No. 21-806

In the Supreme Court of the United States

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, ET AL., PETITIONERS

v.

IVANKA TALEVSKI, PERSONAL REPRESENTATIVE OF THE ESTATE OF GORGI TALEVSKI, DECEASED

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

BRIEF *AMICI CURIAE* FOR THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE, AND 40 DEANS, CHAIRS, AND PUBLIC HEALTH AND HEALTH POLICY SCHOLARS IN SUPPORT OF RESPONDENT

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TABLE OF AUTHORITIES

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Cases:

C.R. ex rel. Reed v. *Noggle*, 559 F. Supp. 3d 1323 (N.D. Ga. 2021) 2, 29

Dreyer v. *Idaho Dep't of Health & Welfare*, 558 F. Supp. 3d 917 (D. Idaho 2021) 30

Harris v. *Olszewski*, 442 F.3d 456 (6th Cir. 2006) 29

K.G. ex rel. Garrido v. *Dudek*, 864 F. Supp. 2d 1314 (S.D. Fla. 2012), aff'd in part, rev'd in part, 731 F.3d 1152 (11th Cir. 2013) 29

K.B. ex rel. T.B. v. *Michigan Dep't of Health & Hum. Servs.*, 367 F. Supp. 3d 647 (E.D. Mich. 2019) 2, 29, 34

Maine v. *Thiboutot*, 448 U.S. 1 (1980) 26

Mitchell v. *Johnston*, 701 F.2d 337 (5th Cir. 1983) 2, 29

National Fed'n of Indep. Bus. v. *Sebelius*, 567 U.S. 519 (2012) 6, 7, 8, 9, 10

Pennhurst State Sch. & Hosp. v. *Halderman*, 451 U.S. 1 (1981) 25

Rabin v. *Wilson-Coker*:

No. 03-cv-555, 2003 WL 1741883 (D. Conn. Mar. 31, 2003) 30

362 F.3d 190 (2d Cir. 2004) 2, 30

Rosie D. v. *Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) 2, 7, 27, 28

Shakhnes v. *Berlin*, 689 F.3d 244 (2d Cir. 2012) 33

Cases—Continued: Page(s)

Thompson ex rel. Bailey v. *Fitzgerald*, 558 F. Supp. 3d 1334 (N.D. Ga. 2021) 32, 33
Waskul v. *Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426 (6th Cir. 2020) 2, 30, 33
Wilder v. *Virginia Hosp. Ass'n*, 496 U.S. 498 (1990) 25, 34

Statutes:

Social Security Act, 42 U.S.C. 301 *et seq.* 5
Tit. XIX, 42 U.S.C. 1396 *et seq.* 5
42 U.S.C. 1396a(a) 5
42 U.S.C. 1396a(a)(8) 5, 25
42 U.S.C. 1396a(a)(10) 5, 9, 25
42 U.S.C. 1396a(a)(23)(A) 29
42 U.S.C. 1396a(a)(43) 7
42 U.S.C. 1396a(e)(4) 12
42 U.S.C. 1396d(a) 5
42 U.S.C. 1396d(r) 7, 28
42 U.S.C. 1397bb(b)(5) 5
Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821 (1968) 28
Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) 7

Miscellaneous:

Heidi Allen et al., *Can Medicaid Expansion Prevent Housing Evictions?*, 38 Health Affs. 1451 (2019), https://doi.org/10.1377/hlthaff.2018.05071 24

Samantha Artiga & Petry Ubri, *Key Issues in Children's Health Coverage*, Kaiser Fam. Found. (2017), https://files.kff.org/attachment/Issue-Brief-Key-Issues-in-Childrens-Health-Coverage 13, 14

Clara Bates, *Federal Government Steps In To Help Pull Missouri Out of Medicaid Backlog*, Mo. Indep. (Aug. 9, 2022), https://missouriindependent.com/2022/08/09/federal-government-steps-in-to-help-pull-missouri-out-of-medicaid-backlog/ 33

Chintan B. Batt & Consuelo M. Beck-Sagué, *Medicaid Expansion and Infant Mortality in the United States*, 108 Am. J. Pub. Health 565 (2018), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304218 21

Clare C. Brown et al., *Association of State Medicaid Expansion Status With Low Birth Weight and Preterm Birth*, 321 JAMA 1598 (2019), https://jamanetwork.com/journals/jama/fullarticle/2731179 21

David W. Brown et al., *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?*, Nat'l Bureau of Econ. Rsch. (Jan. 2015), https://www.nber.org/system/files/working_papers/w20835/w20835.pdf 23

Miscellaneous—Continued: Page(s)

Maggie Clark, *Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options*, Georgetown Univ. Health Pol'y Inst. Ctr. for Children & Fams. (2020), https://ccf.georgetown.edu/wp-content/uploads/2020/11/Pregnancy-primary-v6.pdf 13

CMS:

MAGI Application Processing Time Snapshot Report: January – March 2022 (Sept. 1, 2022), https://www.medicaid.gov/state-overviews/downloads/magi-app-process-time-snapshot-rpt-jan-mar-2022.pdf 33

Mandatory & Optional Medicaid Benefits (2022), https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html 10

May 2022 Medicaid and CHIP Enrollment Trends Snapshot (2022), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2022-medicaid-chip-enrollment-trend-snapshot.pdf 9, 10, 13

Missouri Eligibility & Enrollment Mitigation Plan – July 11, 2022 (2022), https://www.medicaid.gov/medicaid/eligibility/downloads/missouri-mitigation-plan.pdf 32

Miscellaneous—Continued: Page(s)

Seniors & Medicare and Medicaid Enrollees (2022), https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html 14

Who Enrolls in Medicaid & CHIP? (2022), https://www.medicaid.gov/state-overviews/scorecard/who-enrolls-medicaid-chip/index.html 11

Center on Budget & Pol'y Priorities, *The Far-Reaching Benefits of the ACA's Medicaid Expansion* (2020), https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion 19, 20, 23, 24

Sarah Cohodes et al., *The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions*, Nat'l Bureau of Econ. Rsch. (2014), https://www.nber.org/papers/w20178 24

Karen Davis & Cathy Schoen, *Health and the War on Poverty: A Ten Year Appraisal* (1978) 20

Lindsey Dawson & Jennifer Kates, *Insurance Coverage and Viral Suppression Among People with HIV, 2018*, Kaiser Fam. Found. (2020), https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/ 16

Miscellaneous—Continued: Page(s)

P. de Souto Barreto et al., *Recommendations on Physical Activity and Exercise for Older Adults Living In Long-Term Care Facilities: A Taskforce Report*, 2 J. of Nursing Home Research Scis. 7 (2016), http://www.aging-news.net/wp-content/uploads/2016 /08/48-1.pdf 23

Erica L. Eliason, *Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality*, 30 Women's Health Issues 147 (2020), https://doi.org/10.1016 /j.whi.2020.01.005 21

Bita Fayaz Farkhad et al., *Effect of Medicaid Expansions on HIV Diagnoses and Pre-Exposure Prophylaxis Use*, 60 Am. J. Preventative Med. 335 (2021), https://doi.org/ 10.1016/j.amepre.2020.10.021 22

Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Quarterly J. Econ. 1057 (2012), https://doi.org/10.1093/qje/qjs020 ..... 19, 23

Ivette Gomez et al., *Medicaid Coverage for Women* (2022), https://www.kff.org /womens-health-policy/issue-brief/medicaid-coverage-for-women/ 12

Miscellaneous—Continued: Page(s)

Andrew Goodman-Bacon:

The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes (2016), http://www-personal.umich.edu/~ajgb/medicaid_longrun_ajgb.pdf 19, 24

Public Insurance and Mortality: Evidence from Medicaid Implementation, 126 J. Pol. Econ. 1 (2018), https://doi.org/10.1086/695528 20

Sarah H. Gordon et al., *Effects Of Medicaid Expansion On Postpartum Coverage And Outpatient Utilization*, 39 Health Affs. 77 (2020), https://doi.org/10.1377/hlthaff.2019.00547 22

Madeline Guth, *State Policies Expanding Access to Behavioral Health Care in Medicaid*, Kaiser Fam. Found. (2021), https://www.kff.org/report-section/state-policies-expanding-access-to-behavioral-health-care-in-medicaid-appendices/ 16

