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,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF *AMICI CURIAE* HEALTH POLICY SCHOLARS IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*

Amici curiae are professors and scholars who study, teach, and write about health care policy in the United States.[1] Through their work, *amici* have examined the history and operation of the Medicaid program and of congressional action affecting Medicaid. They file this brief to provide the Court with information on Congress's efforts to create and maintain Medicaid—a program enacted pursuant to the Spending Clause that serves over 80 million beneficiaries—as an entitlement for the benefit of low-income people.

Amici also submit this brief to explain that, in maintaining the Medicaid entitlement over more than 50 years, Congress has legislated against the backdrop of cases such as *King v. Smith*, 392 U.S. 309 (1968); *Rosado v. Wyman*, 397 U.S. 397 (1970); *Maine v. Thiboutot*, 448 U.S. 1 (1980); and *Wilder v. Virginia Hospital Association,* 496 U.S. 498 (1990); as well as a host of other decisions of this Court and lower federal courts affirming the availability of a federal court forum for Medicaid beneficiaries who allege that a State has violated their congressionally conferred rights. Indeed, the historical record confirms that Congress has protected and enhanced beneficiaries' ability to bring such suits and that private enforcement under 42 U.S.C. § 1983 has become an integral part of Medicaid's structure. Overruling the long line of decisions permitting such suits, as Petitioners urge,

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[1] The *amici* are listed in the Appendix to this brief. *See* App., *infra*, 1a–3a. Pursuant to Rule 37.6, the *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief. Pursuant to Rule 37.3(a), the parties have given their blanket consent to the filing of timely *amicus* briefs.

would be squarely inconsistent with the individual entitlement Congress has repeatedly acted to preserve and at odds with the high bar this Court applies before disturbing settled issues of statutory interpretation.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress intended 42 U.S.C. § 1983 "to interpose the federal courts between the States and the people, as guardians of the people's federal rights." *Mitchum v. Foster*, 407 U.S. 225, 242 (1972). To determine whether Congress has created the sort of individual federal right for which a private plaintiff may bring a Section 1983 action, this Court has long looked to congressional intent. *See Blessing v. Freestone*, 520 U.S. 329, 340 (1997).

This brief focuses on the Medicaid program, created by one of the most significant pieces of Spending Clause legislation. The brief explains Congress's establishment of Medicaid as an entitlement program and its subsequent maintenance and defense of the entitlement feature against the backdrop of this Court's decisions permitting private enforcement of rights under the Social Security Act. This history makes clear (including to States, all of which have chosen to continue to participate in Medicaid) that the individual rights created under the Medicaid statute are enforceable under Section 1983.

The Brief for Respondent ("Resp. Br.") and the Brief for the United States as Amicus Curiae Supporting Neither Party ("U.S. Br.") filed in this case each rightly identifies a 1994 congressional enactment as confirming Congress's intent that private actions may be brought under Section 1983 to enforce certain provisions of laws enacted under the Spending Clause. *See*

Resp. Br. 22–23; U.S. Br. 13–15. Through that 1994 enactment, Congress overruled in part this Court's decision in *Suter v. Artist M.*, 503 U.S. 347 (1992). In the 1994 enactment, Congress also expressly confirmed that provisions of the Social Security Act are privately enforceable, ratifying the long line of cases that had so held. That history alone (along with the plain language of Section 1983) provides sufficient ground to reject Petitioners' arguments that private enforcement of Spending Clause statutes is contrary to congressional intent. *See* Resp. Br. 26–28.

There is, however, a much longer history—both before and after Congress's 1994 response to the *Suter* decision—that supports the conclusion that Congress intended certain Spending Clause laws—including specifically, the Medicaid statute[2]—to create individual entitlements that beneficiaries may enforce through suits under Section 1983. This brief examines the history showing that Congress created, maintained, and defended Medicaid as an entitlement program.

This history starts in the 1960s, when Congress created Medicaid as an entitlement program, establishing specific rights for individual beneficiaries. It continues through the 1970s, with federal government recognition of the importance of the Medicaid entitlement and its status as part of health insurance coverage for Americans. The history extends into the 1980s, when Congress considered—but ultimately rejected or abandoned—proposals to cap federal Medicaid payments to States, a step that would have undercut the individual entitlement. Congress chose instead to retain that entitlement, as well as the

[2] In this brief, we use the term "Medicaid statute" to refer to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq*.

companion entitlement of States to matching funds, signaling its commitment to the program's focus on benefits and rights conferred on individuals.

