicaid dollars, then an injunction should not be granted with respect to DIS dollars. This suggests something of a tacit admission that the Commissioner views this motion for injunctive relief as an “all or nothing” proposition.

Regardless, this point is academic, given that the Court also finds that Plaintiffs’ preemption argument involving DIS funds has a reasonable likelihood of success. “A fundamental principle of the Constitution is that Congress has the power to preempt state law.” *Crosby v. National Foreign Trade Council*, 530 U.S. 363, 372 (2000) (citations omitted). A preemption analysis requires an examination of congressional intent, and federal regulations have no less preemptive effect than federal statutes. *Fidelity Federal Savings & Loan Ass’n v. de la Cuesta*, 458 U.S. 141, 152-53 (1982). A state statute may be preempted in three ways: (1) “by express language in a congressional enactment,” (2) “by implication from the depth and breadth

of a congressional scheme that occupies the legislative field,” or (3) “by implication because of a conflict with a congressional enactment.” *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 541 (2001) (citations omitted). The latter arises when compliance with both federal and state regulations is physically impossible or when state law impedes “the accomplishment and execution of the full purposes and objectives of Congress.” *Pac Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 204 (1983) (citation and internal quotations omitted). Plaintiffs contend that this type of preemption is present under the circumstances. That is, the defunding provision is preempted by 42 U.S.C. § 247c, which involves allowable uses for certain STD funds.

As a threshold question, the Court must examine whether Plaintiffs have a right to enforce this provision. It is well-settled that “the Supremacy Clause, of its own force, does not create rights enforceable under § 1983.” *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989) (internal citations omitted). Moreover, unlike the “freedom of choice” provision, 42 U.S.C. § 247c does not “unambiguously confer[]” an individual right under the law, which would allow a cause of action under Section 1983. *Gonzaga*, 536 U.S. at 283, 287. To further bolster its contention that no private right of action exists, the Commissioner points out that its research revealed “no Seventh Circuit cases holding that there is a freestanding right of action to enforce federal Spending Clause statutes against States under a theory of preemption.” (Dkt. 28 at 8-9). And, as it happens, the United States Supreme Court is set to tackle this issue in its October 2011 term. In *Maxwell-Jolly v. Independent Living Center of Southern California, Inc.*, 131 S. Ct. 992 (2011) (granting certiorari), the central issue is whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce a provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), by simply asserting

that the provision preempts a state law. Petition for Writ of *Certiorari* at ii, *Maxwell-Jolly*, 2010 WL 599171 (Feb. 16, 2010) (No. 09-958).

The Court is not persuaded, as the Commissioner's argument appears to run contrary to a body of cases involving freestanding claims brought under the Supremacy Clause. For instance, the Supreme Court has reached the merits of a preemption claim concerning a statute enacted pursuant to Congress's spending clause authority. See *PhRMA v. Walsh*, 538 U.S. 644 (2003) (plurality opinion) (involving Medicaid Act). Although *PhRMA* was a plurality decision, "seven Justices assumed both that the federal courts have jurisdiction and that a claim was stated for spending clause preemption." *Planned Parenthood of House & Sec. Tex. v. Sanchez*, 403 F.3d 324, 331-32 (5th Cir. 2005) (recognizing that Supreme Court implicitly rejected the contention "that asserting the preemptive force of federal Spending Clause legislation is itself no claim"); see also *Thompson*, 362 F.3d at 819 n.3 (D.C. Cir. 2004) ("By addressing the merits of the parties' arguments without mention of any jurisdictional flaw, the remaining seven Justices appear to have *sub silentio* found no flaw."). By the Commissioner's own admission, "the Seventh Circuit has indicated that in some circumstances an independent cause of action is not necessary to assert federal preemption against state regulation." (Dkt. 28 at 8) (citing *Illinois Association of Mortgage Brokers v. Office of Banks & Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002)).

While the Supreme Court may indeed reverse course in its upcoming term, inferential leaps – speculation about why the Supreme Court took a case and how it will ultimately rule – are not enough to overcome Plaintiffs' authority, particularly in light of this case's procedural posture. Thus, the Court believes it must address the merits of Plaintiffs' preemption claim relating to the DIS funds.

