STATE OF MICHIGAN
IN THE COURT OF CLAIMS

THE YOUNG WOMEN'S CHRISTIAN ASSOCIATION OF KALAMAZOO, MICHIGAN on behalf of itself and its clients,

Plaintiff,

v

STATE OF MICHIGAN and **DEPARTMENT OF HEALTH AND HUMAN SERVICES,**

Defendants.
_____ /

Case No. 24-000093-MM

Hon. Brock A. Swartzle

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**Pro hac vice applications forthcoming*

VERIFIED COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND MANDAMUS RELIEF

There is no other pending or resolved civil action arising out of the transaction or occurrence alleged in this complaint.

/s/Bonsitu Kitaba-Gaviglio
BONSITU KITABA-GAVIGLIO (P78822)

Plaintiff The Young Women's Christian Association of Kalamazoo, Michigan ("YWCA Kalamazoo"), on behalf of itself and its clients by and through counsel, brings this verified complaint for declaratory, injunctive, and mandamus relief against the above-named Defendants, and in support thereof, claim and allege as follows:

INTRODUCTION

1. For decades, Michigan law has denied public health insurance coverage for one form of vital reproductive health care to countless Michiganders, infringing upon the autonomy, privacy, and medical decision-making of countless pregnant people, and discriminating against Medicaid-eligible patients. Michigan's Medicaid program provides comprehensive coverage for almost every component of reproductive health care. It covers almost all aspects of pregnancy and childbirth care, including related services such as ultrasounds, medication, and some travel costs to and from pregnancy-related visits, as well as preventive care, parenting classes, and meetings with social workers. It covers birth control and voluntary sterilizations. It covers doula care. It covers medically necessary surgeries. But Michigan Medicaid cruelly denies coverage to patients who decide to obtain one particular form of reproductive health care—abortion care—in all but two exceedingly narrow circumstances: to save the life of the pregnant patient or when the pregnancy is the result of rape or incest.

2. MCL 400.109a singles out abortion as the only type of pregnancy care that, by state statute, expressly cannot be covered under Michigan's Medicaid program. MCL 400.109d extends that burdensome and discriminatory ban to any related medical service, such as ultrasounds or

medication, that are necessary for a patient who receives abortion care. And MCL 400.109e imposes a civil penalty on any doctor or health care facility that seeks or accepts Medicaid reimbursement for providing abortion care or any necessary and related medical service. Collectively, these three statutes are referred to herein as "the coverage ban."

3. The coverage ban predictably and obviously burdens, infringes on, and discriminates against the reproductive rights of Medicaid-eligible patients. Some patients whose incomes are too high to qualify for Medicaid may have alternative options available to them, including purchasing private insurance that covers abortion care or paying the costs of abortion care themselves. By contrast, Medicaid-eligible patients, who, by definition, earn less than 130% of the federal poverty guidelines ($37,000 household income for a family of four in 2023), do not have those options and must scrape together their extraordinarily limited funds or rely on charitable assistance to receive abortion care. Inevitably, this burdens and infringes on the autonomous decision-making of Medicaid-eligible patients, destabilizes lower income families' fragile economic situations, and, in some cases, coerces pregnant people into carrying pregnancies against their will. The harms caused by the coverage ban fall most heavily upon those who already face barriers to accessing health care, especially pregnant people of color. The coverage ban also directly discriminates against organizations like YWCA Kalamazoo that are committed to ensuring comprehensive reproductive and child care for low-income Michiganders by forcing an unconstitutional choice between abandoning their mission or diverting their resources to subsidize reproductive health care that would be funded by Medicaid absent the discriminatory ban, effectively transforming YWCA into an funder of last resort for some of the most vulnerable of pregnant persons.

4. In 2022, Michigan voters overwhelmingly voted to amend Michigan's 1963 Constitution to ensure that coercive and discriminatory laws that deny, burden, or infringe on abortion access, such as the coverage ban, would no longer be lawful in Michigan. Article 1, § 28 of the Michigan Constitution now guarantees all Michiganders the fundamental right to reproductive freedom and prohibits any governmental action that denies, burdens, infringes, or discriminates against that right, unless justified by a narrowly and specifically defined compelling state interest.

5. The coverage ban violates the Michigan Constitution as amended. It burdens and infringes on the fundamental right to reproductive freedom for people who are eligible for Medicaid. It also expressly discriminates against abortion-care patients compared to patients who carry their pregnancies to term. And it discriminates on the basis of sex, given that it singles out a sex-correlated medical procedure for disfavor.

6. The coverage ban must therefore be declared unconstitutional and permanently enjoined, and Defendants must be ordered to provide Medicaid coverage for abortion and related services at reimbursement rates that will not unjustifiably deny, burden, or infringe access to abortion, as guaranteed by the Michigan Constitution.

JURISDICTION

7. This Court has jurisdiction over Plaintiff's claims in this action pursuant to MCL 600.6419(1)(a), giving the Court of Claims jurisdiction "[t]o hear and determine any claim or demand, statutory or constitutional, liquidated or unliquidated, ex contractu or ex delicto, or any demand for monetary, equitable, or declaratory relief or any demand for an extraordinary writ against the state or any of its departments or officers notwithstanding another law that confers jurisdiction of the case in the circuit court."

PARTIES

8. YWCA Kalamazoo is a nonprofit membership organization founded in 1885 as the first YWCA in the State of Michigan. Today, YWCA Kalamazoo's mission is to eliminate racism, empower women, stand up for social justice, help families, and strengthen communities.

9. YWCA Kalamazoo provides direct services to women, children, and families. One of those services is YWCA Kalamazoo's Reproductive Health Fund, through which YWCA Kalamazoo uses its own funds to provide direct financial support to its clients who are Kalamazoo County residents receiving reproductive, sexual, and gender-affirming health care services. YWCA Kalamazoo's largest expenditure through its Reproductive Health Fund goes towards covering the cost of its clients' abortion procedures and related care. Between fiscal years 2022 and 2023, YWCA Kalamazoo's Reproductive Health Fund provided direct financial support to 177 clients for abortion care and related services. Of those clients, 156 self-reported being enrolled in Medicaid. YWCA Kalamazoo conducts all of its business in Michigan and exclusively serves individuals residing or receiving services in Kalamazoo County.

10. Defendant State of Michigan is a sovereign state government that is structured and governed by a constitution that was enacted in 1963. The Constitution was amended in 2022 by the people of Michigan to provide a fundamental right to reproductive freedom for all Michiganders.

11. Defendant Department of Health and Human Services ("the Department") is a principal department of the State of Michigan. It oversees health policy and management for the State of Michigan and, as relevant here, administers the State of Michigan's Medicaid program. In that capacity, it investigates alleged violations and enforces the laws challenged herein and promulgates Michigan's Medicaid Provider Manual ("the Manual"), which is the document

governing much of Medicaid administration in Michigan. The Department is also responsible for setting the rates at which medical providers and/or Medicaid patients are reimbursed for all Medicaid-eligible services.

FACTS

In 2022, Michigan's Voters Forcefully Declared Michigan to Be a State Where Reproductive Freedoms Are Strongly Protected in the State Constitution

12. In 1973, the United States Supreme Court held in *Roe v Wade*, 410 US 113 (1973), that a Texas statute making it a crime to "procure an abortion," except for the purpose of saving the pregnant person's life, violated the Fourteenth Amendment to the United States Constitution. The Court held that the Fourteenth Amendment right to privacy barred a state from banning abortion before viability, or after viability when necessary to preserve the pregnant person's life or health.

13. In 2022, the United States Supreme Court decided *Dobbs v Jackson Women's Health Organization*, 597 US 215 (2022), which overruled *Roe* and purported to "return" the authority to regulate abortion to "the people and their elected representatives" in each of the 50 states.

14. As a result of *Dobbs*, Michiganders faced the prospect that, for the first time in generations, they could look only to state law and the Michigan Constitution to protect their reproductive freedom.

15. The voters of Michigan responded resoundingly in the streets and at the polls, gathering a record number of signatures to place a proposed constitutional amendment on the ballot in November 2022 that would make clear that, in Michigan, the Constitution protects everyone's right to bodily autonomy and to make the reproductive choices that are best for them and their families without government intrusion.

16. The constitutional amendment was overwhelmingly passed by Michigan voters. Article 1, § 28 now protects the right to make decisions related to the full spectrum of reproductive health care: "Every individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care."

17. The amendment further provides that the state shall not deny, burden, nor infringe upon the fundamental right to reproductive freedom unless justified by a compelling state interest achieved by the least restrictive means.[1] A state interest is expressly defined by the amendment as compelling "only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making."[2]

18. The voters further approved the inclusion of a broad anti-discrimination clause in Article 1, § 28, prohibiting the state from discriminating "in the protection or enforcement of this fundamental right" to reproductive freedom, which prohibits discrimination on the basis of all protected characteristics.[3]

19. As discussed below, the coverage ban plainly cannot stand in light of this constitutional amendment.

[1] Const 1963, art 1, § 28(1).

[2] Const 1963, art 1, § 28(4).

[3] Const 1963, art 1, § 28(2).

Michigan's Medicaid Program Provides Coverage for Reproductive Medical Care to Low-Income Michiganders for Almost All Types of Reproductive Care—Except Abortion

20. Medicaid is a joint federal and state program, with each state administering its own Medicaid plan within broad federal requirements.

21. In Michigan, the Medicaid program is run by the Department, and it is designed to provide comprehensive health care benefits to qualifying Michigan residents.[4]

22. To qualify for Michigan Medicaid generally, a person must have an annual income at or below 133% of the federal poverty level ("FPL"), which is about $18,000 for a single person or $37,000 for a family of four.[5]

23. In 2021, 24% of Michiganders were enrolled in Michigan's Medicaid program, which translates to over three million people, including one in five adults (ages 19–64).[6] In addition, of non-elderly enrollees, 61% are working adults and 43% are people of color.[7] In 2021 and 2022, 38% of births in the state were covered by Michigan's Medicaid program.[8]

[4] Michigan Medicaid includes several programs such as Medicaid, Healthy Michigan Plan, MIChild, MI Health Link, Freedom to Work, Health Care Coverage for People Impacted by Flint Water, Healthy Kids/Healthy Kids Dental, and TCM for Justice Involved Individuals. See Michigan Department of Health & Human Services, *Medicaid Programs* <https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/programs> (accessed June 26, 2024).

