IN THE SUPREME COURT OF THE STATE OF MONTANA
No. DA 23-0287

PLANNED PARENTHOOD OF MONTANA, *et al.*,

Plaintiffs and Appellees,

v.

STATE OF MONTANA, *et al.*,

Defendants and Appellants.

On appeal from the Montana First Judicial District Court, Lewis and Clark County
Cause No. ADV 23-299, the Honorable Mike Menahan, Presiding

BRIEF OF *AMICUS CURIAE* NATIONAL HEALTH LAW PROGRAM IN SUPPORT OF APPELLEES AND URGING AFFIRMANCE

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STATEMENT OF INTEREST OF AMICUS CURIAE

Founded in 1969, *amicus curiae* the National Health Law Program (NHeLP) is a public interest organization dedicated to advancing access to quality health care, including the full range of reproductive health care services, and protecting the legal rights of low-income and other underserved individuals. To achieve its mission, *amicus curiae* advocates, educates, and litigates at the state and federal levels.

House Bill 862 (2023), House Bill 544 (2023), and the challenged Department of Public Health and Human Services rule, 8 Mont. Admin. Reg. 414 (April 28, 2023), (collectively, "the Challenged Restrictions") severely limit coverage of abortion services for Montana residents who are enrolled in the Medicaid program. HB 544 and the DPHHS rule limit coverage by: (1) narrowly defining when an abortion is medically necessary; (2) only permitting coverage for abortions performed by a physician; and (3) imposing prior authorization requirements that, in effect, eliminate coverage of medication abortions provided via telehealth. HB 862 bans coverage of abortion services except when the pregnancy is the result of rape or incest or when an abortion is necessary to save the life of the pregnant person.

By limiting coverage of abortion services in these ways, the Challenged Restrictions dramatically curtail access to necessary health care services among

Montana Medicaid enrollees. Doc. 62 at 2. NHeLP submits this brief to bring information to the Court about who is eligible for Medicaid in Montana due to pregnancy and who will be disproportionately affected by the elimination of coverage for abortion services provided to Medicaid enrollees via telehealth.

SUMMARY OF THE ARGUMENT

In Montana, only pregnant individuals with very low incomes qualify for Medicaid coverage. American Indian and Alaska Native (AI/AN) Montanans are disproportionately likely to rely on Medicaid for their health care coverage. Similarly, AI/AN individuals and women are disproportionately likely to rely on telehealth to receive care. In addition, telehealth is particularly critical for low-income individuals living in rural areas of Montana, where there is limited access to quality, in-person health care services, including abortion services. As a result, the Challenged Restrictions cause outsize harm to these Montanans.

ARGUMENT

I. Montanans Who Are Eligible for Medicaid

Title XIX of the Social Security Act establishes the federal-state partnership program known as the Medicaid program. *See* 42 U.S.C. §§ 1396-1396w-7 ("the Medicaid Act"). Congress enacted the Medicaid Act to enable states to provide "medical assistance" to families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services." *Id*. § 1396-1.

The Medicaid Act describes the population groups that are eligible to receive medical assistance. *Id*. § 1396a(a)(10)(A), (C). States must provide coverage to certain population groups, *see id*. § 1396a(a)(10)(A)(i), and have the option to provide coverage to other population groups, *see id*. § 1396a(a)(10)(A)(ii), 1396a(a)(10)(C). To receive coverage, individuals who fall within a covered group must meet the financial eligibility criteria applicable to that group, reside in the state in which they apply, and have U.S. citizenship or qualified immigration status. *Id*. § 1396a(a)(10)(A), 1396a(b)(2), (b)(3); 8 U.S.C. §§ 1611, 1641.