Simply stated, the Court believes that Plaintiffs have a reasonable likelihood of success on the merits of this argument. The Commissioner's overarching contention is that 42 U.S.C. §247c does not restrict how states may regulate recipients of funding. Plaintiffs, however, have cited to a body of authority indicating that "when federal law imposes a comprehensive mechanism for funding certain programs, participating states may not add their own eligibility requirements for the receipt of federal monies." (Dkt. 48 at 7 n.7). *See, e.g., Valley Family Planning v. North Dakota*, 661 F.2d 99, 100-01 (8th Cir. 1981) (state statute prohibiting federal monies from flowing to an entity that "performs abortions or encourages its clients to obtain abortions" preempted by Title X); *Planned Parenthood of Billings, Inc. v. State of Montana*, 648 F. Supp. 47 (D. Mont. 1986) (state statute prohibiting the federal funds from being disbursed to entities that perform abortions was preempted by Title X); *Planned Parenthood Fed. of Am. v. Heckler*, 712 F.2d 650, 663 (D.C. Cir. 1983) ("Title X does not provide, or suggest that states are permitted to determine eligibility criteria for participants in Title X programs."); *Planned Parenthood of Central Texas v. Sanchez*, 403 F.3d 324, 336-37 (5th Cir. 2005) ("a state eligibility standard that altogether excludes entities that might otherwise be eligible for federal funds is invalid under the Supremacy Clause.").

The Commissioner emphasizes that these cases relate to Title X, which contains specific text addressing who exactly is eligible for Title X grants. Nonetheless, the Court believes that the basic principle espoused in those cases still holds true in the context of 42 U.S.C. § 247c. The statute does not suggest that states are permitted to determine eligibility criteria for the DIS grants. To the contrary, the operative regulations clarify that upon awarding the funds, the federal government may "impose additional conditions, including conditions governing the use of information or consent forms, when, in the [federal government's] judgment, they are

necessary to advance the approved program, the interest of public health, or the conservation of grant funds.” 42 C.F.R. § 51b.106(e). For these reasons, the Court finds that Plaintiffs have established a reasonable likelihood of success on the merits of their preemption argument relating to DIS funds.

D. Irreparable Harm

In order to prevail on a motion for a preliminary injunction, Plaintiffs must establish that the denial of an injunction will result in irreparable harm. “‘Irreparable’ in the injunction context means not rectifiable by the entry of a final judgment.” *Walgreen Co. v. Sara Creek Property Co.*, 966 F.2d 273, 275 (7th Cir. 1992) (citations omitted). Simply stated, Plaintiffs have satisfied this burden.

HEA 1210 has already affected PPIN in tangible ways. Specifically, PPIN has ceased performing services under the DIS grant and is unable to take new Medicaid patients. Moreover, absent an injunction, Plaintiffs Letitia Clemons and Dejiona Jackson will not be able to receive certain medical services from their Medicaid providers of choice. The denial of freedom of choice has been deemed to be irreparable harm. *Bay Ridge*, 400 F. Supp. At 1108-12.

Also, as discussed above, HEA 1210 has and will continue to dramatically affect PPIN’s operations. PPIN estimates that the new law will force it to close seven health centers and eliminate roughly 37 positions. *See Canterbury Career School, Inc. v. Riley*, 833 F. Supp. 1097, 1105 (D.N.J. 1993) (“Where the result of denying injunctive relief would be the destruction of an ongoing business, such a result generally constitutes irreparable injury.”). More importantly, PPIN’s Medicaid services ceased on June 20, 2011. According to PPIN, thousands of patients have lost or will lose their healthcare provider of choice.

It is true that, as the Commissioner emphasized at oral arguments, PPIN has been the recent recipient of an upsurge in donations from locations spanning the country, even the globe. This newfound influx of cash has allowed PPIN to service existing Medicaid patients and sustain most of its basic operations. Undoubtedly, though, these donations were something of an aberration, presumably fueled by the prominence of HEA 1210 in the news cycle. Common sense suggests that as headlines fade, passions will cool and donations will level off. Thus, with the passage of time, PPIN will be forced to confront the dire financial effects of HEA 1210 head-on. These circumstances warrant granting a preliminary injunction.