In the 1990s, some Members of Congress proposed changes to Medicaid that would have transformed the beneficiary-focused entitlement into a purely State-focused, block grant. Congress passed that bill, but after President Bill Clinton vetoed it, Congress did not override the veto. Rather, Medicaid continued as an entitlement program. As recently as 2017 some Members of Congress tried again to cap Medicaid payments to States, either through a per capita cap or a block grant scheme (as part of a "repeal and replace" effort), but that legislation failed.

Congress designed Medicaid with a focus on the rights of individual beneficiaries and has maintained that focus since, rejecting or abandoning efforts to eliminate the individual entitlement, either directly or by capping federal matching payments to States.

Simultaneously, Congress has acted to both protect and enhance the ability of Medicaid beneficiaries to assert statutory rights in federal court, as a complement to federal agency enforcement. Among other things, Congress in 1980 eliminated the amount-in-controversy requirement for federal question jurisdiction, in part to ease the path of plaintiffs asserting rights under Social Security Act programs to bring their claims in federal court. At later points, Congress rejected or abandoned proposals to eliminate Medicaid beneficiaries' right to enforce provisions of the Medicaid statute in federal court. And Congress has continued to expand Medicaid against the backdrop of *King v. Smith, Rosado v. Wyman, Maine v. Thiboutot, Wilder v. Virginia Hospital Association*, and the host of other decisions confirming that Medicaid beneficiaries and

beneficiaries of other Social Security Act programs on whom Congress conferred rights have a federal court forum to protect those rights.

A holding that Spending Clause legislation, such as Medicaid, categorically cannot create rights enforceable under Section 1983 would undermine the entitlement-based Medicaid program that Congress designed and maintained over decades against the backdrop of federal court enforcement supplementing federal agency compliance actions. Under longstanding *stare decisis* principles there is no basis for this Court to overrule the many decisions that have held, consistent with Congress's intent, that rights-creating provisions of the Social Security Act may be enforced using Section 1983.

ARGUMENT

I. Congress Created Medicaid as an Entitlement Program Providing Rights for Individual Beneficiaries.

Fifty-seven years ago, Congress enacted Medicaid, 42 U.S.C. §§ 1396 *et seq.*, as title XIX of the Social Security Act with the objective of providing health care coverage for low-income people. Pub. L. No. 89-97, 79 Stat. 286 (1965).

Medicaid's precursor, the Kerr-Mills program, had provided federal funding to States to cover certain medical costs for the elderly poor. Pub. L. No. 86-778, 74 Stat. 924 (1960).[3] However, Congress soon recognized

[3] The Kerr-Mills program and Medicaid followed Congress's earlier efforts to provide federal support for health care for the poor. *See, e.g.*, Sheppard-Towner Maternity and Infancy Act, ch. 135, 42 Stat. 224 (1921) (providing for the hiring of social workers and public health workers to serve mothers and children); Hospital Survey and Construction Act, Pub. L. No. 79-725, 60

that the law was ill-suited for that aim. *See* U.S. Senate, Special Committee on Aging: Performance of the States—Eighteen Months of Experience with the Medical Assistance for the Aged (Kerr-Mills) Program at 720 (June 15, 1962) (describing "persistent areas of confusion" including administrative complexity and inadequate and hard-to-understand benefits). Congress enacted the "Improvement and Extension of Kerr-Mills Medical Assistance Program," now known as Medicaid, to address shortcomings in the earlier law. *See* S. Rep. No. 404, 89th Cong., 1st Sess. at 9, 73 (1965).

Congress designed Medicaid as an entitlement program. State participation is voluntary, but States electing to participate must submit and have approved by the Secretary of Health and Human Services (HHS, and originally Health, Education and Welfare (HEW)) a plan to provide certain medical assistance benefits for "all individuals" eligible for Medicaid. 42 U.S.C. §§ 1396-1, 1396a(a)(10)(A), 1396d(a). Compared with Kerr-Mills, the Medicaid statute included more detailed provisions to protect beneficiaries, such as a defined set of benefits. Pub. L. No. 89-97, § 121 (1965), codified at 42 U.S.C. § 1396a(a)(13), subsequently recodified at 42 U.S.C. § 1396a(a)(10)(A).

The Medicaid statute creates two distinct sets of rights. The first is the right of all individuals who meet eligibility requirements to the services provided for under the terms of the state plan and federal requirements. *See* 42 U.S.C. § 1396a(a)(10) (States must provide certain "care and services listed" to "all

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Stat. 1040 (1946) (enacting the Hill-Burton Act, which offered grants for the construction of hospitals conditional on their provision of a reasonable volume of uncompensated care). Unlike Medicaid, these early federal-state cooperative programs did not create entitlements in individual beneficiaries.

individuals" who meet eligibility criteria).[4] The second is an entitlement in each State to receive federal matching funds for a statutorily set percentage of the amount "expended . . . as medical assistance under the State plan" if its state plan conforms to federal requirements. 42 U.S.C. § 1396b(a)(1).