Emily M. Johnston et al., *Post-ACA, More Than One-Third of Women with Prenatal Medicaid Remained Uninsured Before or After Pregnancy*, 40 Health Affs. 571 (2021), https://doi.org/10.1377/hlthaff.2020.01678 12

Miscellaneous—Continued: Page(s)

Kaiser Fam. Found.:

A Look at How Medicaid Agencies Are Assisting with the COVID-19 Vaccine Roll-Out (2021), https://www.kff.org/coronavirus-covid-19/issue-brief/a-look-at-how-medicaid-agencies-are-assisting-with-the-covid-19-vaccine-roll-out/ 10

Distribution of the Nonelderly with Medicaid by Race and Ethnicity (2019), https://www. kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D 11

Health Insurance Coverage of the Total Population (2019), https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Uninsured%22 27

Medicaid Initiatives to Improve Maternal and Infant Health and Address Racial Disparities (2022), https://www.kff.org/report-section/medicaid-initiatives-to-improve-maternal-and-infant-health-and-address-racial-disparities-issue-brief/ 12

Medicaid and HIV (2019), https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/ 16

Miscellaneous—Continued: Page(s)

Medicaid and Racial Health Equity (2022), https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/.....11

Medicaid's Role in Nursing Home Care (2017), https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/.....15

Monthly Child Enrollment in Medicaid and CHIP (2022), https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.....18

Status of State Medicaid Expansion Decisions: Interactive Map (2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.....8, 17

Leighton Ku & Sara Rosenbaum, *How Could Ending Access To The Courts Under Section 1983 Impact Medicaid Enrollees?*, Health Affairs (Sept. 13, 2022), https://www.healthaffairs.org/content/forefront/could-ending-access-courts-under-section-1983-impact-medicaid-enrollees 26, 34

Jessica Penn Lendon & Priyanka Singh, CDC, U.S. Dep't Health & Hum. Servs., *Adult Day Services Center Participant Characteristics: United States, 2018* (2021), https://www.cdc.gov/nchs/products/databriefs/db411.htm#section_2.....15

Miscellaneous—Continued: Page(s)

MACPAC:

MACStats: Medicaid and CHIP Data Book (2021), www.macpac.gov/wp-content/uploads/2021/12/ MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf 7, 11

Medicaid's Role in Financing Maternity Care Fact Sheet (2020), https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf 12

Report to Congress on Medicaid and CHIP (2011), https://www.macpac.gov/wp-content/uploads/2011/03/March-2011-Report-to-Congress-on-Medicaid-and-CHIP.pdf 6, 7

Report to Congress on Medicaid and CHIP (2013), https://www.macpac.gov/wp-content/uploads/2013/03/Medicaid-Coverage-of-Premiums-and-Cost-Sharing-for-Low-Income-Medicare-Beneficiaries.pdf 14

Report to Congress on Medicaid and CHIP (2022), https://www.macpac.gov /wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf 9

Miscellaneous—Continued: Page(s)

Melissa Majerol et al., *Health Care Spending Among Low-Income Households With and Without Medicaid*, Kaiser Fam. Found. (2016), https://www.kff.org/medicaid/issue-brief/health-care-spending-among-low-income-households-with-and-with out-medicaid/ 23

Anitha Menon et al., *The Impact of the Affordable Care Act Medicaid Expansion on Racial/Ethnic and Sex Disparities in HIV Testing: National Findings from the Behavioral Risk Factor Surveillance System*, 36 J. Gen. Internal Med. 1605 (2021), https://doi.org/10.1007/s11606-021-06590-2 22

Bruce D. Meyer & Laura R. Wherry, *Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility*, Nat'l Bureau Econ. Rsch. (2012), https://www.nber.org/papers/w18309 20

MaryBeth Musumeci & Julia Foutz, *Medicaid Restructuring Under the American Health Care Act and Nonelderly Adults with Disabilities*, Kaiser Fam. Found. (2017), https://www.kff.org/medicaid/issue-brief/medicaid-restructuring-under-the-american-health-care-act-and-nonelderly-adults-with-disabilities/ 15, 16

Miscellaneous—Continued: Page(s)

MaryBeth Musumeci & Kendal Orgera, *People with Disabilities Are At Risk of Losing Medicaid Coverage Without the ACA Expansion*, Kaiser Fam. Found. (2020), https://www.kff.org/medicaid/issue-brief/people-with-disabilities-are-at-risk-of-losing-medicaid-coverage-without-the-aca-expansion/ 16

Rebecca Myerson et al., *Medicaid Expansion Increased Preconception Health Counseling, Folic Acid Intake, and Postpartum Contraception*, 39 Health Affs. 188 (2020), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00106..... 21

Julia Paradise, *Data Note: Three Findings About Access to Care and Health Outcomes in Medicaid*, Kaiser Fam. Found. (2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/ 20

Erica L. Reaves & MaryBeth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer*, Kaiser Fam. Found. (2015), https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/ 14

Sara Rosenbaum & Paul Wise, *Crossing The Medicaid-Private Insurance Divide: The Case Of EPSDT*, 26 Health Affs. 382 (2007), https://doi.org/10.1377/hlthaff.26.2.382 28

Miscellaneous—Continued: Page(s)

Sara Rosenbaum et al., *What's at Stake for Beneficiaries When Medicaid's Continuous Enrollment Protection Winds Down?*, Commonwealth Fund (Apr. 13, 2022), https://www.commonwealthfund.org/blog/2022/whats-stake-beneficiaries-when-medicaids-continuous-enrollment-protection-winds-down 17

Sara Rosenbaum:

Medicaid and the Coronavirus: Putting the Nation's Largest Health Care First Responder to Work, Commonwealth Fund (Mar. 9, 2020), https://www.commonwealthfund.org/blog/2020/medicaid-and-coronavirus-putting-nations-largest-health-care-first-responder-work 10

Medicaid and the Role of the Courts, Commonwealth Fund (June 12, 2018), https://www.commonwealthfund.org/publications/fund-reports/2018/jun/medicaid-and-role-courts 27

Scott R. Sanders et al., *Infants Without Health Insurance: Racial/Ethnic and Rural/Urban Disparities in Infant Households' Insurance Coverage*, PLOS One (2020), https://doi.org/10.1371/journal.pone.0222387 22

Miscellaneous—Continued: Page(s)

Jessica Schubel, *Medicaid Helps Schools Help Children*, Ctr. on Budget & Pol'y Priorities (2017), https://www.cbpp.org/research/health/medicaid-helps-schools-help-children 18

S. Rep. No. 404, 89th Cong., 1st Sess. 9 (1965), reprinted in U.S. Code Cong. & Admin. News (1965) 6

Benjamin Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 J. of Am. Med. Ass'n 1501 (2016), http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420 19

U.S. Census Bureau, *Health Insurance: Tables 2018-Forward*, (2021), https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-hi/hi.html 13, 14

Courtney Harold Van Houtven et al., *Association of Medicaid Expansion Under the Patient Protection and Affordable Care Act With Use of Long-term Care*, 3 JAMA Network Open 1 (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771117 23

Miscellaneous—Continued: Page(s)

Matt Warfield et al., *How has the ACA Medicaid Expansion Affected Providers Serving the Homeless Population: Analysis of Coverage, Revenues, and Costs*, Kaiser Fam. Found. (2016), https://www.kff.org/medicaid/issue-brief/how-has-the-aca-medicaid-expansion-affected-providers-serving-the-homeless-population-analysis-of-coverage-revenues-and-costs/ 17

Laura R. Wherry et al., *Childhood Medicaid Coverage and Later Life Health Care Utilization*, Nat'l Bureau Econ. Rsch. (2015), https://www.nber.org/papers/w20929 20

Elizabeth Williams & MaryBeth Musumeci, *Children with Special Health Care Needs: Coverage, Affordability, and HCBS Access*, Kaiser Fam. Found. (2021), https://www.kff.org/medicaid/issue-brief/children-with-special-health-care-needs-coverage-affordability-and-hcbs-access/ 14, 18

INTEREST OF AMICI[1]

The 40 individual *amici* are deans, chairs, and scholars at the Nation's leading academic institutions and research universities. They are experts in the fields of health law, public health, health care policy and research, and national health reform. In their academic research, scholarship, and professional experiences, *amici* have analyzed Medicaid's role as the Nation's leading health insurer for millions of vulnerable pregnant women, children, people with disabilities, and other individuals who face systemic barriers to essential health care services and treatments. The full list of individual *amici*, all of whom are appearing in their individual capacities, is printed in an appendix to this brief. See App., *infra*, 1a.