E. Balance of Harms and the Public Interest

Where, as here, the party opposing the motion for a preliminary injunction is a political branch of government, “the court must consider that all judicial interference with a public program has the cost of diminishing the scope of democratic governance.” *Illinois Bell Telephone Co. v. Worldcom Technologies, Inc.*, 157 F.3d 500, 503 (7th Cir. 1998). Highlighting this principle, the Commissioner emphasizes that the defunding provision promotes the public interest by preventing taxpayer dollars from indirectly funding abortions.

As an initial matter, the Commissioner’s argument ignores the fact that PPIN complies with all state and federal requirements to ensure that taxpayer dollars are not used for abortion services. For the reasons described above in the irreparable harm section, the Court finds that the balance of harms tilts in Plaintiffs’ favor.

Further, in light of recent events, the public interest also tilts in favor of granting an injunction. The federal government has threatened partial or total withholding of federal Medicaid dollars to the State of Indiana, which could total well over \$5 billion dollars annually and affect nearly 1 million Hoosiers. Thus, denying the injunction could pit the federal

government against the State of Indiana in a high-stakes political impasse. And if dogma trumps pragmatism and neither side budes, Indiana's most vulnerable citizens could end up paying the price as the collateral damage of a partisan battle. With this backdrop in mind, along with the reasons discussed above, the Court believes the most prudent course of action is to enjoin the defunding provision while the judicial process runs its course.

IV. INFORMED CONSENT PROVISION

A. Background

In addition to the defunding provision, PPIN challenges two sections of the informed consent provision of HEA 1210. Ind. Code § 16-34-2-1.1(a)(1)(E) and (G), which amend the existing law relating to abortion informed consent requirements and are scheduled to go into effect on July 1, 2011. Plaintiffs contend that these two sections constitute impermissible compelled speech.

Specifically, the contested sections require that certain medical practitioners⁸ involved in abortions services ("Practitioners") inform women seeking abortions that "objective scientific information shows that a fetus can feel pain at or before twenty weeks of postfertilization age" and that "human physical life begins when a human ovum is fertilized by a human sperm." In relevant part, the challenged portions of the new informed consent provisions read as follows:

- (a) An abortion shall not be performed except with the voluntary and informed consent of the pregnant woman upon whom the abortion is to be performed. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if the following conditions are met:
 - (1) At least eighteen (18) hours before the abortion and in the presence of the pregnant woman, the physician who is to perform the abortion, the referring physician or a physician assistant (as defined in IC 25-27.5-2-10), an advanced practice nurse (as defined in IC 25-23-1-1(b)), or a midwife (as defined in IC 34-18-2-19) to whom the responsibility has

⁸ The Practitioner may be the physician who is to perform the abortion, the referring physician, a physician assistant, advanced practice nurse, or midwife to whom the responsibility has been delegated.

been delegated by the physician who is to perform the abortion or the referring physician has informed the pregnant woman **orally and in writing** of the following:

(E) That human physical life begins when a human ovum is fertilized by a human sperm.

...

(F) That objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age.

Indiana Code § 16-34-2-1.1(a) (effective July 1, 2011) (emphasis added).

B. Legal Standard

The Court has already articulated the standard for a preliminary injunction and need not do so again. However, it is worth noting that where, as here, “a party seeks a preliminary injunction on the basis of a potential First Amendment violation, the likelihood of success on the merits will often be the determinative factor.” *Joelner v. Village of Washington Park, Illinois*, 378 F.3d 613, 620 (7th Cir. 2004) (internal citation omitted). “The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury,” *Elrod v. Burns*, 427 U.S. 347, 373 (1976), “and money damages are therefore inadequate.” *Id.* (internal citations omitted). “Concomitantly, there can be no irreparable harm to a municipality when it is prevented from enforcing an unconstitutional statute because it is always in the public interest to protect First Amendment liberties.” *Id.* (internal and citations quotations omitted). Based on these standards, the Court believes if Plaintiffs can show a likelihood of success on the merits, then the contested sections of the statute should be enjoined.