One mandatory population group is pregnant women. 42 U.S.C. § 1396a(a)(10)(A)(i)(III), (IV). The minimum income eligibility cap for this group varies by state, but ranges from 133% to 185% of the federal poverty level (FPL). *Id*. § 1396a(a)(10)(A)(i)(IV), 1396a(l)(1)(A), 1396a(l)(2)(A); States have the option to cover pregnant women with higher household incomes. *Id*. § 1396a(a)(10)(A)(ii)(IX). To be eligible for Medicaid coverage in Montana due to pregnancy, individuals must have a household income below 157% of the FPL. Mont. Dep't of Pub. Health & Hum. Servs., *Medicaid in Montana* 10 (2023), https://dphhs.mt.gov/assets/2023Legislature/2023MedicaidinMontanaReport.pdf ("Medicaid in Montana"). Compared to other states, Montana has one of the lowest income eligibility limits for pregnant people. *See* Kaiser Fam. Found., *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the*

Federal Poverty Level (Jan. 1, 2023), https://bit.ly/3S6zd6n (adding a 5% income disregard, as provided for in the Medicaid Act, and showing Montana tied for the ninth lowest eligibility cut-off). Currently, 157% of the FPL equates to an annual income of $32,091 for a household of two and $48,984 for a household of four. *See* Dep't of Health & Hum. Servs., Annual Update of the HHS Poverty Guidelines, 89 Fed. Reg. 2961, 2962 (Jan. 17, 2024).

Certainly, before they become pregnant, some individuals are already enrolled in Medicaid through a different coverage group. Some of the most common eligibility categories for adults of child-bearing age include parents, *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(I), the Medicaid expansion group, *see id*. § 1396a(a)(10)(A)(i)(VIII), and individuals who receive Supplemental Security Income benefits due to disability, *id*. § 1396a(a)(10)(A)(i)(II). The income eligibility cap for each of those categories is lower than 157% of the FPL. *See* Medicaid in Montana at 10-12. As a result, pregnant individuals who qualify for Medicaid coverage in Montana generally have very low incomes.[1]

Due to a variety of historical, political, and economic factors, the poverty rate among AI/AN individuals in Montana (33.7%) is more than three times higher

[1] Individuals with higher incomes and substantial medical expenses may be able to qualify for Medicaid as "medically needy" when they spend their excess income on health care services. *See* 42 U.S.C. § 1396a(a)(10)(C); Medicaid in Montana at 13 (noting the medically needy income level is $525/month for individuals and couples).

than the poverty rate among White individuals in the State (10.6%). Kaiser Fam. Found., *Poverty Rate by Race/Ethnicity* (2022), https://bit.ly/3H7GBrS. Similarly, the poverty rate is two-and-a-half times higher among Hispanic Montanans (26.9%). *Id*.

As a result, AI/AN and Hispanic individuals disproportionately rely on Medicaid for their health care coverage.[2] AI/AN and Hispanic individuals account for only 6.5% and 4.5%, respectively, of the total population of Montana, U.S. Census Bur., *QuickFacts, Montana* (July 1, 2023), https://census.gov/quickfacts/MT, but 12% and 9.5%, respectively, of nonelderly Medicaid enrollees in the State.[3] Kaiser Fam. Found., *Distribution of the Nonelderly with Medicaid by Race/Ethnicity* (2022), https://bit.ly/3NSDMi9. Conversely, White (non-Hispanic) individuals account for roughly 85% of the State population, U.S. Census Bur., *supra*, but only 70% of nonelderly Medicaid enrollees. *Distribution of the Nonelderly with Medicaid by Race/Ethnicity*, *supra*.

[2] There are additional potential reasons for this. For example, when compared to White individuals, AI/AN adults are significantly less likely to have access to private health insurance coverage, *see* Latoya Hill & Samantha Artiga, Kaiser Fam. Found., *Health Coverage Among American Indian and Alaska Native and Native Hawaiian and Other Pacific Islander People* (2023), https://bit.ly/3U1ZYKR, and as discussed below, significantly more likely to have a disability.

[3] Individuals who identify as two or more races also disproportionately rely on Medicaid for their health care coverage. *See* U.S. Census Bur., *supra* (3% of the population); *Distribution of the Nonelderly with Medicaid by Race/Ethnicity*, *supra* (7.9% of Medicaid enrollees).

The disparity is even starker among pregnant individuals, with AI/AN individuals making up over 20% of all pregnant Medicaid enrollees in Montana. Mont. Dep't Pub. Health & Hum. Servs., *Montana Medicaid Enrollment Dashboard, Medicaid and CHIP Enrollment October 2023* (Jan. 3, 2024), https://dphhs.mt.gov/interactivedashboards/medicaidenrollmentdashboard.