[5] Healthy Michigan Plan, *Who Is Eligible* <https://www.michigan.gov/healthymiplan/who> (accessed June 26, 2024).

[6] KFF, *Medicaid in Michigan* (June 2023), p 1, available at <https://files.kff.org/attachment/fact-sheet-medicaid-state-MI>; *Medicaid State Fact Sheets* (2021) <https://www.kff.org/interactive/medicaid-state-fact-sheets/> (accessed June 26, 2024).

[7] *Medicaid in Michigan*, p 1.

[8] KFF, *Births Financed by Medicaid* (2022) <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22michigan%22:%7

24. Health care providers who serve Michigan Medicaid beneficiaries and want to be reimbursed for covered services rendered must be screened and enrolled in Michigan's Community Health Automated Medicaid Processing System to process their reimbursement claims. The Department promulgates policies by which all enrolled providers must abide. The Department's guidance states that it must terminate a provider's enrollment in Michigan Medicaid if the provider fails to comply with Michigan Medicaid's policies regarding claims submission and billing or fails to submit timely and accurate information, among other reasons.

25. The Department sets a fee schedule that establishes base payment rates for each covered service. Enrolled providers can submit reimbursement claims for covered services through the processing system. Michigan Medicaid then determines reimbursement based on the fee schedule and the submitted claim. Providers must accept Medicaid's payment as payment in full for services rendered, except in specific circumstances authorized by Medicaid. Providers may not seek or accept additional or supplemental payments in addition to amounts paid by Medicaid.

26. Michigan Medicaid provides a broad array of health care coverage, including family planning services (including voluntary sterilizations such as vasectomies and tubal ligations), pregnancy care (prenatal, delivery, and post-partum care), surgery, doctor visits, and mental health services.[9] It also provides for related services for pregnancy and childbirth such as inpatient and outpatient hospital care, anesthesia, prescription medication, lab services, radiology

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B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed June 26, 2024).

[9] Michigan Department of Health and Human Services, *Medicaid* <https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/programs/medicaid> (accessed June 26, 2024); Michigan Department of Health & Human Services, *Medicaid Provider Manual* (April 1, 2024), *Family Planning*, p 1; *Practitioner*, p 59, available at <https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

and ultrasound, transportation to some pregnancy-related appointments, doula services, lactation support, and ambulatory services.[10]

27. Despite this otherwise comprehensive coverage for medical care in general, and reproductive health care in particular, abortion is covered only if a physician certifies that, "for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest."[11]

28. This limitation on coverage for abortion care exists in the Manual only because of MCL 400.109a and MCL 400.109d. MCL 400.109a provides:

> Notwithstanding any other provision of this act, an abortion shall not be a service provided with public funds to a recipient of welfare benefits, whether through a program of medical assistance, general assistance, or categorical assistance or through any other type of public aid or assistance program, unless the abortion is necessary to save the life of the mother. It is the policy of this state to prohibit the appropriation of public funds for the purpose of providing an abortion to a person who receives welfare benefits unless the abortion is necessary to save the life of the mother.[12]

MCL 400.109d extends this coverage ban to any separate or unbundled service that is "directly related to the performance of an abortion."

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10 *Medicaid Provider Manual*, *Maternal Outpatient Medical Services*, p 2; *Practitioner*, p 12, 42; *Non-Emergency Medical Transportation*, p 11.

[11] See *Medicaid Provider Manual*, *Billing & Reimbursement for Institutional Providers*, p 27; MCL 400.109a.

[12] Although exceptions for rape or incest were not included in the coverage ban when passed, both the coverage ban and Manual now include these exceptions after a federal court found that the state's coverage ban conflicted with federal law, which permitted coverage of abortion when the pregnancy is a result of rape or incest. See *Planned Parenthood Affiliates of Mich v Engler*, 860 F Supp 406 (WD Mich, 1994), aff'd 73 F3d 634 (CA 6, 1996).

The Coverage Ban Burdens and Infringes on the Constitutional Rights of Medicaid-Eligible Patients by Denying Them Coverage for Abortion Care and Delaying Their Care, Which Could Increase Health Risks and Costs

29. Michigan's Medicaid program provides coverage for almost all forms of reproductive care yet denies coverage to patients who decide to exercise their constitutional right to abortion. The denial of coverage to patients considering abortion care may delay their access to health care and can increase the likelihood that they face worse health outcomes and higher costs.

30. Accordingly, the coverage ban burdens and infringes upon Medicaid-eligible patients' constitutional right to reproductive freedom.

31. Insurance coverage for abortion is critical to accessing abortion—just as coverage for *any* form of medical treatment is critical to accessing such treatment. Many people with low incomes do not have enough money to cover the unexpected cost of terminating an unintended pregnancy and are forced to find funding for their abortion from multiple sources. This can delay access to care, which can in turn increase health risks and the cost of that care.

32. There is significant overlap between the Medicaid-eligible population—living at or below 133% FPL—and those seeking abortions in Michigan. Women living below the FPL experience rates of unintended pregnancies five times greater than do women with higher incomes.[13] Nationally, around 75% of abortion patients are poor or low-income, with nearly half (49%) having family incomes below 100% FPL and another quarter (26%) having family incomes

[13] Finer & Zolna, *Declines in Unintended Pregnancy in the United States 2008–2011*, 374 New Eng J Med 843, 846 (2016), available at <https://www.nejm.org/doi/pdf/10.1056/NEJMsa1506575>.

between 100–199% FPL.[14] This is due in large part to the larger population of people of reproductive age who are poor,[15] as well as systemic barriers to accessing health care.[16]

33. Nearly three-fourths of abortion patients say that the reason for ending their pregnancy is because they cannot afford to become a parent or to add to their families. The same proportion also cites responsibility to other individuals (such as children or elderly parents), or that having a baby would interfere with work and/or school, as their reason for ending their pregnancy.

34. People who obtain abortions are disproportionately people of color: over 64% of people who obtained an abortion in 2022 were non-white.[17]

35. While abortion is safe at any point in pregnancy, and far safer than childbirth, the risks of abortion increase with gestational age. If a pregnant person cannot raise the funds necessary to pay for an abortion—and they may have only a matter of weeks to do so before an abortion is out of reach—they will likely be forced to carry their pregnancy to term.

36. Being forced to carry a pregnancy to term can have devastating consequences. Pregnancy and childbirth carry significant medical risk compared to abortion. Every pregnancy-

[14] Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (May 2016), p 7, available at <https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf>.

[15] *Id.*

[16] Troutman et al., *Are Higher Unintended Pregnancy Rates Among Minorities a Result of Disparate Access to Contraception?* 5 Contraception & Reprod Med, art No 16, pp 2–5 (2020), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7527248/pdf/40834_2020_Article_118.pdf>.

[17] Michigan Department of Health and Human Services, Division for Vital Records & Health Statistics, *Abortion Rates by Age and Race or Hispanic Ancestry of Woman: Michigan Residents, 2022* <https://www.mdch.state.mi.us/osr/abortion/Tab_5.asp> (accessed June 26, 2024); Jackson et al., *Racial and Ethnic Differences in Contraception Use and Obstetric Outcomes: A Review*, 41 Seminars in Perinatology 273, 275 (2017).

related complication is more common among women giving birth than among those having abortions. The risk of death associated with childbirth, specifically, is approximately 14 times higher than that associated with abortion.[18] Black women face heightened risks of maternal mortality and pregnancy-related complications compared to non-Hispanic white women.[19]

37. Every pregnancy necessarily involves significant physical change, such as a dramatic increase in blood volume, a faster heart rate, increased production of clotting factors, breathing changes, digestive complications, and a growing uterus.

38. As a result of these changes and others, pregnant individuals are more prone to blood clots, nausea, hypertensive disorders, and anemia, among other complications.

39. Pregnancy may aggravate preexisting health conditions, such as hypertension and other cardiac disease, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary diseases.

40. Other health conditions, such as preeclampsia, deep-vein thrombosis, and gestational diabetes, may arise for the first time during pregnancy. People who develop a pregnancy-induced medical condition are at higher risk of developing the same condition in a subsequent pregnancy.

41. Many pregnant people seek care in the emergency department at least once during pregnancy. People with comorbidities (including both people with preexisting comorbidities and

[18] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics and Gynecology 215–219 (February 2012) <https://pubmed.ncbi.nlm.nih.gov/22270271/>.

[19] Hoyert, *Maternal Mortality Rates in the United States 2021*, National Center for Health Statistics (2023), p 4, available at <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf>.

those who develop comorbidities because of their pregnancy), such as asthma, obesity, hypertension, or diabetes, are significantly more likely to seek emergency care.

42. Mental health conditions may also emerge for the first time during pregnancy or in the postpartum period. A person with a history of mental illness may also experience a recurrence of their illness during pregnancy. Pregnant people with a prior history of mental health conditions also face a heightened risk of postpartum mental illness.

43. Separate from pregnancy, childbirth itself is a significant medical event. Even a normal pregnancy can suddenly become life-threatening during labor and delivery. During labor, increased blood flow to the uterus places the patient at risk of hemorrhage and, in turn, death; indeed, hemorrhage is the leading cause of severe maternal morbidity.

44. People who undergo labor and delivery can experience other unexpected adverse events such as transfusion, perineal laceration, ruptured uterus, and unexpected hysterectomy.

45. A substantial proportion of deliveries occur by cesarean section ("C-section"), an open abdominal surgery requiring hospitalization for at least a few days. While common, C-sections carry risks of hemorrhage, infection, and injury to internal organs.

46. Vaginal delivery often leads to injury, such as injury to the pelvic floor. This can have long-term consequences, including fecal or urinary incontinence.

47. The costs to Michigan Medicaid of covering pregnancy and childbirth are far greater than costs associated with abortion care, especially when the above-mentioned complications arise, additional medication is needed, or a C-section is performed.