C. Likelihood of Success on the Merits

In order to properly analyze Plaintiffs’ likelihood of success on the merits, the Court must first examine the law relating to a Practitioners’ First Amendment rights in the context of informed consent requirements. The Court must then determine whether, based upon those

parameters, the statements mandated by Ind. Code § 16-34-2-1.1(a)(1)(E) and (G) constitute impermissible compelled speech.

1. First Amendment Rights of Practitioners

The Supreme Court has found violations of the First Amendment where private individuals are forced to propound government-dictated messages. *See, e.g., Wooley v. Maynard*, 430 U.S. 705, 714 (1977); *Miami Herald Publ'g Co. v. Tornillo*, 418 U.S. 241 (1974); *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943). “[T]he right of freedom of thought protected by the First Amendment against state action includes both the right to speak freely and the right to refrain from speaking at all.” *Wooley*, 430 U.S. at 714.

Compelled speech occurs when the state “penalizes the expression of particular points of view and forces speakers to alter their speech to conform with an agenda that they do not set.” *Entertainment Software Ass'n v. Blagojevich*, 404 F. Supp. 2d 1051, 1082 (N.D. Ill. 2005) (quoting *Pac. Gas & Elec. Co. v. Pub. Util. Comm'n of Calif.*, 475 U.S. 1, 9 (1986)). Where the State's interest is to disseminate an ideology, no matter how acceptable to some, such interest cannot outweigh an individual's First Amendment right to avoid becoming the *courier* for such message. *Wooley*, 430 U.S. at 716.

Against this greater backdrop of the First Amendment right not to speak, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992) (plurality opinion), the Supreme Court considered informed consent legislation impacting the speech rights of Practitioners within the context of their practice and profession. The *Casey* Court succinctly stated:

To be sure, the physician's First Amendment rights not to speak are implicated, *see Wooley v. Maynard*, 430 U.S. 705, 97 S.Ct. 1428, 51 L.Ed.2d 752 (1977), but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State.

Id. at 884. (internal citations omitted). As confirmed by *Casey*, Practitioners' First Amendment rights not to speak are implicated when a statute requires a Practitioner to disseminate particular content to patients seeking to have an abortion; however, these free speech rights are not without restriction or reasonable regulation by the state. *Id.*; see also *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) ("Under our precedents it is clear the State has a significant role to play in regulating the medical profession.").

The state's interest in potential life may be advanced by legislation crafted to ensure that the woman apprehends the full consequences of her decision. *Casey*, 505 U.S. at 882-83. And, as a general matter, a state has wide latitude in imposing regulations that are designed to ensure that "a woman makes a thoughtful and informed choice." *Karlin v. Foust*, 188 F.3d 446, 491 (7th Cir. 1999). Along the same lines, the Supreme Court found that state informed consent legislation aimed at ensuring a "mature and informed" decision is permitted, even when through the legislation "the State expresses a preference for childbirth over abortion." *Casey*, 505 U.S. at 882-83.

In order to ensure that woman's choice is fully informed, the mandated statements need not be restricted to information related to the medical procedure. State informed consent legislation "need not be defined in such narrow terms that all considerations of the effect on the fetus are made irrelevant." *Id.* In *Casey*, the Supreme Court established that mandated statements relating to the nature of the procedure, the attendant health risks and those of childbirth, and the "probable gestational age" of the fetus were permitted. *Id.* "Requiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to ensure an informed choice, one which might cause the woman to choose childbirth over abortion."

Casey, 505 U.S. at 883; *Summit Medical Center of Alabama, Inc. v. Riley*, 274 F. Supp. 2d 1262, 1270 (M.D. Ala. 2003). Ultimately, the *Casey* Court found that “[i]n attempting to ensure that a woman apprehends the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.” *Id.*

Where the required speech is truthful, non-misleading, and relevant to the patient’s decision to have the abortion, no violation of the physician’s right not to speak can be found without further analysis into whether the requirement was narrowly tailored to serve a compelling state interest. *Casey*, at 505 U.S. 882; *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, 530 F.3d 724, 734 (8th Cir. 2008). The question for the Court, therefore, is whether the mandated statements required by the challenged informed consent provisions are truthful, non-misleading, and relevant to a patient’s decision to have an abortion. The Court will discuss each Section in turn.