Similarly, individuals with a disability disproportionately rely on Medicaid for their health coverage. In Montana, approximately 18% of the general population has a disability, while nearly 37% of Medicaid enrollees have a disability. State Health Access Data Assistance Ctr., *Collection of Self-Reported Disability Data in Medicaid Applications: A Fifty-State Review of the Current Landscape* 14 (2024), https://www.shvs.org/wp-content/uploads/2024/01/Collection-of-Self-Reported-Disability-Data-in-Medicaid-Applications_SHVS.pdf. Most Medicaid enrollees who have a disability qualified for the program on a basis other than disability. *Id*. at 2; *see also* MaryBeth Musumeci & Kendal Orgera, Kaiser Fam. Found., *People with Disabilities Are At Risk of Losing Medicaid Coverage Without the ACA Expansion* (2020), bit.ly/4bff3Pi (finding that more than six in ten nonelderly adult Medicaid enrollees with a disability do not receive SSI). Notably, nationwide data show that AI/AN adults are significantly more likely than any other racial or ethnic group to have a disability. *See* Ctrs. for Disease Control & Prevention, *Adults with*

Disabilities: Ethnicity and Race (Sept. 16, 2020), https://www.cdc.gov/ncbddd/disabilityandhealth/materials/infographic-disabilities-ethnicity-race.html.

II. Montanans Who Need to Access Services Via Telehealth

Some groups of individuals are more likely to rely on telehealth to access health care. According to a nationwide survey conducted in 2021, women are more likely than men to use telehealth. Jacqueline W. Lucas et al., Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Stat., *Data Brief No. 445, Telemedicine Use Among Adults: United States*, 2021 at 1 (2022), https://www.cdc.gov/nchs/data/databriefs/db445.pdf (finding approximately 42% of women and 32% of men used telemedicine in the past 12 months). AI/AN individuals are also more likely than any other racial or ethnic group to use telehealth.[4] *Id*. at 2.

A number of studies conducted prior to the COVID-19 pandemic showed that individuals living in rural areas are more likely to use telehealth than those

[4] Research suggests that the rate of telehealth use among individuals of different racial or ethnic backgrounds is not consistent across the income spectrum. *See, e.g.*, Cynthia Williams & Di Shang, *Telehealth Usage Among Low-Income Racial and Ethnic Minority Populations During the COVID-19 Pandemic: Retrospective Observational Study*, J. Med. Internet Rsch. May 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10185335/ (finding, in contrast to studies including individuals with a range of incomes, among individuals with incomes below 200% of FPL, Hispanic patients had higher odds of using telehealth services than non-Hispanic White and Black patients).

living in urban areas. *See, e.g.*, Jean A Talbot et al., *Patterns of Telehealth Use Among Rural Medicaid Beneficiaries*, 35 J. Rural Health 298 (2019), https://pubmed.ncbi.nlm.nih.gov/30288808/ (finding that in 2011, rural Medicaid beneficiaries were more likely than their urban counterparts to use telehealth services); Lincoln R. Sheets et al., *Similarities and Differences Between Rural and Urban Telemedicine Utilization*, Persps. Health Info. Mgmt., Winter 2021, at 7, https://pubmed.ncbi.nlm.nih.gov/33633515/ (examining telemedicine visits with University of Missouri Health Care from 2008 to 2017 and finding that rural patients were nearly four times more likely than urban patients to use telemedicine services). While it is not yet entirely clear where the geographic distribution of telehealth patients will settle now that the public health emergency is over, it is abundantly clear that telehealth is critical for improving access to quality health care in rural areas. Many individuals in rural areas have limited access to care, particularly specialty care, making telehealth an effective tool for reducing the rural health gap. *See generally* Shreya Kolluri et al., *Telehealth in Response to the Rural Health Disparity*, Health Psych. Rsch., Aug. 2022, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9392842/.