48. Beyond childbirth, raising a child is expensive, both in terms of direct costs and lost wages. On average, women experience a large and persistent decline in earnings following the

birth of a child, an economic loss that compounds the additional costs associated with raising a child.

49. In light of the risks posed by pregnancy, it is the position of the American College of Obstetricians and Gynecologists, the nation's leading medical organization dedicated to the health of individuals in need of gynecologic and obstetric care, that "[a]bortion is an essential component of comprehensive, evidence-based health care"[20] and, accordingly, that "[p]ublic . . . insurance coverage of abortion care should be considered part of essential health care services and not singled out for exclusion or additional administrative or financial burdens."[21]

50. A recent study found that "Medicaid substantially alleviates the financial burden of abortion care in states where it can be used to pay for it. In particular, 71% of abortion patients in these states paid $0 for care compared to 10%" in states that ban Medicaid coverage of abortion care. "In turn, people in Medicaid states were substantially less likely to have to generate income through alternative means such as delaying other expenses . . . . [and] were less likely than those in [coverage ban] states to report that they had to take unpaid time off to get the abortion."[22]

51. "Medicaid may make abortion more accessible to populations that are marginalized within the health care system. In Medicaid states, groups more likely to use public insurance to

[20] American College of Obstetricians and Gynecologists, *Abortion Policy* <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy> (accessed June 26, 2024).

[21] American College of Obstetricians and Gynecologists, *Increasing Access to Abortion* (2020) <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion> (accessed June 26, 2024).

[22] Jones, *Medicaid's Role in Alleviating Some of the Financial Burden of Abortion: Findings from the 2021-2022 Abortion Patient Survey*, Perspectives on Sexual & Reproductive Health (2024), p 8, available at <https://doi.org/10.1111/psrh.12250>.

pay for abortion care included those who identified as Black or Latinx, those with the lowest incomes and those obtaining second-trimester abortions."[23]

The Coverage Ban Discriminates Between Childbirth and Abortion by Covering All Costs Associated with Childbirth While Denying Coverage for Abortion Care

52. The coverage ban discriminates between Michigan Medicaid patients who exercise their constitutional right to childbirth and those who exercise their constitutional right to abortion by conferring a public benefit on the former but denying that benefit to the latter.

53. Accordingly, the coverage ban discriminates in the protection and enforcement of the fundamental right to reproductive freedom.

54. Michigan Medicaid covers almost all pregnancy, childbirth and postpartum care. Specifically, this coverage includes antepartum care, pharmaceutical and prescription vitamins, laboratory services, radiology and ultrasound, childbirth education, labor and delivery services, high-risk pregnancy services, multiple gestation services, postpartum care, lactation support, parenting education, maternal infant health, doula services, hysterectomy related to childbirth or pregnancy, genetic counseling, prescription medication, mental health services, and in-patient and outpatient services.

55. By contrast, in the vast majority of cases, the coverage ban prohibits reimbursement for any Medicaid patient's abortion or related medical services, even though those costs are far less than the combined costs of care for someone who carries their pregnancy to term.

56. By providing such lopsided coverage for medical care based on someone's pregnancy decision, the coverage ban also discriminates between childbirth and abortion by

[23] *Id.*

effectively coercing those with the capacity for pregnancy to carry their pregnancy to term against their will.

The Coverage Ban Discriminates Based on Sex

57. The coverage ban also discriminates in the protection and enforcement of the fundamental right to reproductive freedom because it discriminates based on sex.

58. The coverage ban provides less comprehensive Medicaid coverage depending on the insured individual's capacity for pregnancy, a sex-linked characteristic. By its own terms, the ban excludes from coverage a form of medically necessary care used exclusively by people who are or can become pregnant. By excluding treatment options for pregnancy, a sex-linked medical condition, from otherwise comprehensive reproductive health coverage, it confers different benefits and burdens on the basis of sex.

59. The coverage ban also discriminates on the basis of sex because it disproportionately burdens women.[24] The overwhelming majority of abortion seekers are women, who primarily have the capacity for pregnancy, and thus women disproportionately bear the brunt of the coverage ban's denial of the benefits of equal citizenship. Approximately one in four women in this country will have an abortion by age forty-five.

60. The coverage ban also discriminates on the basis of sex because it is based on, and perpetuates, invidious sex-based stereotypes. By covering medical care only for women who decide to carry their pregnancies to term, the coverage ban perpetuates the discriminatory

[24] Plaintiff uses the terms "woman" or "women" as a shorthand for people who are or may become pregnant but notes that people of all gender identities, including non-binary individuals and transgender men, may also become pregnant and seek abortion services and thus also suffer harm as a result of the coverage ban.

stereotype that women are, by nature, destined to become mothers and that any other reproductive decision should be met with governmental, social, and economic opprobrium.

61. By providing unequal coverage for medical care based on someone's pregnancy decision, the coverage ban also discriminates based on sex by effectively coercing those with the capacity for pregnancy to carry their pregnancies to term against their will.

YWCA Kalamazoo and Its Clients Are Directly Discriminated Against and Harmed by the Coverage Ban, as YWCA Kalamazoo Must Use Financial Resources to Fund Abortions for Medicaid-Eligible Patients That Would Otherwise Be Invested in Other Strategic Initiatives

62. YWCA Kalamazoo works in four strategic focus areas: improving the lives of children by providing accessible, high-quality early learning and childcare for families; promoting maternal and child health by addressing racial disparities with evidence-based programs; caring for survivors of abuse by providing services for victims and survivors of domestic violence, sexual assault, and human trafficking; and advocacy and systems change by creating a just community through addressing systems that cause racial and gender disparities.

63. In 2019, YWCA Kalamazoo conducted a survey which identified that one in three individuals in Kalamazoo County did not have access to comprehensive reproductive health care services. The survey established that a major barrier to accessing reproductive health care services was financial: women with lower incomes could not afford abortion care and related services—a direct and predictable result of the coverage ban. Narrowing the gap in access to reproductive health care faced by women with lower incomes is a critical component of YWCA Kalamazoo's mission. Indeed, YWCA Kalamazoo could not practically fulfill its mission nor achieve its four strategic goals without engaging in work targeted to expand access to reproductive health care for people with low incomes.

64. To that end, in late 2021, YWCA Kalamazoo was compelled by necessity to launch a new program, the Reproductive Health Fund, to help women, girls, people with certain immigration statuses, and gender diverse people in Kalamazoo County meet their reproductive health care needs without financial barriers.

65. Through the Reproductive Health Fund, which YWCA Kalamazoo exclusively funds, operates, and controls, YWCA Kalamazoo offers funding to access reproductive health services, including abortion, doula services, and emergency contraception. The Reproductive Health Fund also enables YWCA Kalamazoo to provide funding to access HIV-prevention resources and gender-affirming services, products, and care, such as name changes and hormone replacement therapy.

66. YWCA Kalamazoo works directly with both health care providers and its own clients. YWCA Kalamazoo has a close relationship with its clients seeking funds from the Reproductive Health Fund. When a potential client approaches YWCA Kalamazoo for abortion care funding, YWCA Kalamazoo talks with that person and conducts an intake. The intake asks about sensitive personal and demographic data about the prospective client, the reason for needing funding, information about the person's pregnancy, and medical information related to the request. YWCA Kalamazoo also consults with the prospective client to determine how much they are able to pay themselves. Once YWCA Kalamazoo determines that it has sufficient resources to assist a prospective client, it confirms that the person will be a client of YWCA Kalamazoo and creates a client file for them. All client information is confidential to the organization and is prohibited from being shared with the health care provider or anyone else without the client's written consent. To initiate the funding process, YWCA Kalamazoo then creates an electronic voucher that is sent directly to the health care provider who will provide abortion services to the client. The client then

pays the health care provider for the portion of services that they are able to pay out-of-pocket, and YWCA Kalamazoo covers the rest of the bill, ensuring that every client's balance is "zeroed out."

67. After the client's scheduled abortion, YWCA Kalamazoo calls to confirm that the client was able to obtain an abortion from the health care provider and checks in with them in order to see how the client is doing after the abortion. YWCA Kalamazoo asks whether they need additional services and provides information to them depending on the content of its conversation with the client. If a client received the care from the health care provider, YWCA Kalamazoo sends payment to the health care provider and closes the client's file.

68. In its first two fiscal years (2022 and 2023) of operating the Reproductive Health Fund, YWCA Kalamazoo has covered some portion of the costs for abortion care and related services for 177 clients, a large percentage of whom were enrolled in Michigan Medicaid.

69. During this time period, YWCA Kalamazoo has given 34% of all available funds from the Reproductive Health Fund to individuals seeking abortion care.

70. Of those clients who received funds from YWCA Kalamazoo's Reproductive Health Fund for abortion services in fiscal years 2022 and 2023, approximately 88%, or 156 clients, self-reported being enrolled in Medicaid. The majority of YWCA Kalamazoo's Reproductive Health Fund clients had a household income of less than $24,600.

71. YWCA Kalamazoo paid out over $68,000 during fiscal years 2022 and 2023 to Medicaid-enrolled Reproductive Health Fund clients receiving abortion care. The average allocation for clients receiving abortion care was $440 per person.

72. Fifty percent of YWCA Kalamazoo's Reproductive Health Fund clients who provided information about their race or ethnicity in 2022 identified as people of color.

73. YWCA Kalamazoo also allocates resources in its advocacy and systems change program to eliminating the coverage ban. YWCA Kalamazoo's Director of Public Policy and other staff spend considerable time engaging in coalition work and advocacy to eliminate the coverage ban through the Legislature.

74. The funds that YWCA Kalamazoo expends on abortion care are not restricted to that purpose and could be deployed to other program areas.

75. Thus, if Michigan Medicaid covered abortion, YWCA Kalamazoo would not have to pay for abortions for their clients enrolled Michigan's Medicaid program to fulfill its mission, and more funding would be available to fund abortion services for individuals in need who are not or cannot be enrolled in Medicaid. YWCA Kalamazoo also would be able to redirect those funds—and potentially a portion of the funds expended on development and administrative operation of the Reproductive Health Fund—to providing additional support for related services, such as childcare; financial assistance to individuals seeking other forms of reproductive health care, like doula services for people who are not eligible to receive them through Medicaid or who require more expansive doula care than is available through Medicaid; contraception; HIV-prevention; gender-affirming services; and/or to other strategic focus areas of the organization.