The individual nature of many Medicaid benefits is clear from the text of the statute. For example, 42 U.S.C. § 1396a(a)(8) mandates that state plans provide individuals with the opportunity to apply for assistance and requires "that such assistance shall be furnished with reasonable promptness to all eligible individuals." And under a comparability-of-services provision, "the medical assistance made available to any individual described . . . shall not be less in amount, duration, or scope than the medical assistance made available" to others under Medicaid. 42 U.S.C. § 1396a(a)(10)(B); *see* 42 C.F.R. § 440.240.[5]

In the years following establishment of the Medicaid program, government leaders understood that the program created a right for individual beneficiaries, as

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[4] Medicaid also creates certain statutory entitlements in providers. *See, e.g.*, 42 U.S.C. § 1396a(bb) ("the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished by a Federally-qualified health center"); *see also, e.g.*, *Ariz. All. for Cmty. Health Ctrs. v. Ariz. Health Care Cost Containment Sys.*, No. 21-16262, slip op. at 14 (9th Cir. Sept. 2, 2022) (holding that federally-qualified health center services "are a mandatory benefit that [the state Medicaid entity] must cover and for which [such centers] have a right to reimbursement under § 1396a(bb) that is enforceable under § 1983").

[5] States may limit comparability of services only as allowed by federal statute or federal regulation, or if the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) grants a waiver of certain requirements. 42 U.S.C. § 1396a(a)(10)(G); *see* 42 C.F.R. § 440.250.

well as for States. *See, e.g.*, 116 Cong. Rec. 39700 (1970) (testimony of Secretary of Health, Education, and Welfare Eliot Richardson) (stating that a family losing benefits under the Aid to Families with Dependent Children (AFDC) program because a family member had found work would lose its "entitlement to Medicaid").

Congress's Medicaid Source Book, prepared by the Congressional Research Service for the House Commerce Committee, recognized both the entitlement for individuals and the entitlement for States:

> Medicaid is a Federal-State entitlement program that pays for medical services in [sic] behalf of certain low income persons. . . . Medicaid is a means-tested entitlement program. Persons who meet [program eligibility standards] are entitled to have payment made by the State for covered, medically necessary services furnished by qualified providers. States are entitled to have matching payments made by the Federal Government for outlays for covered services.

Library of Cong. & United States, *Medicaid Source Book: Background Data and Analysis: A Report*, Washington, D.C.: U.S. Govt. Pub. Office at 1 (1988). Congress plainly intended Medicaid to benefit not only the States whose plans HHS approved, but also individual beneficiaries who received services promised under the Medicaid statute.

Over time, Medicaid came to be recognized as a key component of the broader set of health insurance benefits available to Americans, including private health insurance and other forms of public insurance, such as Medicare. By 1976, the National Center for Health Statistics listed Medicaid coverage together

with Medicare and private health insurance in its reports.[6] And several years later, a Commerce Department report referred to "Medicaid health insurance."[7]

II. Congress Has Repeatedly Protected Medicaid's Status as an Entitlement.

Throughout the existence of the program, Congress has acted to protect Medicaid's status as an entitlement. Congress's commitment to preserving the entitlement continued as this Court and the lower courts recognized private actions by beneficiaries and providers to enforce rights conferred by the Medicaid statute and other Spending Clause legislation.

In 1981, Congress rejected efforts to cap federal Medicaid matching payments to participating States. Capping these payments would have undermined the individual entitlement of Medicaid beneficiaries, which is structurally dependent upon the entitlement of States to federal matching funds for all allowable expenditures necessary to implement the individual entitlement. The Reagan Administration had proposed, and the Senate passed, a cap on annual increases in Medicaid spending. *See* Omnibus Reconciliation Act of 1981, S. 1377, 97th Cong., title VII, § 721(a) (1981). However, the House-Senate Conference Committee eliminated the Senate cap proposal in favor of the House bill, which instead reduced the percentage of

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[6] *See* National Center for Health Statistics, *Current Estimates from the Health Interview Survey, United States-1976*, at 70, 80 (1977), *available at* https://www.cdc.gov/nchs/data/series/sr_10/sr10_119.pdf. The National Center for Health Statistics is a unit within the Centers for Disease Control.