The American Public Health Association (APHA) champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. APHA represents more than 22,000 individual members and is the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

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[1] Both parties provided blanket consent to the filing of this brief. No counsel for any party authored this brief in whole or in part, and no person or entity, other than amici curiae or their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

The American College of Preventive Medicine (ACPM) is a 501(c)(3) non-profit organization and professional medical society of more than 2,000 physicians dedicated to improving the health and quality of life of individuals, families, communities, and populations. Preventive medicine physicians bridge the divide between public health and clinical practice by applying their knowledge and skills in medicine and social, economic, and behavioral sciences to improve health through disease prevention and health promotion. ACPM advocates for policy and practice that bolsters disease prevention efforts and creates healthier communities.

SUMMARY OF THE ARGUMENT

The Medicaid Act entitles the Nation's most vulnerable to health care. Yet decades of litigation show that States do not always recognize Medicaid beneficiaries' rights. Over the past half century, States unlawfully slashed coverage for pediatric health care services, see *Rosie D.* v. *Romney*, 410 F. Supp. 2d 18, 22 (D. Mass. 2006); *Mitchell* v. *Johnston*, 701 F.2d 337, 341 (5th Cir. 1983); *C.R. ex rel. Reed* v. *Noggle*, 559 F. Supp. 3d 1323, 1330-1333 (N.D. Ga. 2021), reduced benefits for children and adults with mental health issues or disabilities, see *K.B. ex rel. T.B.* v. *Michigan Dep't of Health & Hum. Servs.*, 367 F. Supp. 3d 647, 651 (E.D. Mich. 2019); *Waskul* v. *Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426, 445-452 (6th Cir. 2020), and prevented low-income, working parents from accessing their rightful Medicaid benefits. See *Rabin* v. *Wilson-Coker*, 362 F.3d 190, 192 (2d Cir. 2004).

In these and many more cases, Medicaid beneficiaries and providers relied on Section 1983 to enforce the rights Congress guaranteed through the Medicaid Act.

Petitioners, however, ask this Court to prevent the beneficiaries of any Spending Clause legislation from relying on Section 1983 to protect their rights. If petitioners succeed, millions of Medicaid beneficiaries would be powerless to prevent States from slashing coverage and denying benefits, and States would no longer be subject to judicial oversight. As explained further below:

I. Medicaid establishes three interlocking rights that play a critical role in keeping the Nation's most vulnerable people healthy and safe: the right to apply for coverage; the right to prompt medical assistance if determined eligible; and the right to a carefully defined scope of covered care. Congress clearly enumerated those rights in the Medicaid Act, and States clearly acknowledged those rights by submitting plans to protect them. Over time, Congress has adjusted the Medicaid Act's eligibility and coverage, but always in a single direction: to provide more health care rights to more of the Nation's most vulnerable.

II. The demographic data on Medicaid beneficiaries bears out Congress's goal of providing coverage to the people most in need. Medicaid disproportionately benefits pregnant women and children: more than a quarter of all pregnant women in the United States lack other health insurance coverage; Medicaid pays for nearly half of the live births in the United States; and Medicaid insures nearly half of the Nation's children under the age of three. Medicaid also guarantees indispensable health care coverage to elderly Medicare beneficiaries, Medicare beneficiaries with disabilities, and others who experience severe disabilities, by funding long-term services and supports in both institutional and community settings. Within each beneficiary group, people of color and

people living in rural areas are the most likely to rely on Medicaid for crucial medical care.

III. By granting the Nation's most vulnerable a right to health insurance coverage, Medicaid helps reduce disparities and improve health outcomes. Medicaid makes it more likely that mothers can safely give birth to healthy children, and less likely that those mothers and children experience adverse outcomes during the children's early years. Medicaid beneficiaries are also more likely to receive routine preventive treatment, to experience stable health care coverage, to spend a higher proportion of their income on bare necessities other than health care, and to experience academic success. In contrast, Medicaid beneficiaries are less likely to visit the emergency room or require emergency treatment. And because Medicaid pays for nearly half of the Nation's long-term care, Medicaid grants disabled and elderly people the right to age with dignity.

IV. Medicaid coverage means nothing, however, if beneficiaries cannot protect their right to health care. Section 1983 directly secures that right. Section 1983 provides the means by which beneficiaries can secure targeted injunctive relief while preventing interruptions in Medicaid eligibility and coverage. And even when Medicaid beneficiaries do not prevail on the merits of their claims, Section 1983 enables them to present their cases in court and deters States from engaging in unlawful behavior. If petitioners prevail here, however, Medicaid beneficiaries would effectively lose the ability to protect their rights: administrative hearings are no substitute for court-ordered injunctions, and the government's only enforcement mechanism (cutting federal funding) is far too damaging to the entire state program

to pose a realistic remedy and no substitute for Section 1983 enforcement. States could eliminate services, slash coverage, and restrict eligibility (all of which they have done in the past), and Medicaid beneficiaries would lack any enforcement mechanism to quickly right States' wrongs. As recent empirical analysis shows, the loss of an effective means to vindicate their rights would have a profound and negative effect on Medicaid beneficiaries.

ARGUMENT

I. MEDICAID IS AN INDISPENSABLE SOURCE OF COVERAGE WITHIN THE NATION'S HEALTH SYSTEM

Enacted in 1965, and codified at Title XIX of the Social Security Act, Medicaid is a joint federal and state needs-based program that entitles eligible people to "medical assistance" for the costs of medically necessary health care. See 42 U.S.C. 1396 *et seq.* By its very terms, Medicaid guarantees people three rights: the right to apply for coverage; the right to prompt medical assistance if determined eligible; and the right to coverage of a carefully defined amount, duration and scope that helps ensure access to medically necessary care. See 42 U.S.C. 1396a(a)(8), (a)(10); 42 U.S.C. 1396d(a). In the Medicaid Act, Congress spoke clearly, using language focused on creating individual rights, compare 42 U.S.C. 1396a(a)(8), (a)(10), with 42 U.S.C. 1397bb(b)(5) (disclaiming individual rights in separate State Children's Health Insurance Program), and Congress ensured that States were on notice of those individual rights by requiring States to develop federally approved plans recognizing these rights. See 42 U.S.C. 1396a(a).

These rights revolutionized access to health care coverage and care for tens of millions of poor and medically vulnerable individuals who lacked employer-sponsored coverage and were excluded from private insurance or could not afford it. Indeed, Congress intended that Medicaid serve as a companion to Medicare by "extend[ing] the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals in the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need." S. Rep. No. 404, 89th Cong., 1st Sess. 9 (1965), reprinted in U.S. Code Cong. & Admin. News (1965).

Medicaid eligibility initially followed the contours of cash welfare assistance, covering families with children who received such assistance, people who were elderly, blind, or living with severe disabilities, and populations recognized as "medically needy." As Medicaid's enormous achievements in extending insurance coverage to key populations became evident, Congress repeatedly expanded Medicaid to broaden coverage rules and reach new populations. See *National Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 627 (2012) (*NFIB*) (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("Since 1965, Congress has amended the Medicaid program on more than 50 occasions, sometimes quite sizably."); see also MACPAC, *Report to Congress on Medicaid and CHIP* 11-13 (2011) (*2011 MACPAC Report to Congress*), https://www.macpac.gov/wp-content/uploads/2011/03/March-2011-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

For example, beginning with the enactment of the Supplemental Security Income program in 1972, Congress steadily expanded eligibility for poor children and adults with severe disabilities. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972); MACPAC, *MACStats: Medicaid and CHIP Data Book* 22 (2021) (*2021 MACPAC Medicaid and CHIP Data Book*), www.macpac.gov/wp-content/uploads/2021/12/ MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf. Moreover, between 1984 and 1990, Congress "made significant changes to Medicaid." *2011 MACPAC Report to Congress*, at 29. Moving beyond eligibility predominantly linked only to the receipt of cash welfare, Congress mandated eligibility for low-income pregnant women and children regardless of whether they received welfare payments. These reforms transformed health care access for these populations by requiring "participating States to include among their beneficiaries pregnant women with family incomes up to 133% of the federal poverty level." *NFIB*, 567 U.S. at 627 (citing 42 U.S.C. 1396a(a)(10)(A)(i), 42 U.S.C. 1396a(*l*)).