76. Instead, by enforcing the discriminatory coverage ban, Defendants have predictably foisted their own obligations to provide comprehensive reproductive health care services to low-income Michiganders onto nonprofit organizations such as YWCA Kalamazoo who cannot fulfill their own mission without diverting funds to pay for services their clients need. This discriminates against YWCA Kalamazoo by forcing them to choose between seeing their mission undermined or diverting resources and taking on a financial obligation that would belong to the government but for the discriminatory ban.

77. YWCA Kalamazoo has a substantial interest in eliminating the coverage ban because many of its clients are enrolled in or are income-eligible for Michigan Medicaid but cannot use this health insurance to pay for their abortion procedures on account of the coverage ban. As a result, the coverage ban discriminates against YWCA Kalamazoo and frustrates its mission, as it must divert its resources to advocate for the elimination of the ban, while paying for abortions for people who would otherwise have their abortions covered by Medicaid if not for the coverage ban.

78. Additionally, if YWCA Kalamazoo's clients with low incomes were able to get their abortion care covered by Michigan Medicaid, they would avoid delays caused by having to investigate and secure funding from abortion funds like YWCA Kalamazoo's Reproductive Health Fund. Although YWCA Kalamazoo does everything in its power to avoid imposing unnecessary administrative barriers to receiving abortion care through its Reproductive Health Fund, some delay is inevitable, as many patients first approach YWCA Kalamazoo after having already consulted with a medical provider and realizing that they need financial assistance because Medicaid will not cover the costs of the abortion care they require.

Other States' Coverage Bans Have Been Determined to be Unconstitutional

79. A growing number of states provide equal access to pregnancy-related medical care to their residents who are enrolled in Medicaid. State courts in "the majority of jurisdictions that have considered" similar coverage bans "have concluded that, under their state constitutions, government health care programs that fund other medically necessary procedures may not deny assistance to eligible women" for abortion.[25]

[25] *Dep't of Health & Soc Servs v Planned Parenthood of Alaska, Inc*, 28 P3d 904, 905 (Alas, 2001), citing *Simat Corp v Ariz Health Care Cost Containment Sys Admin*, 56 P3d 28 (Ariz, 2002); *Comm to Defend Reproductive Rights v Myers*, 625 P2d 779 (Cal, 1981); *Doe v Maher*, 515 A2d 134

80. Today, seventeen states cover abortion in their state Medicaid programs.[26]

81. New Mexico and Connecticut have relied on general equal rights amendments—which do not address reproductive care as directly as the Michigan Constitution—in finding that government health care programs that single out abortion from coverage are unconstitutional.[27]

82. In an eighteenth state (Pennsylvania), the state's high court recently overruled a lower court's dismissal of a lawsuit challenging the state's Medicaid ban and has held that the ban must be subjected on remand to strict scrutiny under the Pennsylvania Constitution's equal rights amendment and its guarantees of privacy.[28]

Current Medicaid Reimbursement Rates Will Burden or Infringe on the Fundamental Right to Reproductive Freedom by Reducing Access to Abortion Care Even When the Coverage Ban Is Lifted

83. The current reimbursement rates promulgated by the Department for the very few categories of abortion it does cover (i.e., those to preserve the life of the pregnant person or those in cases of rape and incest) are so low that Medicaid-eligible individuals' actual access to abortion

(Conn, 1986); *Doe v Wright*, unpublished opinion of the Cook Co, Ill Circuit Court, issued December 2, 1994 (Docket No. 91 CH 1958) (Ex 1); *Humphreys v Clinic for Women, Inc*, 796 NE2d 247 (Ind, 2003); *Moe v Sec'y of Admin & Fin*, 417 NE2d 387 (Mass, 1981); *Women of Minn v Gomez*, 542 NW2d 17 (Minn, 1995); *Right to Choose v Byrne*, 450 A2d 925 (NJ, 1982); *NM Right to Choose/NARAL v Johnson*, 975 P2d 841 (NM, 1998); *Doe v Celani*, unpublished opinion of the Chittenden Co, Vt Superior Court, issued May 26, 1986 (Docket No. S81-84CnC) (Ex 2); *Women's Health Ctr of W Va, Inc v Panepinto*, 446 SE2d 658 (W Va, 1993); *Planned Parenthood Ass'n, Inc v Dep't of Human Resources,* 687 P2d 785 (Or, 1984).

[26] FKK, *State Funding of Abortions Under Medicaid* (June 1, 2023) <https://www.kff.org/medicaid/state-indicator/abortion-under-medicaid/> (accessed June 26, 2024).

[27] See *NM Right to Choose/NARAL*, *supra*; *Doe v Maher*, 515 A2d at 160-162.

[28] *Allegheny Reproductive Health Center v Pa Dep't of Human Services*, __ Pa __; 309 A3d 808 (2024).

would be substantially and unconstitutionally burdened once the coverage ban is lifted if those rates applied to all abortions, and some individuals may not be able to access abortion at all.

84. Low reimbursement rates that do not come close to covering the actual cost of abortion care may deny, burden, or infringe an individual's ability to exercise their fundamental right to reproductive freedom.

85. Enrollment in Medicaid does not legally require a provider to render services to every Medicaid beneficiary seeking care, except emergency services as required by federal law. Providers may decline to accept Medicaid beneficiaries.[29] Health care providers who are not legally required to accept Michigan Medicaid patients may decline to do so if the reimbursement rates make it impracticable for them to provide care.

86. In 2008, the Michigan Medicaid reimbursement rate for a dilation and curettage abortion ("D&C"), most commonly performed in the first trimester, was $125.95 when the procedure was performed in a non-hospital facility. That year, the reimbursement rate for a dilation and evacuation abortion ("D&E"), the most common second-trimester abortion procedure, was $214.65 in a non-hospital facility.[30]

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[29] See *Medicaid Provider Manual*, *General Information for Providers*, p 24, available at <https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>; MCL 400.109a.

[30] *See* American College of Obstetricians & Gynecologists, *Billing for Interruption of Pregnancy* <https://www.acog.org/practice-management/coding/coding-library/billing-for-interruption-of-early-pregnancy-loss> (accessed June 26, 2024) (Medicaid billing code 59840 is an induced abortion "[b]y D&C any trimester"; Medicaid billing code 59841 is an induced abortion "[b]y D&E 14 weeks to 20 weeks"); Michigan Department of Community Health, *MDCH - Practitioner Medical Clinic Database* (October 30, 2008), p 130, available at <https://web.archive.org/web/20081214223622/http://www.michigan.gov/documents/mdch/Practitioner_October_2008_Final_jk_251300_7.pdf> (accessed June 26, 2024) (non-facility reimbursement rate for billing code 59840 was $125.95; non-facility reimbursement rate for billing code 59841 was $214.65).

87. In 2024, the Michigan Medicaid reimbursement rate for a D&C abortion in a non-hospital facility was $162.09, and the reimbursement rate for a D&E procedure in a non-hospital facility was $276.05.[31]

88. In other words, in sixteen years, the reimbursement rate for first- and second-trimester abortion procedures have increased by only 28%, well short of the approximately 46% general inflation rate that has occurred in the American economy during the same time period.[32]

89. Upon information and believe, Michigan outpatient abortion providers conclude that reimbursement rates for abortion do not cover the providers' costs to provide this critical care and are not adequate to sustain provision of the care. The current rates are significantly lower than the actual cost of care, commercial insurance rates, and other states' Medicaid rates. The providers need the Department to increase the reimbursement rates for abortion to come more in line with the actual cost of providing care and other states' Medicaid rates.

90. In Michigan, the actual cost of abortion services tends to be similar to or slightly higher than the national average. For example, Planned Parenthood clinics in Michigan offer first-trimester abortion procedures for $600, while second-trimester procedures cost between $600 and

[31] *See* Michigan Department of Health & Human Services, *Practitioner & Medical Clinic Fee Schedule* (April 17, 2024), available at <http://michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/April-2024-DBs/Podiatrist-042024.x/sx?rev=548b0bca4dd5475c97f0b3d43ffb1534> (non-facility reimbursement rate for billing code 59840 is $162.09; non-facility reimbursement rate for billing code 59841 is $276.05).

[32] See *US Inflation Calculator*, Coin News Media Group Company (accessed June 26, 2024) <https://www.usinflationcalculator.com/>.

$1000.[33] At other clinics, costs range from $595 to $695 in the first trimester, and from $595 to more than $895 in the second.[34]

91. Thus, the reimbursement rates currently provided by Michigan's Medicaid program would cover only around—and sometimes less than—a quarter of the cost of either a first- or second-trimester abortion.

92. Currently, because Michigan covers abortion in only very narrow circumstances in the Medicaid program, the vast majority of Medicaid-eligible patients in Michigan who cannot afford the cost of their abortion procedures must work with clinics and abortion funds, like the one operated by YWCA Kalamazoo, to close the gap.

93. However, Defendants' obligations to guarantee constitutional rights do not depend on whether other sources offer charitable funding. Many sources of charitable funding are limited—such as in the case of YWCA Kalamazoo, which provides funding only to Kalamazoo County residents—or are available only because, in general, Medicaid *does not* cover abortion care in Michigan. Were Michigan's Medicaid program to cover abortion care, charitable funding would likely be redirected to those states where abortion care remains excluded from Medicaid, and funds like those available through YWCA Kalamazoo's Reproductive Health Fund would not be able to, and should not be expected to, cover the gap in Michigan. Without charitable funding or health care providers who take Michigan Medicaid, patients with low incomes may not be able

[33] Planned Parenthood, *Abortion in Ann Arbor, MI* <https://www.plannedparenthood.org/health-center/michigan/ann-arbor/48104/power-family-health-center-3296-90630/abortion> (accessed June 26, 2024).

[34] Women's Center Michigan, *Fee Schedule* <https://www.womenscenterofmichigan.com/fee-schedule/> (accessed June 26, 2024).

to get the care they need, thus denying, burdening, and/or infringing on their fundamental right to reproductive freedom—even in the absence of the coverage ban.