2. Ind. Code § 16-34-2-1.1(a)(1)(E) – Human Physical Life

Section 16-34-2-1.1(a)(1)(E) requires that the Practitioner inform the woman seeking an abortion that “human physical life begins when a human ovum is fertilized by a human sperm.” Notably, the term “human physical life” is neither a medical term nor statutorily defined. The question arises: Does this statement amount to compelled speech in violation of Practitioners’ First Amendment rights?

The Supreme Court has been loath to address issues relating to the genesis of life. In *Roe v. Wade*, 410 U.S. 113 (1979), the Supreme Court expressed the belief that the question of when human life begins is moral, philosophical, and theological in origin. In its ruling, the Supreme Court stated, “When those trained in the respective disciplines of medicine, philosophy,

and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.” *Id.* at 159. “We need not resolve the difficult question of when life begins.” *Id.* On several occasions post-*Roe*, the Supreme Court has reaffirmed its reticence to define when human life begins. *City of Akron v. Akron Center of Reproductive Health, Inc.*, 462 U.S. 416, 444 (1983) (overruled on other grounds).

Plaintiffs argue that classifying the fertilized egg and subsequent organism as a “human physical life” is an ideological statement that goes to the heart of the abortion debate and is thus impermissible compelled speech. The Commissioner disagrees, framing the statement as a biological truth conveying the fact that postfertilization, the existing living organism is indeed a “human physical life.” The Commissioner has some support for its position. Specifically, Maureen L. Condic, Ph.D, a Professor of Neurobiology and Anatomy at the University Of Utah School Of Medicine whose primary research focuses has been the development and regeneration of the nervous system, testified as follows:

The unique behavior and molecular composition of embryos, from their initiation at sperm-egg fusion onward, can be readily observed and manipulated in the laboratory using the scientific method. Thus, the conclusion that a human zygote is a human being (i.e. a human organism) is not a matter of religious belief, societal convention or emotional reaction. It is a matter of observable, objective, scientific fact.

(Dkt. 28-8 at 5).⁹

The Commissioner argues that the mandated statement is simply a scientific fact referring to the “full and complete, albeit developmentally immature, *human organism* [which] comes into existence at the fusion of sperm and egg.” (Dkt. 28 at 3). The Commissioner further asserts that

⁹ Dr. Condic’s testimony is contrary to assertions made in Plaintiff’s declarations. Having weighed the testimony of all declarants, the Court resolves this conflict in Defendants favor.

the term “human physical life” is a ‘biological truism’ supported by objective scientific evidence.¹⁰ To bolster its argument, the Commissioner relies heavily on *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, 530 F.3d 724, 742 (8th Cir. 2008). However, it is worth noting that *Rounds* made clear that its decision was based in part on the fact that “human being” was a statutorily defined term. *Id.* at 733. (“In the instant case, the district court rested its conclusion on an error of law when it ignored the statutory definition of “human being” in § 8(4) of the Act). Because the words used in Section 16-34-2-1.1(a)(1)(E) are *not* statutorily defined, they are given their plain, ordinary and usual meaning. *VanHorn v. Statem*, 889 N.E.2d 908, 911 (Ind. Ct. App. 2008); *see also Redden v. State*, 850 N.E.2d 451, 463 (Ind. Ct. App. 2006), *trans. denied*.

“In order to determine the plain and ordinary meaning of words, courts may properly consult English language dictionaries.” *Id.* (quoting *Redden*, 850 N.E.2d at 463). Here, the words “human,” “physical,” and “life”¹¹ are all used frequently in common parlance. Nevertheless, Plaintiffs contend that in the context of abortion, the meaning of these words, both individually

¹⁰ The Court will not delve deeply into the Commissioner’s contention that a living organism is formed at successful fertilization. This point is undisputed by Plaintiffs. The issue presently before the Court is whether “physical human life” is a consummation of these undisputed medical facts regarding fertilization and the resulting living organism. Further, in *Gonzales v. Carhart*, 550 U.S. 124 (2007), the Supreme Court stated that by common understanding and scientific terminology, a fetus is a living organism while within the womb.