[7] U.S. Department of Commerce, *Characteristics of Households and Persons Receiving Selected Noncash Benefits 1980*, at 1 (1982), *available at* https://tinyurl.com/commercereport1982.

federal matching payments without a strict cap. *See* H.R. Rep. No. 97-209, pt. 2, at 958–61 (1981) (Conf. Rep.); Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2161(a), 95 Stat. 357, 803 (1981).

Members of the House celebrated the protection of Medicaid, with Representatives John Dingell and Henry Waxman underscoring the "commitment" the federal government made to provide coverage for qualifying individuals. Representative Dingell described "the greatest achievement of the conference—the preservation of the medicaid program which dates back to 1965 and represents the firm commitment of the Federal Government to assure that States can provide medical care for their indigent populations." 127 Cong. Rec. 18957 (1981) (statement of Rep. Dingell); *see also id.* at 18948 (statement of Rep. Waxman) ("We have beat back the medicaid cap, an ill-conceived and poorly disguised attempt to undermine the Federal commitment to health care for the poor.").

In the mid-1990s, Congress again ultimately retained Medicaid's design as an individual entitlement program following efforts to remove both the individual entitlement and the matching entitlement for States. In 1995, Congress initially included in budget reconciliation legislation a measure converting most of Medicaid into a "MediGrant" block grant program. Under H.R. 2491, federal support for health care expenditures would have been limited to a fixed allotment or shifted to block grants to States.

The MediGrant legislation proposed by some members of the House would have removed the individual entitlement feature of Medicaid. *See* Balanced Budget Act of 1995, H.R. 2491, 104th Cong., § 16001 (1995) (amending Social Security Act by adding "Title XXI–MediGrant Program for Low-Income Individuals and

Families") ("Nothing in this title (including section 2112) shall be construed as creating an entitlement under Federal law in any individual or category of individuals for medical assistance under a MediGrant plan.").

The President vetoed H.R. 2491, noting that it "would cut deeply into Medicare, Medicaid" and that transforming Medicaid into a block grant program would result in "eliminating guaranteed coverage to millions of Americans." William J. Clinton, Veto of H.R. 2491, H. Doc. No. 104-141, at 1 (1995). The President also vetoed a subsequent welfare reform bill, H.R. 4, explaining that its provisions were at odds with the need to restore "the guarantee of health coverage for poor families." William J. Clinton, Veto of H.R. 4, H. Doc. No. 104-164, at 2 (1996). Congress did not override the veto of either H.R. 2491 or H.R. 4.

In 1996, some legislators again introduced bills that would have limited Medicaid. These Members tried to revive MediGrant's block grant provisions and restructure Medicaid by purporting to guarantee eligibility and benefits for some groups for some services, but relegating others to "umbrella supplemental funding." *See* Personal Responsibility and Work Opportunity Act of 1996, H.R. 3507, 104th Cong., title XV, § 1502 and title XI, §§ 2001-2005 ("Restructuring Medicaid"); Welfare and Medicaid Reform Act of 1996, H.R. 3734, 104th Cong., title II, §§ 2001–2005 (similar to H.R. 3507, but purportedly covering more teenagers). However, Congress ultimately dropped the block grant provisions from the budget reconciliation package. A separate bill included a provision preserving the entitlement for individuals who would have qualified for Medicaid under AFDC standards. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 114, 110 Stat. 2105,

2177-78 (1996) ("Assuring Medicaid Coverage for Low-Income Families.").

More recently, Congress again preserved Medicaid rights in considering proposals to "repeal and replace" the Affordable Care Act. In 2017, Congress rejected a proposal to restructure Medicaid by replacing the open-ended entitlement to States with either a per capita cap or a block grant. *See* Better Care Reconciliation Act of 2017, Discussion Draft, ERN17500, §§ 132 ("Per Capita Allotment for Medical Assistance"), 133 ("Flexible Block Grant Option for States"), at 55, 98 *available at* https://www.budget.senate.gov/imo/media/doc/ERN17500.pdf. By the time this legislation reached the Senate floor, these provisions had been removed. *See* Health Care Freedom Act of 2017, S. Amendment 667, 115th Cong. (2017).

Congress's repeated decisions not to strip away the entitlement feature of Medicaid is significant. When Congress does not want to create an individual entitlement, it has said so. For example, in creating the Temporary Assistance for Needy Families (TANF) program, Congress explicitly stated: "NO INDIVIDUAL ENTITLEMENT. This part shall not be interpreted to entitle any individual or family to assistance under any State program funded under this part." Pub. L. No. 104-193, § 103(a)(1), 110 Stat. 2105, 2113 (1996) (amending 42 U.S.C. § 601 *et seq.* by adding § 401(b)). In the State Children's Health Insurance Program, it provided: "NONENTITLEMENT.—Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan." Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 554 (1997).