And as part of a "breathtaking" commitment to the Nation's children, Congress ensured through the guarantee of early and periodic screening, diagnostic, and treatment services (EPSDT), that "no Medicaid-eligible child in this country, whatever his or her economic circumstances, will go without treatment deemed medically necessary by his or her clinician." *Rosie D.* v. *Romney*, 410 F. Supp. 2d 18, 21-22 (D. Mass. 2006); see also 42 U.S.C. 1396a(a)(43) (requiring state plans to make EPSDT services available); 42 U.S.C. 1396d(r) (defining EPSDT to include physical exams as well as vision, dental, hearing, and other periodic screening services).

More recently, the Affordable Care Act (ACA) further expanded Medicaid's reach by establishing a new eligibility category for low-income, working-age adults. That new eligibility category includes adults with incomes up to 133 percent of the federal poverty level who do not fall into a traditional eligibility group and are not entitled to Medicare. As of July 2022, 38 states and the District of Columbia have adopted this expansion made optional by *NFIB*. 567 U.S. at 542 (citing 42 U.S.C. 1396a(a)(10)(A)(i)(VIII)); Kaiser Fam. Found., *Status of State Medicaid Expansion Decisions: Interactive Map* (2022) (*Medicaid Expansion Decisions*), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

In short, although Congress's changes to Medicaid have been frequent, they have always resulted in more eligibility and coverage rights for more people. As a result, those with the right to Medicaid coverage now represent the broad spectrum of the Nation's most vulnerable persons.

II. MEDICAID IS THE SOURCE OF HEALTH CARE COVERAGE FOR THE NATION'S MOST VULNERABLE POPULATIONS

Congress's actions have had their desired effect. Medicaid now provides a wide range of covered health care services, and it has become the essential health insurer for tens of millions of people. Medicaid's vital role is the natural result of Congress's decision to grant rights directly to people in great need; although States have flexibility to tailor their programs in certain respects, once States codify their choices in federally approved State plans or waivers, eligible individuals have

the right to apply for and receive assistance if determined eligible. This binding, direct obligation is the central tenet of Medicaid: "to assist pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care." *NFIB*, 567 U.S. at 541 (majority opinion); see also 42 U.S.C. 1396a(a)(10); MACPAC, *Report to Congress on Medicaid and CHIP* 3 (2022), https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf ("Medicaid provides coverage for health care and other related services to * * * the nation's most economically disadvantaged people, including low-income children and their families, pregnant women, people over the age of 65, and people with disabilities[.]").

Since its enactment in 1965, Medicaid has done just that. As of May 2022, nearly 82 million individuals were enrolled in Medicaid, with another seven million enrolled in the related Children's Health Insurance Program (CHIP), codified at Title XXI of the Social Security Act. See CMS, *May 2022 Medicaid and CHIP Enrollment Trends Snapshot* (2022) (*May 2022 Snapshot*), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2022-medicaid-chip-enrollment-trend-snapshot.pdf. Once enrolled, people covered by Medicaid have access to a wide range of services for their medical needs: comprehensive preventive care for children and adolescents; preventive care to promote reproductive health; pregnancy-related and postpartum care; comprehensive primary and specialty care; prescription drugs; inpatient and outpatient hospital care; and extended institutional and home- and community-based care for the frail elderly and disabled children

and adults. CMS, *Mandatory & Optional Medicaid Benefits* (2022), https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html.

Medicaid is also the Nation's largest health care first responder during public health emergencies, a recurring role for the program most recently employed beginning with the earliest days of the COVID-19 pandemic. Sara Rosenbaum, *Medicaid and the Coronavirus: Putting the Nation's Largest Health Care First Responder to Work*, Commonwealth Fund (Mar. 9, 2020), https://www.commonwealthfund.org/blog/2020/medicaid-and-coronavirus-putting-nations-largest-health-care-first-responder-work. Between February 2020 and April 2022, Medicaid enrolled approximately 17.5 million additional Americans who otherwise would have faced the worst pandemic in a century without health insurance. See *May 2022 Snapshot*, *supra*. Medicaid coverage also was crucial to ensuring access to COVID-19 vaccines. Kaiser Fam. Found., *A Look at How Medicaid Agencies Are Assisting with the COVID-19 Vaccine Roll-Out* (2021), https://www.kff.org/coronavirus-covid-19/issue-brief/a-look-at-how-medicaid-agencies-are-assisting-with-the-covid-19-vaccine-roll-out/.

Medicaid has likewise become the cornerstone of health care for the Nation's poorest pregnant women, children, elderly people, people with disabilities, and low-income families—the persons in this Nation who are the most in need of care but who have no means to obtain it otherwise. See *NFIB*, 567 U.S. at 634 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("The purpose of Medicaid is to enable States 'to furnish * * * medical assistance on behalf of [certain persons] whose income and resources are

insufficient to meet the costs of necessary medical services.'" (quoting Social Security Amendments of 1965, Section 121(a), 79 Stat. 343) (brackets in original)). Medicaid beneficiaries are disproportionately people of color, disproportionately in fair to poor health, disproportionately at risk for exposure to ongoing health threats as a result of the impoverished living conditions they face, as well as the health burdens borne by populations that frequently have been the subject of racism and cultural exclusion. See Kaiser Fam. Found., *Medicaid and Racial Health Equity* (2022), https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/; Kaiser Fam. Found., *Distribution of the Nonelderly with Medicaid by Race and Ethnicity* (2019), https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; *2021 MACPAC Medicaid and CHIP Data Book*, at 112.

As described in more detail below, Medicaid plays a critical role as a health insurer for each of these subsets of the Nation's population.

A. Coverage for women and children

Women and children make up the vast majority of Medicaid and CHIP enrollees. In 2020, 54 percent of Medicaid and CHIP enrollees were female, while 53 percent of enrollees were under age 21. CMS, *Who Enrolls in Medicaid & CHIP?* (2022), https://www.medicaid.gov/state-overviews/scorecard/who-enrolls-medicaid-chip/index.html.

As the Nation's single largest source of coverage for pregnancy care, Medicaid plays an outsize role for pregnant women and infants. Ivette Gomez et al., *Medicaid Coverage for Women* (2022) (Gomez et al.), https://www.kff.org/womens-health-policy/issue-brief/medicaid-coverage-for-women/. Medicaid is often the only pathway to insurance coverage during pregnancy. An estimated 27 percent of pregnant women enrolled in Medicaid were uninsured before qualifying based on pregnancy status. Emily M. Johnston et al., *Post-ACA, More Than One-Third of Women with Prenatal Medicaid Remained Uninsured Before or After Pregnancy*, 40 Health Affs. 571 (2021), http://doi.org/10.1377/hlthaff.2020.01678.

Medicaid insures nearly half of all live births in the United States, see Gomez et al., *supra*, and is the largest payer of births to rural women, women under age 19, and women of color. See MACPAC, *Medicaid's Role in Financing Maternity Care Fact Sheet* (2020), https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf.

Medicaid continues to play a vital role after women give birth, offering postpartum coverage and care, which now, at a State's option, can extend to 12 months. Kaiser Fam. Found., *Medicaid Initiatives to Improve Maternal and Infant Health and Address Racial Disparities* (2022), https://www.kff.org/report-section/medicaid-initiatives-to-improve-maternal-and-infant-health-and-address-racial-disparities-issue-brief/. In order to ensure access to essential care during the first year of life, babies born to women whose pregnancies were Medicaid-insured are automatically entitled to 12 months of continuous coverage. 42 U.S.C. 1396a(e)(4). In 2020, Medi-

caid covered over one third (34.8 percent) of all U.S. children. U.S. Census Bureau, *Health Insurance: Tables 2018-Forward*, Table H-05 (2021) (U.S. Census Bureau), https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-hi/hi.html. As of April 2022, over 40 million children were enrolled in Medicaid or CHIP. *May 2022 Snapshot*, *supra*.