94. The experience of other states shows that when a state expands Medicaid coverage for abortion, extremely low, inequitable reimbursement rates for abortion care—like Michigan's, as laid out above—may have the perverse result of inhibiting low-income patients' access to care. Illinois is one such state, and it provides both a cautionary tale and a path forward to ensuring that the expansion of Medicaid coverage for abortion creates meaningful access for Medicaid-eligible individuals.

95. In 2017, Illinois enacted Public Act 100-0538 ("HB 40"), requiring the state Medicaid program to cover abortions. Abortion providers in Illinois expressed strong support for HB 40, focusing on its potential to help their patients access this critically needed care. At the same time, providers expressed concern regarding "Medicaid reimbursement rates [that] were outdated and insufficient to cover costs of providing abortion care."[35] (That year, Illinois's Medicaid program reimbursed the limited number of covered abortions at a rate of $199.95 for both D&C and D&E procedures.) In a bitter irony, following the expansion of Illinois's Medicaid coverage, "one abortion clinic closed and one multiservice clinic stopped providing abortion care. Another abortion clinic operating in a multiservice health center halted abortion services temporarily."[36]

96. Providers at each of these clinics cited low Medicaid reimbursement rates as a contributing factor. Because "rates had remained flat for decades and did not account for a patient's specific procedure," the reimbursement rate covered less than half of the true cost of providing

[35] Hasselbacher et al., *Lessons Learned: Illinois Providers' Perspectives on Implementation of Medicaid Coverage for Abortion*, 103 Contraception 414, 416 (2021).

[36] *Id.*

abortion care, particularly for patients who were later in pregnancy.[37] In the immediate wake of Medicaid expansion, many clinics in Illinois were able to remain open solely because of "transitional grant funding, internal funding, and technical assistance from external sources to help mitigate financial losses and ensure patient access."[38]

97. Eventually, the Illinois agency responsible for Medicaid reimbursement rates promulgated new rates for abortion care, which are sufficient to cover the actual cost of the procedures and, thereby, meaningfully expand access to abortion services for people with lower incomes in the state. Specifically, a first-trimester procedure is reimbursed at a rate of $660, while a second-trimester procedure is reimbursed at a rate of $1600.

98. Other states' Medicaid reimbursement rates for abortion more adequately cover the cost of care. For example, starting on July 1, 2024, the Colorado Medicaid reimbursement rate for a D&C will be $1,000 and $1,600 for a D&E. In New York, the reimbursement rates are $1,000 for a D&C and $1,300 for a D&E.

99. To ensure Medicaid-eligible individuals can exercise their constitutional right to abortion, this Court must lift the coverage ban *and* order the Department to address the reimbursement rates for abortion procedures so that they do not unconstitutionally burden the rights enshrined in Section 28 of the Michigan Constitution.

[37] *Id.*

[38] *Id.*

CLAIMS FOR RELIEF

COUNT I
Violation of the Fundamental Right to Reproductive Freedom
Const 1963, art 1, § 28(1)
Reproductive Health Act, MCL 333.26105

100. Plaintiff incorporates by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

101. MCL 400.109a, 400.109d, and 400.109e violate the fundamental right to reproductive freedom of Plaintiff and its clients as guaranteed by Article 1, § 28 of the Michigan Constitution, and as enforceable through the Reproductive Health Act, MCL 333.26105.

102. The Michigan Constitution provides: "Every individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care."[39]

103. The Michigan Constitution prohibits Defendants from denying, burdening, or infringing upon this fundamental right unless justified by a compelling state interest achieved by the least restrictive means.[40] A state interest is "compelling" only if it is for "the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making."[41]

[39] Const 1963, art 1, § 28(1).

[40] *Id.*

[41] Const 1963, art 1, § 28(4).

104. For the reasons stated herein, the coverage ban violates Plaintiff's and its Medicaid-eligible clients' fundamental right to reproductive freedom by infringing and burdening their ability to make and effectuate decisions related to abortion.

105. Michigan's extremely low, inequitable Medicaid reimbursement rates for abortion care also deny, burden, and/or infringe on Medicaid-eligible patients' fundamental right to reproductive freedom by limiting access to abortion care.

106. By denying, burdening, and/or infringing on Medicaid-eligible patients' fundamental right to reproductive freedom, the coverage ban effectively coerces those with the capacity for pregnancy to carry their pregnancy to term.

107. The coverage ban is not justified by a "compelling state interest" as defined in Article 1, § 28 because any interest the state may have in the coverage ban is not for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and/or because it infringes on that individual's autonomous decision-making.

108. To the extent the coverage ban is justified by any compelling state interest within the meaning of Article 1, § 28, the coverage ban violates Article 1, § 28 because it does not achieve any such interest through the least restrictive means.

COUNT II
Discrimination in the Protection and Enforcement of the Exercise of the Right to Abortion
Const 1963, art 1, § 28(2)
Reproductive Health Act, MCL 333.26105

109. Plaintiff incorporates by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

110. MCL 400.109a, 400.109d, and 400.109e discriminate between childbirth and abortion in violation of Article 1, § 28 of the Michigan Constitution, and as enforceable through the Reproductive Health Act, MCL 333.26105.

111. Article 1, § 28 contains an anti-discrimination clause, providing that the state may not discriminate in the "protection or enforcement" of the fundamental right to reproductive freedom. As such, the state cannot favor one reproductive health care choice over another.[42]

112. The coverage ban discriminates in the protection and enforcement of the fundamental right to reproductive freedom because it favors childbirth over abortion. For pregnant people who decide to continue a pregnancy, the Michigan Medicaid program covers all costs, but for pregnant people who decide to terminate their pregnancy, the Medicaid program denies coverage in all but the most extreme circumstances.

113. For entities such as YWCA Kalamazoo, the coverage ban singles out one reproductive choice—abortion—for which YWCA Kalamazoo must bear all of the costs that its clients cannot afford. The coverage ban thereby discriminates in the protection or enforcement of abortion by disfavoring that reproductive choice and placing additional burdens on YWCA Kalamazoo in the pursuit of its goals to comprehensively support the reproductive health care and choice of its clients, including the constitutional right to choose abortion. Essentially, the state's discrimination means that YWCA Kalamazoo must, as part of its mission, compensate for the state's unconstitutional conduct, even as that mission is undermined because it cannot support reproductive health care and choices as comprehensively as it otherwise would absent the coverage ban.

[42] Const 1963, art 1, § 28(2).

114. Michigan's extremely low, inequitable Medicaid reimbursement rates for abortion care also discriminate between childbirth and abortion, creating conditions whereby health care providers are willing to take Medicaid patients for pregnancy and childbirth but may decline or limit the number of Medicaid patients they would take for abortion care.

115. By favoring childbirth over abortion, the coverage ban also effectively coerces some people with the capacity for pregnancy to carry their pregnancy to term.

116. The coverage ban is not justified by a "compelling state interest" as defined in Article 1, § 28 because any interest the state may have in the coverage ban is not for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and/or because it infringes on that individual's autonomous decision-making.

117. To the extent the coverage ban is justified by any compelling state interest within the meaning of Article 1, § 28, the coverage ban violates Article 1, § 28 because it does not achieve any such interest through the least restrictive means.

COUNT III
Sex Discrimination
Const 1963, art 1, § 28(2)
Reproductive Health Act, MCL 333.26105

118. Plaintiff incorporates by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

119. MCL 400.109a, 400.109d, and 400.109e discriminate on the basis of sex in violation of Article 1, § 28 of the Michigan Constitution, and as enforceable through the Reproductive Health Act, MCL 333.26105.

120. Article 1, § 28 contains an anti-discrimination clause, prohibiting the state from discriminating in the "protection or enforcement of this fundamental right."[43]

121. The coverage ban discriminates on the basis of sex because it provides less comprehensive coverage on the basis of the insured individual's capacity for pregnancy, a sex-linked characteristic.

122. The coverage ban also discriminates on the basis of sex because it disproportionately burdens women.

123. The coverage ban also discriminates on the basis of sex because it is based on and perpetuates invidious sex-based stereotypes.

124. The coverage ban also discriminates on the basis of sex because it effectively coerces some people with the capacity for pregnancy to carry their pregnancy to term.

125. Michigan's extremely low Medicaid reimbursement rates for abortion care may limit a pregnant person's ability to access abortion care, further compounding the discriminatory treatment and impact of the coverage ban.

126. The coverage ban is not justified by a "compelling state interest" as defined in Article 1, § 28 because any interest the state may have in the coverage ban is not for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and/or because it infringes on that individual's autonomous decision-making.

127. To the extent the coverage ban is justified by any compelling state interest within the meaning of Article 1, § 28, the coverage ban violates Article 1, § 28 because it does not achieve any such interest through the least restrictive means.

[43] Const 1963, art 1, § 28(2).

COUNT IV
Writ of Mandamus
Const 1963, art 1, § 28
MCR 3.305

128. This count is expressly pled in the alternative, in the event that this Court were to otherwise dismiss Counts I-III.

129. Plaintiff incorporates by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

130. For all the reasons stated above, on their face, MCL 400.109a, 400.109d, and 400.109e violate Article 1, § 28 of the Michigan Constitution.

131. Article 1, § 28 of the Michigan Constitution provides a clear legal right to reproductive freedom:

> Every individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care. An individual's right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means. . . . The state shall not discriminate in the protection or enforcement of this fundamental right. . . . A state interest is "compelling" only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making.

132. The State of Michigan and Department of Health and Human Services have a clear legal duty not to enforce statutes that violate the Michigan Constitution, including Article 1, § 28, and to ensure that the administration of Michigan's Medicaid program complies with constitutional requirements.

133. The coverage ban violates Article 1, § 28 by infringing and burdening Plaintiff's Medicaid-eligible clients' fundamental right to reproductive freedom, discriminating between abortion and childbirth, and discriminating on the basis of sex.

134. Michigan Medicaid's extremely low, inequitable reimbursement rates for abortion care also violates Article 1, § 28 by denying, infringing and/or burdening Plaintiff's and/or their Medicaid-eligible clients' fundamental right to reproductive freedom.