¹¹ Compare Merriam-Webster Collegiate Dictionary (11th ed. 2008) which defines “human” as 1) of, relating to, or characteristic of humans, 2) homo sapiens; “physical” as of or relating to natural science, having material existence, of or relating to the body; and “life” as 1) the quality that distinguishes a vital and functional being from a dead body, a principle or force that is considered to underlie the distinctive quality of animate beings, an organismic state characterized by capacity for metabolism, growth, reaction to stimuli, and reproduction, and 2) the period from birth to death, a specific phase of earthly existence with The American Heritage Dictionary which defines “human” as of, relating to, or characteristic of human beings; “physical” as ‘of or relating to the body as distinguished from the mind or spirit’; and “life” as 1) the property or quality that distinguishes living organisms from dead organisms and inanimate matter, manifested in functions such as metabolism, growth, reproduction, and response to stimuli or adaptation to the environment originating from within the organism, 2) the characteristic state or condition of a living organism, 3) a living being, especially a person, 4) the physical, mental, and spiritual experiences that constitute existence, 5) the interval of time between birth and death.

and in combination, represent a plethora of opinions and beliefs about life and its inception. The Court respectfully disagrees. When read together, the language crafted by the legislature in this provision supports a finding that the mandated statement refers exclusively to a growing organism that is a member of the *Homo sapiens* species.

Although the Court recognizes that the term “human being” may refer to a theological, ideological designation relating to the metaphysical characteristics of life, that is not the language found before the Court today. Rather, the inclusion of the biology-based word “physical” is significant, narrowing this statement to biological characteristics. The adjectives “human” and “physical” reveal that the legislature mandated only that the Practitioner inform the woman that at conception, a living organism of the species *Homo sapiens* is created. When the statement is read as a whole” it does not require a physician to address whether the embryo or fetus is a “human life” in the metaphysical sense.

Further, this Court finds that Ind. Code Section 16-34-2-1.1(a)(1)(E)’s mandated statement is not misleading. In *Casey*, the controlling opinion held that an informed consent requirement in the abortion context was “no different from a requirement that a doctor give certain specific information about any medical procedure.” *Casey*, 505 U.S., at 884; *see also Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Informed consent provisions serve not only to communicate information that would not necessarily be known to the patient, but also help the woman to make a fully informed decision. “Requiring that the woman be informed of the availability of information relating to fetal development ... is a reasonable measure to ensure an informed choice.” *Casey*, 505 U.S. at 883. Here, the mandated statement states only a biological fact relating to the development of the living organism; therefore, it may be reasonably read to provide accurate, non-misleading information to the patient.

Under Indiana law, a physician must disclose the facts and risks of a treatment which a reasonably prudent physician would be expected to disclose under like circumstances, and which a reasonable person would want to know. *Spar v. Cha*, 907 N.E.2d 974, 984 (Ind. 2009); *see also Weinberg v. Bess*, 717 N.E.2d 584, 588 n.5 (Ind. 1999). In *Casey*, the Supreme Court recognized that mandated statements need not be restricted to information related to the medical procedure, or materials concerning carrying the fetus to term. *Casey*, U.S. at 882. (“We also see no reason why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health.”). The overarching consideration was “to ensure that a woman apprehend the full consequences of her decision,” and through this, “the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.” *Id.* “If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible.” *Id.*

The Court’s ruling is reinforced by the deference owed the Indiana legislature. The Supreme Court has articulated that “[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people.” *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 329 (2006) (quoting *Regan v. Time, Inc.*, 468 U.S. 641, 652, 104 S.Ct. 3262, 82 L.Ed.2d 487 (1984)). Because Ind. Code § 16-34-2-1.1(a)(1)(E)’s mandated statement reflects only the moment, biologically speaking, a living organism of the human species is formed, the Court is not persuaded that PPIN has demonstrated a reasonable likelihood of success on the merits. As the Supreme Court has observed, “A preliminary injunction is an extraordinary and drastic remedy, one that should not be granted unless the movant, by a *clear showing*, carries the

burden of persuasion.” *Mazurek v. Armstrong*, 520 U.S. 968, 972, (1997) This Court finds that PPIN has not met its requisite burden. The Motion for Injunctive Relief as to Section 16-34-2.1.1(a)(1)(E) is **DENIED**.