Medicaid is thus fundamental to children's insurance coverage, having reduced the proportion of uninsured children in the United States from 14 percent in 1997 to five percent by 2016. Samantha Artiga & Petry Ubri, *Key Issues in Children's Health Coverage* 2, Kaiser Fam. Found. (2017) (Artiga & Ubri), https://files.kff.org/attachment/Issue-Brief-Key-Issues-in-Childrens-Health-Coverage. Young children are especially reliant on Medicaid. In 2020, Medicaid covered nearly half of all children under the age of three, making Medicaid the single largest source of coverage for infants and toddlers. Maggie Clark, *Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options*, Georgetown Univ. Health Pol'y Inst. Ctr. for Children & Fams. (2020), https://ccf.georgetown.edu/wp-content/uploads/2020/11/Pregnancy-primary-v6.pdf; see U.S. Census Bureau, at Table H-05 (providing that 38 percent of children under the age of three had Medicaid in 2020).

Medicaid and CHIP play an even larger role for children from low-income households who have special health needs, insuring 66 percent of low-income children (household incomes below 200 percent of the poverty level) and 76 percent of children in the poorest families (household incomes below 100 percent of the poverty

level) in 2017. Artiga & Ubri, *supra*; see also U.S. Census Bureau, at Table H-05. In 2019, Medicaid and CHIP insured over 40 percent of children with special health care needs, including needs related to physical and behavioral disabilities or chronic health conditions. Elizabeth Williams & MaryBeth Musumeci, *Children with Special Health Care Needs: Coverage, Affordability, and HCBS Access*, Kaiser Fam. Found. (2021) (Williams & Musumeci), https://www.kff.org/medicaid/issue-brief/children-with-special-health-care-needs-coverage-affordability-and-hcbs-access/.

B. Coverage for the elderly

Medicaid plays a vital role for the elderly, working in tandem with Medicare by covering supplemental benefits and Medicare's steep cost-sharing requirements. In 2022, Medicaid acted as a supplemental insurer to 7.2 million low-income Medicare beneficiaries aged 65 and older. CMS, *Seniors & Medicare and Medicaid Enrollees* (2022), https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html. Among the benefits Medicaid guarantees is coverage of Medicare cost sharing for low-income elderly beneficiaries, which otherwise would be a barrier to care. MACPAC, *Report to Congress on Medicaid and CHIP* (2013), https://www.macpac.gov/wp-content/uploads/2013/03/Medicaid-Coverage-of-Premiums-and-Cost-Sharing-for-Low-Income-Medicare-Beneficiaries.pdf.

Medicaid is also the primary payer for long-term care in the United States, paying for well over half of care furnished in nursing facilities and adult day centers. Medicaid pays for 51 percent of assistance with daily self-care tasks. Erica L. Reaves & MaryBeth Musumeci,

Medicaid and Long-Term Services and Supports: A Primer, Kaiser Fam. Found. (2015), https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/. In 2015, Medicaid covered 60 percent of the Nation's 1.4 million nursing home residents. Kaiser Fam. Found., *Medicaid's Role in Nursing Home Care* (2017) (*Medicaid's Role in Nursing*), https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/. In 2018, Medicaid insured 72 percent of adult day center participants. Jessica Penn Lendon & Priyanka Singh, CDC, U.S. Dep't Health & Hum. Servs., *Adult Day Services Center Participant Characteristics: United States, 2018* (2021), https://www.cdc.gov/nchs/products/databriefs/db411.htm#section_2. Over the next 30 years, the number of adults needing long-term care will rise dramatically; about one-third of all people aged 65 or older will require long-term care at some point in their lives. *Medicaid's Role in Nursing*, *supra*.

C. Coverage for the highest-need populations

Medicaid is an indispensable source of coverage for people for whom standard insurance, even if available, would fall vastly short of need—children and adults with lifelong disabilities, people living with severe mental illness and addiction disorders, people with chronic, life-threatening conditions such as HIV/AIDS, and people who experience homelessness.

For example, Medicaid covers more than 30 percent of nonelderly disabled adults in the United States. MaryBeth Musumeci & Julia Foutz, *Medicaid Restructuring Under the American Health Care Act and Nonelderly Adults with Disabilities*, Kaiser Fam. Found. (2017) (Musumeci & Foutz), https://www.kff.org/medicaid/issue-brief/medicaid-restructuring-under-the-ameri

can-health-care-act-and-nonelderly-adults-with-disabilities/; MaryBeth Musumeci & Kendal Orgera, *People with Disabilities Are At Risk of Losing Medicaid Coverage Without the ACA Expansion*, Kaiser Fam. Found. (2020), https://www.kff.org/medicaid/issue-brief/people-with-disabilities-are-at-risk-of-losing-medicaid-coverage-without-the-aca-expansion/. Adults with disabilities who are enrolled in Medicaid are four times as likely to receive nursing or other health care at home, more than two-and-a-half times as likely to have three or more functional limitations, and more than one-and-a-half times as likely to have ten or more health care visits in a year. Musumeci & Foutz, *supra*.

Medicaid is also the largest source of coverage for life-threatening and chronic conditions such as HIV, substance abuse disorders, and mental illness. In 2017 Medicaid covered approximately 42 percent of adults living with HIV/AIDS, creating access to life-saving treatment for countless people. Kaiser Fam. Found., *Medicaid and HIV* (2019), https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/; Lindsey Dawson & Jennifer Kates, *Insurance Coverage and Viral Suppression Among People with HIV, 2018*, Kaiser Fam. Found. (2020), https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/.

In 2020, Medicaid covered 23 percent of nonelderly adults living with mental illness, and 22 percent of nonelderly adults living with a substance abuse disorder. Madeline Guth, *State Policies Expanding Access to Behavioral Health Care in Medicaid*, Kaiser Fam. Found. (2021), https://www.kff.org/report-section/state-policies-expanding-access-to-behavioral-health-care-in-medicai

d-appendices/. Compared to their privately insured counterparts, adults enrolled in Medicaid and CHIP were more likely to have a substance abuse disorder or mental illness, which in turn carries a greater need for mental health services. Sara Rosenbaum et al., *What's at Stake for Beneficiaries When Medicaid's Continuous Enrollment Protection Winds Down?*, Commonwealth Fund (Apr. 13, 2022), https://www.commonwealthfund.org/blog/2022/whats-stake-beneficiaries-when-medicaids-continuous-enrollment-protection-winds-down.

Beyond its specialized role for people with disabilities, Medicaid is also a dominant insurer for low-income workers in States adopting the ACA's eligibility expansion (38 states and the District of Columbia as of July 2022). *Medicaid Expansion Decisions*, *supra*. In Medicaid-expansion States, Medicaid mitigates the lack of coverage for those employed in jobs without benefits or in jobs with benefits that carry prohibitively expensive premiums. Medicaid is likewise vital for people experiencing homelessness, particularly in States that have adopted the ACA Medicaid expansion. In those States, 67 percent of individuals experiencing homelessness had Medicaid coverage in 2014, compared to 30 percent in non-expansion States. Matt Warfield et al., *How has the ACA Medicaid Expansion Affected Providers Serving the Homeless Population: Analysis of Coverage, Revenues, and Costs*, Kaiser Fam. Found. (2016), https://www.kff.org/medicaid/issue-brief/how-has-the-aca-medicaid-expansion-affected-providers-serving-the-homeless-population-analysis-of-coverage-revenues-and-costs/.

Because Medicaid can supplement private insurance coverage as well as Medicare, Medicaid is also essential

for thousands of children with severe disabilities who live in families enrolled in employer plans but whose plans do not cover advanced, long-term care. Williams & Musumeci, *supra*. Medicaid is also the source of coverage for 40 million children and is the major source of coverage for children receiving special education and early intervention services under the Individuals with Disabilities Education Act. Kaiser Fam. Found., *Monthly Child Enrollment in Medicaid and CHIP* (2022), https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Jessica Schubel, *Medicaid Helps Schools Help Children*, Ctr. on Budget & Pol'y Priorities (2017), https://www.cbpp.org/research/health/medicaid-helps-schools-help-children ("Medicaid helps fill this gap by providing reimbursement for health care services that are necessary for students with disabilities to succeed in school * * * .").

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In short, Medicaid plays a vital role for the Nation's most vulnerable, including pregnant women and children; the elderly; and people of all ages with severe disabilities.

III. Medicaid Has Improved Health Outcomes For The Most Vulnerable

Medicaid's achievements in protecting these vulnerable individuals can be measured in their improved quality of life. The care made accessible through Medicaid has produced myriad health benefits. Those health benefits, in turn, are correlated with reduced economic strain and greater academic success.