135. The coverage ban is not justified by a "compelling state interest" as defined in Article 1, § 28 because any interest the state may have in the coverage ban is not for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and/or because it infringes on that individual's autonomous decision-making.

136. To the extent the coverage ban is justified by any compelling state interest within the meaning of Article 1, § 28, the coverage ban violates Article 1, § 28 because it does not achieve any such interest through the least restrictive means.

137. Defendants' legal duty requires the State of Michigan and Department of Health and Human Services to refrain from enforcing MCL 400.109a, 400.109d, and 400.109e and to cover abortion and all related services on the same basis as the Department pays for all other medical expenses under the Michigan Medicaid program.

138. Defendants' legal duties are ministerial and will involve no exercise of discretion or judgment. Directing the Department of Health and Human Services to stop enforcing the coverage ban, to initiate processes to cover abortion and related services, and to initiate a process to set a fee schedule to cover the actual cost of abortion and related services are all actions that require no exercise of discretion.

139. If this Court has dismissed Counts I, II, and III, then Plaintiff has no other adequate remedy in law or equity.

COUNT V
Declaratory Judgment
Const 1963, art 1, § 28
MCR 2.605

140. Plaintiff incorporates by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

141. For all the reasons stated above, MCL 400.109a, 400.109d, and 400.109e violate Article 1, § 28 of the Michigan Constitution.

142. For the reasons stated above, Michigan Medicaid's reimbursement rates for abortion care violate Article 1, § 28 of the Michigan Constitution.

143. Plaintiff and its clients suffer special injuries and are detrimentally affected by the coverage ban in direct ways that are different from the citizenry at large.

144. A judgment that the coverage ban is unconstitutional and that the Medicaid reimbursement rates are too low to provide sufficient access to the fundamental right to abortion will shape the future conduct of both Plaintiff and Defendants prospectively.

REQUESTED RELIEF

WHEREFORE, Plaintiff respectfully requests that this Court:

A. Enter judgment in favor of Plaintiff and against Defendants;

B. Enter a permanent injunction prohibiting Defendants from enforcing MCL 400.109a, 400.109d, and 400.109e, and any other Michigan statute or regulation to the extent that it prohibits state-funded reimbursement for abortion and related services, and requiring Defendants to cover abortion and all related services under Michigan Medicaid.

C. Enter a declaratory judgment that MCL 400.109a, 400.109d, and 400.109e, and any other Michigan statute or regulation violate the fundamental right to reproductive freedom in Article 1, § 28 of the Michigan Constitution to the extent that they prohibit reimbursement for abortion and related services under Michigan Medicaid;

D. Enter a declaratory judgment and permanent injunction addressing the constitutional insufficiency of Defendants' current reimbursement rates for abortion services, and order Defendants to promulgate a fee schedule that is constitutionally sufficient to ensure that Medicaid enrollees are not unjustifiably burdened in their ability to access abortion care due to an inadequate Medicaid reimbursement rate;

E. In the alternative, issue an order of mandamus prohibiting Defendants from enforcing MCL 400.109a, 400.109d, and 400.109e, and any other Michigan statute or regulation to the extent that it prohibits state-funded reimbursement for abortion and related services, ordering Defendants to initiate processes to cover abortion and related services, and ordering Defendants to initiate a process to set a fee schedule to cover the actual cost of abortion and related services.

F. Award Plaintiff reasonable costs and attorney fees pursuant to MCL 333.26105;

G. Grant such other relief as this Court deems just and proper.

Respectfully submitted,

/s/Bonsitu Kitaba-Gaviglio
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* *Pro hac vice application forthcoming*

ATTORNEYS FOR PLAINTIFF

Dated: June 27, 2024

VERIFICATION

STATE OF MICHIGAN)
) ss
COUNTY OF KALAMAZOO)

I declare that the above statements set forth in this Verified Complaint are true to the best of my knowledge, information, and belief.

Susan Rosas, CEO,
on behalf of YWCA Kalamazoo

Subscribed and sworn before me

this 25 day of June, 2024

Signed: Gloria O Wilkerson

Printed name: Gloria O. Wilkerson

Notary Public
County of Kalamazoo, State of Michigan

My Commission Expires: 07/08/2029

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

THE YOUNG WOMEN'S CHRISTIAN ASSOCIATION OF KALAMAZOO, MICHIGAN on behalf of itself and its clients,

Plaintiff,

v

STATE OF MICHIGAN and **DEPARTMENT OF HEALTH AND HUMAN SERVICES,**

Defendants.
_____ /

Case No.

Hon.

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**Pro hac vice applications forthcoming*

EXHIBITS TO

VERIFIED COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND MANDAMUS RELIEF

INDEX OF EXHIBITS

EXHIBIT 1	*Doe v Wright*, unpublished opinion of the Cook Co, Ill Circuit Court, issued December 2, 1994 (Docket No. 91 CH 1958)
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unpublished opinion of the Cook Co, Ill Circuit Court,
issued December 2, 1994 (Docket No. 91 CH 1958)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

Jane Doe et al.,
Plaintiffs

v.

Robert Wright, Director,
Illinois Department of Public
Aid,
Defendant

No. 91 CH 1958

ORDER

This matter coming before the Court for ruling on the parties' Cross-Motions for summary judgment, the parties appearing through counsel, a IT IS HEREBY ORDERED THAT:

1. Plaintiffs' Cross-Motion for Summary Judgment is granted, on the grounds that 305 ILCS 5/5-5 and 5/6-1 and their accompanying regulations are in violation of the Constitution of the State of Illinois.

2. Defendant is hereby enjoined from enforcing 305 ILCS 5/5-5 and 5/6-1 and their accompanying regulations ~~to the extent that~~ insofar as they deny reimbursement for abortion necessary to protect a woman's health although not necessary to preserve her life.

3. Defendant is ordered to provide reimbursement through the State's medical assistance programs for abortions necessary to protect a woman's health.

4. Defendant's Cr Motion for Summary Judgment is denied.

ENTER: DEC 2 1994, 19....

Judge, Judge's No.

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AURELIA PUCINSKI, CLERK OF THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

EXHIBIT 2

Doe v Celani,
unpublished opinion of the Chittenden Co, Vt Superior Court,
issued May 26, 1986 (Docket No. S81-84CnC)

STATE OF VERMONT

CHITTENDEN COUNTY, ss.

JANE DOE On behalf of herself and all others similarly situated v. VERONICA CELANI, Commissioner of the Department of Social Welfare	CHITTENDEN SUPERIOR COURT DOCKET NO. S81-84CnC

OPINION AND ORDER

The Plaintiff seeks to enjoin the Defendant from denying Medicaid coverage to indigent Vermonters for medically necessary abortions.

The parties have submitted the case to the Court for a final decision on the legal issues raised by the pleadings and the Stipulation of Facts filed September 3, 1985.

On January 27, 1984, this Court preliminarily enjoined the Commissioner from denying Medicaid coverage to the named Plaintiff for a medically necessary abortion. On September 28, 1984, the preliminary injunctive relief was continued and extended to cover the class that Plaintiff represents. This class is defined as:

> [a]ll indigent pregnant women in Vermont who qualify for Medicaid and whose pregnancy is not life threatening but for whom an abortion is medically necessary and who desire an abortion.

The Commissioner's denial of Medicaid was based upon Department of Social Welfare Regulation M617, which states:

Providers will be reimbursed by Vermont Medicaid for abortions performed only under circumstances for which Federal Financial Participation is available.

Regulation M617 was adopted after the passage of the so-called Hyde Amendment to a federal appropriations bill. In its current version the Hyde Amendment limits federal reimbursement for abortions to situations where the life of the woman would be endangered if the fetus were carried to term.

Except for the restriction contained in Regulation M617 Vermont provides Medicaid coverage for all medically necessary non-experimental procedures and the Federal Government reimburses the State pursuant to Title XIX of the Social Security Act, 42 U.S.C.A. §§1396 - 1396q (West 1983 & Supp. 1985). But for the provisions of the Hyde Amendment, medically necessary abortions would qualify for reimbursement under the joint Federal-State Medicaid program according to the terms of both Title XIX and 33 V.S.A. §§2901-2903. Prior to passage of the first Hyde Amendment the Vermont Department of Social Welfare provided Medicaid coverage for medically necessary abortions.

Even without Regulation M617, Vermont would still receive full reimbursement for all medically necessary services, except non-life threatening abortions. See, e.g. Moe v. Secretary of Administration, 417 N.E.2d 387, 391 (Mass. 1981).

Plaintiff and all other members of the class by categorical definition are eligible for Medicaid. Plaintiff has one non-functioning kidney and one partially functioning transplanted

kidney. In Plaintiff's case, the continuation of her pregnancy posed serious medical risks. Her physician indicated that these risks included adverse effects on the viability of her transplanted kidney from spontaneous abortion; serious complications directly related to the pregnancy, such as, high blood pressure and seizures resulting from a further decrease in the functioning of her transplanted kidney (which is only partly functional) and, finally, kidney failure which would require dialysis treatment to sustain her life. This medical opinion was confirmed by a second physician. Both doctors indicated that an abortion was medically necessary.

The adoption of Regulation M617 sets up the only exception to the clearly established public policy of providing health care services to the indigent for all conditions requiring medically necessary non-experimental procedures. Indeed, it is clear that Regulation M617 is not so much an exception to the stated public policy of providing medically necessary services to the indigent, as it is a complete negation of that policy as it relates to one medically necessary service.

Vermont passed its medical assistance program, 33 V.S.A. §§2901 - 2904 in 1967 under Title XIX of the Federal Social Security Act. Title XIX was passed

> [f]or the purpose of enabling each State, as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, ...

42 U.S.C.A. §1396.

The Commissioner reads into the Vermont statute which

provides for a medical assistance program a federal appropriations restriction which opposes the legislative goal of the program.

Unlike some other jurisdictions, Vermont does not prefer childbirth over abortion as a matter of public policy. Defendant advances two reasons for Regulation M617. She maintains that without federal reimbursement she does not have administrative authority to fund medically necessary procedures for which federal reimbursement is unavailable. She also maintains that funding medically necessary abortions in non-life-threatening pregnancies would increase the State's financial contribution to the Medicaid program due to the denial of federal reimbursement.