3. Ind. Code § 16-34-2-1.1(a)(1)(G) – Fetal Pain

Ind. Code § 16-34-2-1.1(a)(1)(G) relates to the fetus and its potential ability to feel pain. Specifically, this provision requires the Practitioner to inform the woman seeking an abortion that ‘*objective scientific information*’ – a term statutorily defined as “data that have been reasonably derived from scientific literature and verified or supported by research in compliance with scientific methods”¹² – shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age. This section’s mandated statement is based upon the following legislative findings, enacted as part of the bill:

- 1) There is substantial medical evidence that a fetus at twenty (20) weeks of postfertilization age has the physical structures necessary to experience pain.
- 2) There is substantial medical evidence that a fetus of at least twenty (20) weeks of postfertilization age seeks to evade certain stimuli in a manner similar to an infant’s or adult’s response to pain.
- 3) Anesthesia is routinely administered to a fetus of at least twenty (20) weeks of postfertilization age when prenatal surgery is performed.
- 4) A fetus has been observed to exhibit hormonal stress responses to painful stimuli earlier than at twenty (20) weeks of postfertilization age.

2011 Ind. Legis. Serv. P.L. 193-2011, Sec. 6.

The Commissioner contends that based upon the statutory definition of “objective scientific information” and the legislative findings enacted as part of the bill, Ind. Code § 16-34-2-1.1(a)(1)(G)’s statement is truthful, non-misleading, and relevant. In the context of Plaintiffs’ as-applied challenge, however, the Court respectfully disagrees.

¹² Ind. Code § 16-18-2-254.2 (effective July 1, 2011).

The Commissioner presents evidence in the form of articles, affidavits, declarations, and reports relating to the present research and growing science of fetal pain perception. The Commissioner principally argues that in order to be “objective scientific information” as defined by the statute and therefore truthful and non-misleading, the statement need not be the ‘majority’ view within the scientific community. Instead, it need only be reasonably derived or supported by research in compliance with scientific methods. *Gonzales v. Carhart*, 550 U.S. 124, 129 (2007) (“Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts.”).

Although this argument has merit, the Court has been given no evidence to support the finding that within the scientific community even a minority view exists that contends pain perception is possible during the first trimester of pregnancy – the time during which PPIN *exclusively* performs its abortion services.¹³ The Commissioner’s evidence posits only preliminary evidence that may support the *inference* that pain is felt by a fetus at as early as *sixteen (16) weeks* postfertilization.

Evidentiary documents that contain statements such as “the substrate and mechanisms for conscious pain perception are developed in a fetus *well before* the third trimester of human gestation,”¹⁴ “by twenty weeks, *perhaps even earlier*, all the essential components of anatomy, physiology, and neurobiology exist to transmit painful sensations from the skin to the spinal cord and to the brain,”¹⁵ “therapeutic response in pain receptors of fetuses at *16-21 weeks*,”¹⁶ and “we

¹³ Notably, PPIN performs 100% of its abortions within the first 12 weeks postfertilization and 92% of abortions performed in the state of Indiana, take place during the first trimester.

¹⁴ Def.’s Ex. E at 2 (*A Scientific Appraisal of Fetal Pain and Conscious Sensory Perception: Hearing on H.R. 356 Before the U.S. House Committee on the Judiciary*, 109th Cong. 2 (2005) (written statement of K. J. S. Anand, MBBS, D.Phil., FAAP, FCCM, FRCPCH)).