Thus, Medicaid has made its beneficiaries not only healthier, but better off across a variety of qualify-of-life metrics.

A. Medicaid improves health

Medicaid is associated with improved health outcomes for beneficiaries, including increased use of primary and preventive care, as well as better self-reported physical and mental health. See Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Quarterly J. Econ. 1057 (2012) (Finkelstein), https://doi.org/10.1093/qje/qjs020; Benjamin Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 J. of Am. Med. Ass'n 1501 (2016), http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420. Research also shows that Medicaid expansion has saved thousands of lives. See Ctr. on Budget & Pol'y Priorities, *The Far-Reaching Benefits of the ACA's Medicaid Expansion* (2020) (*ACA's Medicaid Expansion*), https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion ("Medicaid expansion saved the lives of at least 19,200 adults aged 55 to 64 between 2014 and 2017.").

Medicaid coverage plays a vital role in promoting the health and well-being of children and adolescents. Numerous studies on the effect of the ACA's Medicaid expansion, for example, show that Medicaid eligibility during childhood has long-term positive impacts, including reduced disability, decreased adolescent mortality, and lower rates of emergency room visits and hospitalization later in life. See, *e.g.*, Andrew Goodman-Bacon,

The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes (2016), http://www-personal.umich.edu/~ajgb/medicaid_longrun_ajgb.pdf; Julia Paradise, *Data Note: Three Findings About Access to Care and Health Outcomes in Medicaid*, Kaiser Fam. Found. (2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/. Research also shows that children are more likely to attend annual primary care check-ups if their parents are enrolled in Medicaid. *ACA's Medicaid Expansion*, *supra*. Among Black children, evidence suggests that Medicaid coverage during childhood was associated with fewer emergency room visits and hospitalizations in adulthood. Laura R. Wherry et al., *Childhood Medicaid Coverage and Later Life Health Care Utilization*, Nat'l Bureau Econ. Rsch. (2015), https://www.nber.org/papers/w20929. Another study outside of the Medicaid expansion context found that childhood Medicaid coverage at ages fifteen through eighteen substantially decreased the later-life mortality of Black children. Bruce D. Meyer & Laura R. Wherry, *Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility*, Nat'l Bureau Econ. Rsch. (2012), https://www.nber.org/papers/w18309.

Extensive research has shown Medicaid's impact on maternal and infant health. As Medicaid opened access to hospital births for the most disadvantaged women, the program had a documented impact on infant mortality rates across all races. See Karen Davis & Cathy Schoen, *Health and the War on Poverty: A Ten Year Appraisal* (1978). Medicaid continues to contribute to declines in U.S. infant and child mortality rates. See Andrew Goodman-Bacon, *Public Insurance and Mortality:*

Evidence from Medicaid Implementation, 126 J. Pol. Econ. 1 (2018), https://doi.org/10.1086/695528 (observing that "[a]fter Medicaid, * * * mortality fell more rapidly among children and infants in high-Medicaid-eligibility states"). Several studies of States that expanded Medicaid indicate that access to Medicaid has narrowed disparities for women of color, especially on measures of maternal mortality, infant mortality, low birthweight, and preterm birth. See Chintan B. Batt & Consuelo M. Beck-Sagué, *Medicaid Expansion and Infant Mortality in the United States*, 108 Am. J. Pub. Health 565 (2018), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.304218 ("Infant mortality rate decline was greater in Medicaid expansion states, with greater declines among African American infants."); Clare C. Brown et al., *Association of State Medicaid Expansion Status With Low Birth Weight and Preterm Birth*, 321 JAMA 1598 (2019), https://jamanetwork.com/journals/jama/fullarticle/2731179 (finding that States that expanded Medicaid saw "significant improvements" in rates of Black infants' low birth weight and preterm birth outcomes); Erica L. Eliason, *Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality*, 30 Women's Health Issues 147, 150 (2020), https://doi.org/10.1016/j.whi.2020.01.005 (concluding that the data "indicat[es] that Medicaid expansion could be contributing to a reduction in the large racial disparity in maternal mortality faced by Black mothers").

Medicaid also plays a vital role in encouraging healthy pregnancies. For instance, research on Medicaid expansion States reveals that Medicaid coverage is associated with greater use of reproductive health counseling and increased folic acid intake. Rebecca Myerson et al., *Medicaid Expansion Increased Preconception*

Health Counseling, Folic Acid Intake, and Postpartum Contraception, 39 Health Affs. 188 (2020), https:// www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00106. Similar research also reveals that Medicaid coverage is associated with increased health care screenings for diseases such as HIV. See, *e.g.*, Anitha Menon et al., *The Impact of the Affordable Care Act Medicaid Expansion on Racial/Ethnic and Sex Disparities in HIV Testing: National Findings from the Behavioral Risk Factor Surveillance System*, 36 J. Gen. Internal Med. 1605 (2021), https://doi.org/10.1007/s11606-021-06590-2; Bita Fayaz Farkhad et al., *Effect of Medicaid Expansions on HIV Diagnoses and Pre-Exposure Prophylaxis Use*, 60 Am. J. Preventative Med. 335 (2021), https://doi.org/10.1016/j.amepre.2020.10.021.

Medicaid is associated with increased health coverage stability for mothers and infants in the months following birth. One study comparing a State that expanded Medicaid (Colorado) to one that did not (Utah) found that mothers enrolled in Medicaid sought more postpartum care than those without coverage; such care, in turn, is associated with lower maternal mortality and morbidity. Sarah H. Gordon et al., *Effects Of Medicaid Expansion On Postpartum Coverage And Outpatient Utilization*, 39 Health Affs. 77 (2020), https://doi.org/10.1377/hlthaff.2019.00547; see also Scott R. Sanders et al., *Infants Without Health Insurance: Racial/Ethnic and Rural/Urban Disparities in Infant Households' Insurance Coverage*, PLOS One (2020), https://doi.org/10.1371/journal.pone.0222387 ("[T]he Medicaid expansion benefited infants across the rural/urban spectrum and ethnic/racial groups.").

Medicaid coverage is also associated with increased use of long-term services and supports by beneficiaries. See Courtney Harold Van Houtven et al., *Association of Medicaid Expansion Under the Patient Protection and Affordable Care Act With Use of Long-term Care*, 3 JAMA Network Open 1 (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771117; *ACA's Medicaid Expansion*, *supra*. Such care can potentially, in turn, improve beneficiaries' health outcomes. See, *e.g.*, P. de Souto Barreto et al., *Recommendations on Physical Activity and Exercise for Older Adults Living In Long-Term Care Facilities: A Taskforce Report*, 2 J. of Nursing Home Research Scis. 7 (2016), http://www.aging-news.net/wp-content/uploads/2016/08/48-1.pdf (explaining how long-term care facilities can improve residents' health outcomes by monitoring their physical activity to ensure that they meet scientific standards).

B. Medicaid improves economic wellbeing

On the economic front, Medicaid makes health care affordable for low-income households and enables them to pay for other necessities—including food, housing, and transportation. Melissa Majerol et al., *Health Care Spending Among Low-Income Households With and Without Medicaid*, Kaiser Fam. Found. (2016), https://www.kff.org/medicaid/issue-brief/health-care-spending-among-low-income-households-with-and-without-medicaid/. Research shows that Medicaid decreases financial strain by lowering out-of-pocket medical expenditures and medical debt. Finkelstein, *supra*. Medicaid coverage during childhood also increases beneficiaries' income. See David W. Brown et al., *Medicaid as an Investment in Children: What is the Long-Term Impact*

on Tax Receipts?, Nat'l Bureau of Econ. Rsch., at 30 (Jan. 2015), https://www.nber.org/system/files/working_papers/w20835/w20835.pdf ("Our main coefficient suggests that each year of Medicaid eligibility during childhood increases cumulative income and payroll taxes at age 31 by $1,561 on a base of $35,268, a 4.4% increase."). In addition to protecting against potentially catastrophic medical bills, Medicaid is associated with improved economic mobility through better access to credit and fewer evictions among low-income renters. *ACA's Medicaid Expansion*, *supra*. Indeed, one study found that early Medicaid expansion in California was associated with a significant reduction in the number of evictions. Heidi Allen et al., *Can Medicaid Expansion Prevent Housing Evictions?*, 38 Health Affs. 1451 (2019), https://doi.org/10.1377/hlthaff.2018.05071.