It should be noted that under the facts as stipulated, if in one year all 264 abortions are paid for entirely out of state funds at a normal cost of $200.00, the cost to the State would be $52,800.00. If federal funding were available at the rate of 67.06 percent, which it is not, savings to the State would be $35,407.68. If those 264 pregnancies went to term and resulted in normal births, at a cost of $1,225.00, the total cost would be $323,400.00. With federal reimbursement available at 67.06 per cent the cost to the State of these procedures would be $106,527.96. Thus, the cost to the State of funding live births with federal reimbursement is slightly over three times the cost of State funding for abortions without federal funding.

The State has failed to demonstrate a connection between the regulation and the only public purpose claimed, that of saving money. The regulation's sole demonstrable effect is to negate the purpose of the enabling statute under which it was

promulgated. The only purpose to which Regulation M617 relates rationally is to favor childbirth over abortion. But the State disavows this as public policy of the State of Vermont. [1] This disavowal leaves the Commissioner with no rational reason for retaining or enforcing Regulation M617.

Clearly the Federal Constitution as interpreted by the United States Supreme Court in Harris v. McRae, 448 U.S. 297 (1980), does not provide protection to Plaintiff in this situation. The question therefore is whether or not Regulation M617 impermissibly impinges upon some protection afforded or right guaranteed by the Vermont Constitution. See, State v. Badger, 141 Vt. 430, 438 (1982).

Initially it should be noted that the Vermont Constitution provides more protection for the individual than the United States Constitution, and delineates rights not recognized or guaranteed by that document. These textual differences provide a valid basis for independent analysis, and a determination that greater protection is provided by the Vermont Constitution. State v. Jewett, 146 Vt. 221 (1985).

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[1] Were the state to assert favoring childbirth over abortion as a public policy Regulation M617 would fall as an impermissible infringement of constitutionally guaranteed rights. Beecham v. Leahy, 130 Vt. 164, 169 (1972); see, Right to Choose v. Byrne, 450 A.2d 925 (N.J. 1982); Moe v. Secretary of Administration, 417 N.E.2d 387 (Mass. 1981); Committee to Defend Reproductive Rights v. Myers, 29 Cal.3d 352, 172 Cal.Rptr 866, 625 P.2d 770 (1981); but see, Fischer v. Commonwealth, 502 A.2d 114 (Pa. 1985); cf. Planned Parenthood Association v. Department of Human Resources, 687 P.2d 785 (Ore. 1984).

Article One of Chapter One of the Vermont Constitution provides: "That all men are born equally free and independent and have certain natural, inherent and unalienable rights, amongst which are the enjoying and defending of life, liberty, acquiring, possessing and protecting property, and pursuing and obtaining happiness and safety; . . ."

The language in Article One was obviously influenced by that portion of the United States Declaration of Independence which states: "We hold these truths to be self-evident; that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness. . . ."

It is significant that the United States Constitution contains no such language.

It is perhaps more significant that Article One of the Vermont Constitution is not an isolated statement in that document. Several other articles in Chapter One deal with equality and protection of rights, including Articles Four, Five, Six, Seven, Nine and Eighteen.

Of particular relevance is Article Seven, which provides in relevant part

> That government is, or ought to be, instituted for the common benefit, protection, and security of the people, nation or community, and not for the particular emolument or advantage of any single man, family, or set of men, who are a part only of that community;. . . .

Greater protection for the individual under the Vermont

Constitution also derives from the nature of state government exercising its reserved sovereign power to promote and protect the health and welfare of its inhabitants. See, Jewett at 227. The Ninth and Tenth Amendments of the Federal Constitution, recognizing the concern for the federal-state balance of power, explicitly recognize that additional rights and protections are retained by the people as inhabitants of the states. See, Id.

The Vermont Bill of Rights was adopted prior to the existence of the United States Constitution, and was retained in the Constitution of the State of Vermont after the United States Constitution was adopted and ratified in the state. The retention, unaltered in substance, of additional human rights guarantees and constraints on governmental action indicates a deliberate and still enduring intent on the part of Vermont to recognize greater protections and benefits for its inhabitants under the rule of law than those recognized federally. The Vermont Supreme Court has "never intimated that the meaning of the Vermont Constitution is identical to the federal document. Indeed, [it has] at times interpreted our constitution as protecting rights which were explicitly excluded from federal protection." Badger at 449.

While the Federal Constitution establishes minimum levels below which states cannot go in treating individuals, it has never been questioned but that states can, and often do, afford persons within their jurisdiction more protection for individual rights. See, e.g. McRae at 311, n. 16, PruneYard Shopping Center v. Robins, 447 U.S. 74, 81 (1980). States are free to provide

additional protections by statute, and are obligated to do so by the terms of their own constitutions. "[O]ne of the strengths of our federal system is that it provides a double source of protection for the rights of our citizens." Brennan, State Constitutions and the Protection of Individual Rights, 90 Harv. L. Rev. 489, 503 (1977).

It is this Court's duty and function to examine for constitutionality and to determine the precise meaning of our own constitutional provisions provided "no federal proscriptions are transgressed," In re E.T.C., 141 Vt. 275, 278 (1982); and obligation to determine the constitutional validity of the regulation in question. Badger at 449; Vermont Woolen Corporation v. Wackerman, 122 Vt. 219, 225 (1960).

Article Seven protects individuals against the discriminatory provision of government benefits by proscribing any particular emolument or advantage granted to only part of a community, whether or not that benefit affects fundamental rights. Article One gives constitutional stature to individuals' unalienable rights to health in the form of happiness, safety and the ability to enjoy life. Article One also protects individuals against discriminatory government treatment affecting fundamental constitutionally protected rights.

The safety of all Vermonters is promoted by the ready availability of adequate health care and the delivery of necessary health services. There is, therefore, a direct relationship between the availability of medically necessary services and the constitutionally guaranteed unalienable right to pursue and

obtain happiness and safety and to enjoy life. Health is central to personal safety and happiness. From medical well-being one may well say all other benefits flow. Faced with a threat to one's health, one's safety is integrally at risk. When one seeks a health service which is medically necessary, one is seeking, by definition, what is indispensable for the protection of one's health and safety. In a health care provider's judgment, a medically necessary service is essential for the treatment of a condition which if left untreated would affect adversely one's health.

This case does not present an issue involving the freedom of choice to obtain an abortion so much as it concerns an unequal protection by the State of indigent inhabitants' unconstitutionally protected right to personal health, safety and happiness. At issue is the constitutional validity of Regulation M617 when tested against the constitutionally protected fundamental right to personal safety and the constitutional prohibition against unequal provision of governmental benefits.

Recognizing that many of our inhabitants are not in a position to financially pursue happiness and safety and to enjoy life, it has long been the policy of the state to provide the necessities of life to qualified indigent persons. See, e.g. 33 V.S.A. Chap. 38, §3001(4).

Congress recognized the financial burden such programs place on the states, and provided for reimbursement to the

states which established appropriate assistance programs, e.g. 42 U.S.C.A. §§1396 - 1396q.

Consistent with the objectives of providing greater access to health care for indigents, a state is free under federal law "to include in its Medicaid plan those medically necessary abortions for which federal reimbursement is unavailable." McRae at 311, n.16. Although this Court does not rely on federal law in reaching its decision it does note that no federal proscriptions have been transgressed in arriving at a decision. See, In re E.T.C. at 278.

The purpose of these assistance programs is to place the indigent in a position to obtain services on an equal basis with those more fortunate people who can obtain these services for themselves. The Vermont Medicaid program was established to "furnish medical assistance [to those] . . . whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C.A. §1396; 33 V.S.A. §2901.

Regulation M617 singles out one necessary medical service and denies access to indigents for reasons which have nothing to do with promoting access to health care. Regulation M617 discriminates not only against indigents versus non-indigents, but between indigents seeking the medical procedure in question and those indigents seeking any other medically necessary service, all of which are reimburseable to providers by the State. More particularly Regulation M617 creates a single instance where the availability of reimbursement is conditioned on whether a woman's life or her health is threatened.

Regulation M617 impinges directly on the constitutionally guaranteed right to safety. It increases the danger to health by precluding access by indigents to a necessary medical procedure. It also treats Vermonters unequally by singling out small group of people for denial of access to medically necessar care.

Once the State has established a program of emoluments and advantages to a community of Vermonters, under Article Seven, it must ensure that the establishment and administration of that program is carried out for the common benefit, protection and security of that community. This prohibits discrimination among the provision of benefits once those benefits are being provided

The Vermont Supreme Court has set a standard under Article by which to measure the constitutionality of regulatory legisla- tion. See, State v. Ludlow Supermarkets, Inc., 141 Vt.261 (198: The Court's general concern was "with the propriety of the legislature's exercise of its general police power, and whether that power has been exercised so as to affect all citizens equally." Ludlow Supermarkets at 265. That concern generated the following constitutional tests. "[I]nequalities [in impact are not fatal with respect to constitutional standards if the underlying policy supporting the regulation is a compelling one and the unbalanced impact is, as a practical matter, a necessar consequence of the most reasonable way of implementing that policy." State v. Ludlow Supermarkets, Inc., 141 Vt. 261, 265 (1982).

> Classifications are permissible only
>
> if a case of necessity can be established for overriding the prohibition of Article 7 by reference to the 'common benefit, protection, and security of the people.'
>
> Given the breadth of the police power, . . .its exercise, even in the presence of other generalized restraints on state action, may be supported if premised on an appropriate and overriding public interest.

Id. at 268.

The Commissioner has failed to establish a case of necessity by failing to show any compelling public policy which Regulation M617 implements. She has failed to establish any rational basis for the regulation. The only necessary consequence of Regulation M617, besides favoring childbirth over abortion, is piecemeal and selective dismantling of the legislative policy of providing medical assistance.

"[The] objective of favoring one part of the community over another is totally irreconcilable with the Vermont Constitution." Ludlow Supermarkets at 269. Once benefits are granted to a part of the community they must further a goal independent of the preference awarded. Id. This proposition applies to the selective withholding of benefits. One person's preference is another person's discrimination. Medical assistance furthers the independent goals of improving the level of health of Vermonters and lessening the impact of economic inequalities on the protection of fundamental rights to health, safety and enjoyment of life. By contrast, Regulation M617 bears no rational relation to any independent public policy goal.