¹⁵ Def.’s Ex. F at 3 (*Testimony, Hearing on H.R. 356 Before the U.S. House Committee on the Judiciary*, 109th Cong. 1 (2005) (statement of Jean A. Wright MD MBA)).

cannot dismiss the *high likelihood of fetal pain perception before the third trimester*,”¹⁷ do not show that a fetus at twelve weeks or earlier of postfertilization can feel pain. Nor do they support a view that has been reasonably derived from scientific literature and verified or supported by research in compliance with scientific methods. Even in its own statement of facts, the Commissioner admits only that “[m]ultiple lines of scientific evidence converge to support the conclusion that the human fetus can experience pain from 20 weeks of gestation, and *possibly as early as 16 weeks of gestation*.” (Dkt. 28 at 3) (emphasis added). Importantly, the Commissioner conceded at oral arguments that to his knowledge, there is no objective scientific information that a fetus can feel pain at 12 weeks.

Because PPIN exclusively performs abortion services on patients in their first trimester, this Court finds that Plaintiffs have provided sufficient evidence demonstrating that requiring PPIN Practitioners to state that “objective scientific information shows that a fetus can feel pain at or before twenty week of postfertilization age” may be false, misleading, and irrelevant. In this as-applied challenge, PPIN has demonstrated likelihood of success on the merits. When a party seeks a preliminary injunction on the basis of a potential First Amendment violation, the likelihood of success on the merits will often be the determinative factor. Here, the Court has found that Plaintiffs’ possess the requisite likelihood of success on the merits that the mandated statement found in § 16-34-2-1.1(a)(1)(G) would constitute impermissible compelled speech. The loss of First Amendment freedoms, for even minimal periods of time, constitutes irreparable injury.

¹⁶ Def.’s Ex. G at 3 (Decl. of Jean A. Wright).

¹⁷ Def.’s Ex. E, A scientific appraisal of Fetal Pain and Conscious Sensory Perception, Written testimony of: K. J. S. Anand, MBBS, D.Phil., FAAP, FCCM, FRCPCH.

In its briefing, the Commissioner addressed the possibility that the Court might find it misleading to tell a first-trimester patient that her fetus would feel pain at or before twenty weeks postfertilization. (Dkt. 28 at 31). Relying on *Ayotte*, 546 U.S. at 328-29, the Commissioner argues that facial invalidation is disfavored, even in abortion-regulation cases, and that the Court may not enjoin application of the provision in its entirety. The Court is persuaded. The enjoining of § 16-34-2-1.1(a)(1)(G), as applied only to Plaintiffs, cannot be shown to inflict irreparable harm to Defendants when the injunction prevents the enforcement of a potentially unconstitutional statute. It is always in the public interest to protect First Amendment liberties. Although a preliminary injunction is an “extraordinary remedy,” based upon the aforementioned analysis, the Court finds that Plaintiffs have made the requisite showing. Accordingly, the Court **GRANTS** Plaintiffs’ Motion and enjoins the enforcement of Ind. Code § 16-34-2-1.1(a)(1)(G) as applied to Plaintiffs’ performance of first-trimester abortions.

V. CONCLUSION

For the reasons set forth below, Plaintiffs’ Motion for Preliminary Injunction (Dkt. 9) is **GRANTED** with respect to the defunding provision, **DENIED** with respect to Ind. Code § 16-34-2-1.1(a)(1)(E) and **GRANTED** with respect to Ind. Code § 16-34-1.1(a)(1)(G) as applied to Plaintiffs only.

A preliminary injunction is therefore issued in this case as follows:

- (1) All attempts to stop current or future funding contracted for or due PPIN should be enjoined and defendants ISDH, Director of the Indiana State Budget Agency, Commissioner of the Indiana Department of Administration, and FSSA should be enjoined to take all steps to insure that all monies are paid.
- (2) The informed consent provision of Ind. Code § 16-34-2-1.1(a)(1)(G) shall be enjoined as applied to Plaintiffs, and Defendants ISHD and the Marion, Monroe and Tippecanoe County Prosecutors shall be enjoined from taking any actions against Plaintiffs for failure to comply with this provision as-applied to first trimester abortions only.

The issuance of a preliminary injunction will not impose any monetary injuries. In the absence of such injuries, **NO BOND** is required.

IT IS SO ORDERED.

Date: 06/24/2011


Hon. Tanya Walton Pratt, Judge
United States District Court
Southern District of Indiana

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