Medicaid is also associated with greater academic success. Research has documented Medicaid's role in improving long-term educational attainment among children. See Andrew Goodman-Bacon, *The Long-Run Effects of Childhood Insurance Coverage*, *supra*. Another study determined that providing health care coverage to low-income children increases high school and college completion rates. See Sarah Cohodes et al., *The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions*, Nat'l Bureau of Econ. Rsch. (2014), https://www.nber.org/papers/w20178 ("Our findings indicate that expanding health insurance coverage for low-income children increases the rate of high school completion and college completion.").

IV. WITHOUT SECTION 1983 ENFORCEMENT RIGHTS, THE NATION'S MOST VULNERABLE WOULD LOSE HEALTH INSURANCE COVERAGE

Medicaid owes its well-documented success in improving coverage, access, and health to its entitlement structure. Medicaid applicants have rights to timely eligibility determinations and enrollment if found eligible. See 42 U.S.C. 1396a(a)(8). Medicaid beneficiaries also have a right to comprehensive coverage. See 42 U.S.C. 1396a(a)(10). If those rights are no longer enforceable, States seeking rapid cost savings could choose—and indeed *have chosen*—to close the Medicaid application process, place arbitrary limits on enrollment, and impose across-the-board or system-wide restrictions that reduce coverage below mandatory minimums, all in clear violation of federal law that States knowingly agreed to implement when accepting Medicaid funding.

The federal government alone, however, lacks tools to enforce Medicaid beneficiaries' rights effectively without thwarting Medicaid's other policy goals. Besides pursuing negotiated corrective action plans or threatening to withhold federal funding (a blunt and unworkable federal remedy, see *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 52 (1981) (White, J., dissenting in part) (describing "funds cutoff" as a "drastic remedy with injurious consequences to the supposed beneficiaries" of a statute)), the federal government is unable to fashion targeted remedies that protect Medicaid beneficiaries from irreparable harm.

Against that backdrop, this Court has consistently recognized Medicaid as creating privately enforceable rights under Section 1983. *Wilder* v. *Virginia Hospital*

Ass'n, 496 U.S. 498, 502 (1990), rests on decisions by this Court dating back decades, including *Maine* v. *Thiboutot*, 448 U.S. 1 (1980). *Thiboutot*'s commonsense, plain-language interpretation of Section 1983, see *id.* at 4, opened the courthouse doors to Medicaid beneficiaries to pursue injunctive relief in cases where States unlawfully attempted to limit Medicaid eligibility and coverage, and when States refused to furnish necessary medical assistance with reasonable promptness. Together, *Thiboutot* and the cases that came before it mean that pregnant women, children, the elderly, people with disabilities, low-income families, poor working-age adults, people who are homeless, people living with HIV/AIDS, and people who relied on Medicaid to survive the COVID-19 pandemic can depend on Medicaid's statutory entitlements.

Were private enforcement rights to be eliminated, a State would be free to, for example, turn away hundreds of thousands of eligible applicants or to withdraw preventive benefits for children. States have attempted to do both, and the implications of both types of unlawful actions are measurable and significant. Leighton Ku & Sara Rosenbaum, *How Could Ending Access To The Courts Under Section 1983 Impact Medicaid Enrollees?*, Health Affairs (Sept. 13, 2022) (Ku & Rosenbaum), https://www.healthaffairs.org/content/forefront/could-ending-access-courts-under-section-1983-impact-medicaid-enrollees. Yet, time and again, Section 1983 has enabled people to seek *targeted* judicial relief in cases involving unlawful actions by state Medicaid officials—relief that honors the balance of federalism by enabling pinpointed remedies that spare the entirety of a State's Medicaid program, thereby protecting both Medicaid beneficiaries and state budgets. Petitioners,

however, ask this Court to eliminate that method of enforcement. This case thus effectively puts Medicaid's coverage guarantees for some 82 million people on the line.

A. Section 1983 protects Medicaid coverage

Through Medicaid participation, States accept the statutory federal commitment to individual rights that lies at the heart of the Medicaid program. Judicial protection of these statutory rights to eligibility and coverage under Section 1983 is integral to Medicaid's existence as the Nation's single largest health insurer. Sara Rosenbaum, *Medicaid and the Role of the Courts*, Commonwealth Fund (June 12, 2018) (*Medicaid & Courts*), https://www.commonwealthfund.org/publications/fund-reports/2018/jun/medic aid-and-role-courts.

Throughout Medicaid's history, the importance of a judicial remedy has been driven home time and again. See *Medicaid & Courts*, *supra* ("For a half century, judicial decisions have shaped virtually every aspect of Medicaid policy * * * ."). Access to courts does not guarantee victory on the merits, but it offers Medicaid beneficiaries a chance to present their cases and hold States accountable. Among the many actions brought over decades are cases considered especially significant because of the profound nature of the rights at issue.

In *Rosie D.*, the "neediest of the needy"—Medicaid-eligible children in Massachusetts with serious emotional disturbances—relied on Section 1983 to enforce their right to access covered care with reasonable promptness. Even in Massachusetts, a state renowned for its public commitment to health coverage, see Kaiser Fam. Found., *Health Insurance Coverage of the Total*

Population (2019), https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22desc%22%7D (finding that Massachusetts has the lowest uninsured rate of any State), the court found that state officials' "efforts to comply with * * * minimum EPSDT assessment and service coordination requirements were woefully inadequate," resulting in "heartbreaking" "detrimental consequences for thousands of vulnerable children." 410 F. Supp. 2d at 23-24. Without access to private enforcement, the children in *Rosie D.* "may [have] face[d] a stunted existence, eked out in the shadows and devoid of almost everything that gives meaning to the gift of life." *Ibid.*

Section 1983 has also provided a vehicle for children to enforce their coverage rights under Medicaid's EPSDT benefit. Unique among all forms of health insurance coverage, public or private, EPSDT guarantees a comprehensive range of primary and preventive care, as well as care needed to "ameliorate" physical and mental health conditions disclosed during health "screening" exams. 42 U.S.C. 1396d(r). The result of landmark child health provisions enacted as part of the 1967 Social Security amendments, EPSDT's purpose is the prevention of lifelong disability in adults. Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821 (1968); Sara Rosenbaum & Paul Wise, *Crossing The Medicaid-Private Insurance Divide: The Case Of EPSDT*, 26 Health Affs. 382 (2007), https://doi.org/10.1377/hlthaff.26.2.382. And yet, in 1979, the Texas legislature slashed its Medicaid EPSDT budget by 45 percent, which in turn led the State to virtually eliminate the mandatory EPSDT dental benefit for Texas children. As a result of Texas's "drastic cutback" in funding,

children could access dental care only once every three years, and most forms of treatment would be eliminated. Facing extraordinary pain and the potential for lifelong disability, the children sued under Section 1983, leading to an appeals court ruling that restored the children's required coverage and demanded that Texas "bear the responsibilities and requirements of its participation" in Medicaid. *Mitchell* v. *Johnston*, 701 F.2d 337, 351 (5th Cir. 1983).

The courts have played a similarly pivotal role for children with advanced needs such as: "irreversible language and behavioral impairments," *K.G. ex rel. Garrido* v. *Dudek*, 864 F. Supp. 2d 1314, 1327 (S.D. Fla. 2012), aff'd in part, rev'd in part, 731 F.3d 1152 (11th Cir. 2013); disabilities that caused children to "los[e] the ability to vocalize," swallow, or move their tongue, *C.R. ex rel. Reed* v. *Noggle*, 559 F. Supp. 3d 1323, 1332-1333 (N.D. Ga. 2021); or conditions that would force them to enter "institutions (such as psychiatric hospitals and juvenile delinquency facilities)" in order to receive adequate mental health treatment. *K.B. ex rel. T.B.* v. *Mich. Dep't of Health & Hum. Servs.*, 367 F. Supp. 3d 647, 651 (E.D. Mich. 2019).