Indeed, research demonstrates the importance of telehealth for individuals in rural areas who need abortion care. One recent study involving patients receiving abortion services via telehealth from a clinic in Washington found that individuals

living further from the clinic were more likely to opt for a telehealth appointment. *See* Anna E. Fiastro et al., *Telehealth vs. In-Clinic Medication Abortion Services*, JAMA Network Open, Sept. 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10474522/. A second recent study found that telehealth was more likely to make timely access to abortion possible for patients living in rural areas (vs. urban areas) and for patients who avoided more than 100 miles of round-trip driving (vs. fewer miles of round-trip driving) by receiving services via telehealth. *See* Leah R. Koenig et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, JMIR Pub. Health & Surveillance, Nov. 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10664017/ (concluding that telehealth "has the potential to address geographic inequities in access to care for those living in abortion deserts or rural areas" within states where abortion is legal). *See also* Fekede Asefa Kumsa et al., *Medicaid Abortion Via Digital Health in the United States: A Systematic Scoping Review*, 6 NPJ Digit. Med. 128 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10338479/ (conducting a review of the literature and determining that telehealth increases access to abortion care, especially for patients living in remote places).

Given the size of Montana, its many rural areas, and the scarcity of abortion providers in the State, coverage of abortion services provided via telehealth is

particularly critical. For example, without the option of receiving care via telehealth, individuals living on the Fort Peck Indian Reservation in need of abortion care would have no choice but to travel more than four-and-a-half hours each way to the nearest abortion clinic in Billings. *See* Doc. 44 at ¶¶ 13, 17, 19 (noting the locations of abortion providers in the State); googlemaps.com (directions from Fort Peck Indian Reservation to Planned Parenthood in Billings) (last accessed Jan. 27, 2024).

To travel such distances for care, individuals need to have transportation, lodging (depending on the timing of the appointment), childcare, and time off of work. *See generally* Ushma D. Upadhyay & Daniel Grossman, *Telemedicine for Medication Abortion*, 100 Contraception 351 (2019), https://pubmed.ncbi.nlm.nih.gov/31356771/. These financial and logistical obstacles can be insurmountable for individuals with low incomes. Compared to individuals with higher incomes, individuals with low incomes are more likely to face transportation barriers, Mary K. Wolfe et al., *Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017*, 110 Am. J. Pub. Health 815, 819 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7204444/, and less likely to have paid leave from work. U.S. Bur. of Labor Stat., *Economic News Release, Table 6. Selected paid leave benefits: Access* (March 2023),

https://www.bls.gov/news.release/ebs2.t06.htm (showing paid leave decreases with wages). Traveling a long distance to receive in-person care can pose additional challenges for individuals with disabilities. For example, some individuals with a disability need the assistance of a caregiver to leave home and/or have a health condition that requires them to avoid busy public spaces. In sum, eliminating coverage of medication abortions provided via telehealth will disproportionately harm AI/AN individuals and individuals living in rural areas (particularly those with very low incomes and/or a disability).

Finally, even for patients who choose to access abortion services in-person, the prior authorization requirements in HB 544 and the DPHHS rule will delay access to abortion care. Recent evidence calls into question whether DPHHS has the capacity to process prior authorization requests in a timely manner. In August 2023, the Centers for Medicare & Medicaid Services notified DPHHS of its concerns that eligible individuals were losing Medicaid coverage because they could not get through to DPHHS call center staff. Letter from Anne Marie Costello, Deputy Dir., Ctr. for Medicaid & CHIP Servs., CMS, to Mike Randol, State Medicaid Dir., Mont. DPHHS (Aug. 9, 2023), https://www.medicaid.gov/sites/default/files/2023-08/Montana-may-2023-unwinding-data-ltr.pdf. In addition, in November 2023, DPHHS acknowledged that its contractor was experiencing staffing shortages, leading to a delay in claims

processing. Mont. DPHHS, *Welcome to the Montana Healthcare Programs Provider Information Website* (Nov. 9, 2023), https://medicaidprovider.mt.gov/.

CONCLUSION

Amicus curiae respectfully requests that this Court affirm the judgment below.

Dated: January 29, 2024

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this amicus curiae brief is printed with a proportionately spaced, 14-point Times New Roman font, is double spaced, and the word count calculated by Microsoft Word is 2,453 words, excluding the cover page, tables, and certificates.

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