The Commissioner maintains that under §§2901 and 2902 of the Vermont Medical Assistance Act, that state Medicaid funds can only be used to pay for services for which federal reimbursement is available. She argues that because the Hyde Amendment limits Medicaid funds to the states under Title XIX, by state law the Commissioner must follow suit. However, state law compels the opposite conclusion.

A Court's primary object in interpreting a statute is to ascertain and give effect to legislative purpose. Paquette v. Paquette, 146 Vt. 83, 86 (1985).

Absent compelling indications that administrators' construction is wrong the Court must follow those conclusions. Petition of Village of Hardwick Electric Department, 143 Vt. 437, 444 (1983), so long as they are "'reasonably related to the purposes of the enabling legislation.'" Farmers Production Credit Association of South Burlington v. State of Vermont, 144 Vt. 581, 584 (1984)[quoting Committee to Save the Bishop's House, Inc. v. Medical Center Hospital of Vermont, Inc., 137 Vt. 142, 150 (1979)].

3 V.S.A. §203 provides that "[t]he commissioner or board at the head of each department herein specified shall exercise only the powers and perform the duties imposed by law on such department." This statute together with 3 V.S.A. §212, (which creates and enumerates the various administrative departments) have been construed by the Vermont Supreme Court to mean that "the Legislature has established that authority in an administrative

department cannot arise through implication. An explicit grant of authority is required." Miner v. Chater, 137 Vt. 330, 333 (1979).

33 V.S.A. §2901 empowers the Commissioner of the Department of Social Welfare to administer a medical assistance program under Title XIX of the Social Security Act. Section 2901 provides that the Commissioner shall issue regulations not in conflict with federal regulations under Title XIX of the Social Security Act. It does not preclude the Commissioner from taking measures to protect individuals' health above and beyond federal ones.

33 V.S.A. §2902 provides: "In determining whether a person is medically indigent, the commissioner shall prescribe and use the minimum income standard or requirement for eligibility which will permit the receipt of federal matching funds under Title XIX of the Social Security Act."

Regulation M617 negates the clear legislative intent of the Vermont Medical Assistance Act, thereby providing compelling indications that the Commissioner has erred in her construction of the statute. A regulation such as M617 which creates an unjust result and which also runs contrary to a clear legislative purpose goes against the "fundamental rule in regard to any statute that no unjust or unreasonable result is presumed to have been contemplated by the Legislature." Nolan v. Davidson, 134 Vt. 295, 299 (1976).

The Commissioner interprets the statute to mean that she

has the power to withhold medical assistance based simply on the availability of federal funding. Nowhere does the statute so provide or imply. The fact that federal grants to state programs established under federal law can be limited and shaped by Congressional policies does not give state administrators power to ignore the mandate of state statutes. "[U]nder our constitutional system, administrative agencies are subject to the same checks and balances which apply to our three formal branches of government. An agency must operate for the purposes and within the bounds authorized by its enabling legislation, or this Court will intervene." In re Agency of Administration, State Buildings Division, 141 Vt. 68, 75 (1982). An administrative desire to synchronize funding with that reimburseable with federal funds, simply because a federal statute restricts reimbursement, is not within authorized bounds when that action is not expressly permitted by the enabling legislation.

Section 2902 merely says that the state definitions of a medically indigent person must be the same as federal guidelines provide in order for matching funds to be available. Section 2902 does not address limitations on medically necessary procedures for which a state may provide reimbursements to providers. Section 2902 only limits the "who" receiving medical assistance, it provides no authority for limiting the "what" of medically necessary services based on availability of federal funding.

Both Title XIX and 33 V.S.A. §§2901 and 2902 predate the Hyde Amendment and therefore cannot have contemplated that the

language at issue could have applied to limit funding based on selected procedures rather than on levels of income and resources. Indeed, Title XIX and 33 V.S.A. Chapter 36 were passed initially on a premise of universal access to all medically necessary procedures. The aberration to this universality, as embodied in the Hyde Amendment and Regulation M617 does nothing but further a social policy couched in terms of favoring childbirth over abortion at the expense of the health of the mother, which is antithetical to the medical assistance purpose of protecting health by equalizing and facilitating universal access to all medically necessary health care.

Nothing in Chapter 36 of 33 V.S.A. or Title XIX of the Federal Social Security Act suggests that federal matching funds for all other medically necessary services would be endangered if the State should choose independently to fund procedures for which federal funds are unavailable. The Commissioner points to no authority, state or federal, which compels the conclusion that independent state funding beyond that matched by federal funding endangers federal funding already available. There is no mandate in federal law which prohibits states from funding medically necessary abortions where the life of the mother is not threatened. The reverse, if anything, was implied by the Roe v. Wade, 410 U.S. 113 (1977), decision and its progeny. Maher v. Doe, 432 U.S. 464 (1977) and McRae held that no federal obligation existed to fund the right protected by the Federal Constitution to choose an abortion. Despite these holdings, the freedom of states to fund such abortions was explicitly

acknowledged, McRae at 311, n.16.

State funding for medically necessary abortions under Vermont's medical assistance program would have no effect on forfeiture of state eligibility for federal funds for reimbursable medical procedures. Therefore, Regulation M617 has no sound fiscal basis in light of the law and the facts stipulated to by the parties and adopted by the Court.

The only effect which the limitation on federal reimbursement embodied in the Hyde Amendment has, is to not provide federal reimbursement to abortions in instances of non-life threatening pregnancies. Absent Regulation M617, and despite the Hyde Amendment, Vermont would still receive federal reimbursement for a percentage of the costs of all other medically necessary services. See Moe v. Secretary of Administration and Finance, 417 N.E.2d 387, 391 (Mass. 1981)["Thus, the relief sought here would not jeopardize Federal reimbursement for other services provided by the Massachusetts Medicaid program."]

The onus is not on the Commissioner to find authority to fund medically necessary abortions, that funding is mandated by the language and purpose of the Medical Assistance Act and Title XIX. The onus on her is to provide a purpose for Regulation M617 which is expressly authorized and reasonably related to the purpose of medical assistance, Farmer's Production Credit Association at 584, Miner at 333. Patently that relation is missing and Defendant is exercising power beyond that delegated to her under the enabling act.

Regulation M617 operates contrary to the purpose of the Vermont Medical Assistance Act. "Article 5 of the bill of rights of this state expressly reserves to the legislature the right to regulate this [police] power. . . . But in exercising this right, the legislature cannot deprive a citizen of an essential right secured by the bill of rights or constitution,. . . ." State v. Hodgson, 66 Vt. 134 (1893), aff'd 168 U.S. 262 (1897). This exercise of administrative power violates Article Five of Chapter One of the Vermont Constitution in two ways. First, Regulation M617 impinges on the exclusive power of the Legislature to regulate the police power. Second, Regulation M617 exercises police power so as to deprive certain Vermonters of their constitutionally guaranteed rights to health and safety, and does so in a discriminatory manner.

Regulation M617 violates Vermont Constitutional principles of separation of powers and the accountability of officers of government to the people. The Commissioner's violation of 3 V.S.A. §§203 and 212 violates the principle of Chapter I, Article Six that to exercise authority which creates policy there must first be accountability to the people via popular elections, see, Welch v. Seery, 138 Vt. 126, 128 (1980). The cases decided under Chapter II, §2, 5 and 6, reach the same conclusions of unconstitutionality based on principles of separation of powers. State v. Auclair, 110 Vt. 147 (1939); Village of Waterbury v. Melendy, 109 Vt. 441 (1938). By contrast to Article Six of Chapter I, these Chapter II sections allow

direct recourse to the courts in the event of their violation.

The Commissioner's expansion of her authority with a result contrary to the purpose envisioned for that statute by the Legislature violates the separation of powers required by the Vermont Constitution in Chapter II, §5. Cf., State v. Jacobs, 144 Vt. 70, 75 (1984).

Plaintiff has failed to establish grounds to take her out of the scope of the general Vermont rule that attorneys' fees are not recoverable as an element of damages. Albright v. Fish, 138 Vt. 585, 590-91 (1980). Therefore, Plaintiff's request for attorneys' fees is denied.

ORDER

This Court finds Department of Social Welfare Regulation M617 unconstitutionally null and void. IT IS THEREFORE ORDERED: The State of Vermont, through its Department and Commissioner of Social Welfare is permanently enjoined from enforcing Regulation M617 or any other regulation which purports to deny reimbursement for medically necessary abortions.

Dated at Burlington, Vermont, this 23rd day of May, 1986.

Hilton H. Dier, Jr.
SUPERIOR JUDGE

TrueFiling Case Initiation - Summons and Complaint

Case Title: YWCA KALAMAZOO V. STATE OF MICHIGA

Case Type: MM

Case Description:

Constitutional Claims: All claims for money damages brought under the Michigan Constitution

Party 1 (Plaintiff)

Business: YWCA Kalamazoo **Phone:**

Address: 353 E. Michigan Ave.

City: Kalamazoo **State:** Michigan **Zip:** 49007

Attorney(s) for Party 1

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Name: Philip Mayor **Bar Number:** P81691 **(Lead Counsel)**

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City: Lansing **State:** Michigan **Zip:** 48909

Party is Pro Se

STATE OF MICHIGAN
COURT OF CLAIMS

Bundle Cover Sheet

Lower Court:	L Ct No.:	COC No.:
		TEMP-JCJLZM7W

Case Title:
YWCA KALAMAZOO v. STATE OF MICHIGAN

Priority:	Filing Option:
NONE	File Only

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Filing Summary

Filing Type	Filing Name		Fee
Summons and Complaint	Complaint		$150.00
		eFiling System Fee:	$25.00
Other	Exhibits to Complaint		$0.00
		NON-REFUNDABLE Automated Payment Service Fee:	$5.25
		Total:	**$180.25**

Alternate Payment Reason: None

The document(s) listed above were electronically filed with the Michigan Court of Claims.

TEMP-JCJLZM7W-43239240