Section 1983 has been no less vital to the enforcement of rights among Medicaid-eligible adults. And even when the cases lose on the merits, their facts show the importance of the issues at stake. In *Harris* v. *Olszewski*, Medicaid recipients argued that Michigan had violated the Medicaid Act's freedom-of-choice provision, 42 U.S.C. 1396a(a)(23)(A), by so restricting coverage of access to incontinence products as to defeat the very purpose served by its coverage. 442 F.3d 456, 460 (6th

Cir. 2006). Beneficiaries lost on the merits, but the ability to secure judicial oversight mattered: it held the State accountable to Medicaid beneficiaries and reflected the federal government's reliance on Section 1983 private enforcement of the Medicaid Act. See Former HHS Officials Amicus Curiae Br., at *14-15, *Armstrong* v. *Exceptional Child Center, Inc.*, No. 14-15 (U.S.); see also *Waskul* v. *Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426, 445-452 (6th Cir. 2020) (holding that Section 1983 allowed Medicaid recipients who "may not be able to succeed on [their] claim at later stages of their litigation" to challenge change in State's financing calculation methodology); *Dreyer* v. *Idaho Dep't of Health & Welfare*, 558 F. Supp. 3d 917, 924 (D. Idaho 2021) (allowing claims that State violated the Medicaid Act by abusing residents of an intermediate care facility to proceed under Section 1983).

Section 1983 cases have also focused on the core issue of Medicaid eligibility itself. In *Rabin* v. *Wilson-Coker*, plaintiffs challenged the State of Connecticut's unlawful termination of eligibility when beneficiaries who worked and whose countable income from earnings potentially made them ineligible for Medicaid benefits were still entitled under federal law to a period of transitional eligibility. Had the people affected by this state action, which violated their federal rights, been without recourse, some 23,000 poor working adults would have lost coverage in violation of federal law, leaving thousands of parents of young children without the means to afford "necessary care, treatment and prescription drugs," and leaving these families vulnerable to "significant adverse consequences, including, in some instances, seizures, swelling, and pain." *Rabin* v. *Wilson-Coker*,

No. 03-cv-555, 2003 WL 1741883, at *1 (D. Conn. Mar. 31, 2003) (granting temporary restraining order).

These cases are not mere history.

In the United States District Court for the Northern District of Florida, for example, B.T. and A.G. currently challenge Florida's speech therapy coverage. See First Am. Compl., *B.T. ex rel. Robin T.* v. *Marstiller*, 22-cv-212 (N.D. Fla. June 16, 2022), ECF No. 10 (*B.T.* Compl.). B.T. is nine years old and was diagnosed with autism spectrum disorder. *Id.* ¶ 1. She has a "core vocabulary of only 30 words, and she is working to master use of simple two-word commands." *Ibid.* "She has never been able to establish meaningful relationships with peers," and her "inability to express herself frustrates her," causing her to "engage in maladaptive behaviors, including self-injury." *Ibid.* A.G. is only four years old. *Id.* ¶ 3. His speech is "less than 50 [percent] intelligible to a familiar listener," preventing him "from communicating his wants and needs." *Ibid.* Before Florida changed its payment calculations, B.T. "was maintaining her speech abilities and working on two-word commands." *Id.* ¶ 2. Now, B.T. and A.G. receive only half the speech therapy sessions their providers prescribed. *Id.* ¶¶ 2, 4. Whether or not the plaintiffs prove their allegations, Section 1983 gives them the opportunity to present their claims and seek relief specific to curing their plight and that of thousands of other children in Florida living with profound disabilities.

B. State administrative processes and federal government oversight are no substitute for Section 1983

Petitioners argue that Medicaid beneficiaries have no need for Section 1983 enforcement rights because state administrative procedures and federal government oversight suffice to protect their interests. Pet. Br. 39-40. But state administrative procedures move slowly and test only whether state practices comply with their Medicaid plans and state rules implementing those plans. And the federal government can remedy state violations only by issuing nonbinding corrective action plans or threatening to withhold funding—a drastic and counterproductive remedy. State administrative processes and federal government oversight are thus ineffective in remedying situations in which the issue is whether state actions violate federally secured rights and in which the plaintiffs need immediate injunctive relief.

Indeed, state administrative processes routinely function far more slowly, with less oversight and accountability, than judicial proceedings. In *Thompson ex rel. Bailey* v. *Fitzgerald*, the State of Georgia denied a "non-verbal, incontinent, and non-ambulatory" sixty-three-year-old with "developmental and intellectual disabilities, spastic quadriplegia, and a hearing impairment" a fair hearing after reducing by more than two-thirds his hours of covered services. 558 F. Supp. 3d 1334, 1337-1339 (N.D. Ga. 2021). The State denied a fair hearing not because of any delays or errors by the Medicaid beneficiary, but because the State's staff attorney who received the fair hearing request failed to forward it to the appropriate agency for approximately 137 days.

Id. at 1339. In Missouri, 82 percent of Medicaid applicants have endured waits for eligibility determinations that exceed the federal standard governing the right to reasonable promptness, waiting an average of 115 days for the State to process their claims. CMS, *Missouri Eligibility & Enrollment Mitigation Plan – July 11, 2022* (2022), https://www.medicaid.gov/medicaid/eligibility/downloads/missouri-mitigation-plan.pdf; see also CMS, *MAGI Application Processing Time Snapshot Report: January – March 2022* (Sept. 1, 2022), https://www.medicaid.gov/state-overviews/downloads/magi-app-process-time-snapshot-rpt-jan-mar-2022.pdf. And yet, the federal government's remedy is a mitigation plan that, as of the end of August 2022, is still being negotiated. See Clara Bates, *Federal Government Steps In To Help Pull Missouri Out of Medicaid Backlog*, Mo. Indep. (Aug. 9, 2022), https://missouriindependent.com/2022/08/09/federal-government-steps-in-to-help-pull-missouri-out-of-medicaid-backlog/.

The judicial process also allows courts to grant tailored and class-wide relief while preserving States' autonomy to fashion their own plans. In *Waskul*, for example, Section 1983 allowed a group of Medicaid recipients to challenge the State's budgeting methodology rather than forcing each Medicaid recipient to engage in an individualized administrative hearing. 979 F.3d at 441. And although the court allowed the plaintiffs' claims to proceed, it did so without invalidating and thereby disrupting the State's home- and community-based care waiver, which allowed the State flexibility to provide services in homes and communities, rather than institutionalized facilities. See *id.* at 452-447.

Crucially, Section 1983 also provides a safety valve for Medicaid recipients when States fail to comply with their own administrative processes. In *Shakhnes* v. *Berlin*, New York's Department of Health failed to reach decisions on Medicaid applicants' eligibility and coverage for Medicaid-funded home health services within 90 days of their requests, as federal *and* State laws and regulations required. 689 F.3d 244, 248-249 (2d Cir. 2012). When the State's administrative processes proved inadequate, New York's Medicaid recipients relied on Section 1983 to enforce their fair-hearing rights. See also *K.B. ex rel. T.B.*, 367 F. Supp. 3d at 662 ("[T]he fact that [State rules requiring administrative hearings] exist does not alone mean that [the State is] complying with them.").

C. A ruling in petitioners' favor would have significant, negative effects on public health

As the examples above demonstrate, despite receiving federal funds concomitant with legal requirements to "furnish medical care to needy individuals," *Wilder* 496 U.S. at 502, States have attempted to reduce coverage, limit eligibility, and deny access to EPSDT for needy individuals despite the threat of a Section 1983 action. If this Court holds that Medicaid recipients cannot rely on Section 1983 to enforce their rights, States could predictably make further unlawful cuts to their programs.

According to a recent simulation, preventing Medicaid recipients from asserting Medicaid Act violations under Section 1983 would have disastrous effects. If, for example, Texas froze enrollment for the final three months of the year (as Missouri has effectively done through its processing delays), more than a quarter-million Texans eligible for Medicaid benefits—including

tens of thousands of children—would lose their opportunity to secure coverage, with potentially disastrous health consequences. See Ku & Rosenbaum, *supra*. These effects would be felt most acutely by members of racial minority groups and by women, and they would affect nearly 10,000 Texans in need of hospital admissions, including 2,400 Texans seeking hospital care related to pregnancy or childbirth. *Ibid.*

Section 1983 serves as a check on the States' worst cost-cutting impulses. Without the threat of a Section 1983 suit, States would likely cut benefits and coverage even more than they already have, leaving millions of pregnant women, children, and other needy people without adequate care or an effective remedy.

CONCLUSION

For the foregoing reasons, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted.

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SEPTEMBER 2022

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