These congressional debates over eliminating the individual entitlement make sense only if Congress

created such an entitlement in the first instance. Despite numerous efforts to modify Medicaid, Congress has preserved Medicaid's status as an entitlement with rights for individual beneficiaries, rejecting or abandoning proposals to end the individual entitlement and the entitlement of States to federal matching funds to help finance the individual entitlement.

III. Private Enforcement of Rights Conferred by the Medicaid Statute Has Long Been a Key Feature of the Medicaid Program.

A statutory entitlement to benefits means nothing without enforceability, which assures that individuals will receive the benefits Congress conferred on them through the Medicaid program.

For decades, private enforcement of rights has been an integral feature of Medicaid. The reason lies in the structure of Social Security Act grant-in-aid programs. In federal-state programs such as Medicaid and AFDC, the federal government plays a key role in enforcing rights Congress conferred on beneficiaries and providers. Enforcement can occur through the approval process for state plans and proceedings to enforce state agency compliance with the statutory requirements and the terms of the state plan. *See, e.g.*, 42 U.S.C. §§ 1396c, 1316; 42 C.F.R. § 430.35. But the sheer size and scope of these programs make it practically impossible for the federal agency (CMS, in the case of Medicaid) to identify and address all state violations through compliance hearings, appeals, judicial review, and withholding of federal funds.

As the United States has acknowledged in prior briefing before this Court, withholding federal funds from States that violate Medicaid requirements is a draconian remedy and may work against Congress's

aim of ensuring health care to the poor. *See* Brief for the United States as Amicus Curiae at 19, *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, No. 09-958 (Dec. 3, 2010) ("[T]hose programs in which the drastic measure of withholding all or a major portion of federal funding is the only available remedy would be generally less effective than a system that also permits awards of injunctive relief in private actions in appropriate circumstances.").

The United States's suggestion was on target. An injunction can provide targeted relief covering just the harm at issue. A Section 1983 suit can seek pinpointed prospective relief to prevent a harm, as opposed to the draconian relief of withdrawing federal funding from a State's Medicaid program. *See, e.g., Rosado*, 397 U.S. at 421 (suggesting that in some cases there will be a "discrete and severable provision whose enforcement can be prohibited"); Edward A. Tomlinson & Jerry L. Mashaw, *Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement*, 58 Va. L. Rev. 600, 683 (1972) ("An advantage of judicial enforcement is the flexibility inherent in an equity decree."). And injunctive relief is likely to be relatively expeditious, compared with the delay involved in the cumbersome federal agency compliance process.

In the early years of Medicaid, commentators recognized the structural dilemma inherent in federal-state programs under the Social Security Act. They documented the difficulties that had resulted from relying exclusively on federal enforcement to address state statutory violations, citing the exceptionally low number of compliance proceedings. *See* Note, *Federal Judicial Review of State Welfare Practices*, 67 Colum. L. Rev. 84, 91 (1967) (only 16 conformity hearings for all Social Security Act federal-state grant-in-aid

programs between 1935 and 1965). Beneficiaries could not force federal agencies to institute compliance hearings and were given little or no opportunity to participate in such hearings. *See id*. at 91–96.[8] In addition, the statutory sanction for a State's substantial noncompliance is loss of some or all federal Medicaid payments, creating a significant disincentive for the federal agency to impose a sanction. *See* Tomlinson & Mashaw, 58 Va. L. Rev. at 631. Medicaid needed a complementary enforcement mechanism, particularly one in which beneficiaries could play a role.

In this same period, this Court and the lower federal courts began to open the door to suits brought by beneficiaries and providers to enforce statutory rights under Social Security Act programs. In *King v. Smith*, the Court held that a class of AFDC beneficiaries had shown that a state regulation was inconsistent with the federal statutory obligation to furnish aid "with reasonable promptness to all eligible individuals." 392 U.S. at 333.

Two years later, in *Rosado*, the Court "considered and rejected the argument that a federal court is without power to review state welfare provisions . . . in view of the fact that Congress has lodged in the Department of [Health, Education, and Welfare] the power to cut off federal funds for noncompliance with statutory requirements." 397 U.S. at 420. Because the Department had no procedures by which beneficiaries could trigger or participate in the agency's review of the state program, the Court saw no basis for a court

[8] Though beneficiaries may now intervene in compliance hearings, they cannot initiate such proceedings.

to refuse to hear the claims. *See id.* at 406 & n.8.[9] The Court found "not the slightest indication" that Congress meant to deprive federal courts of their jurisdiction to enforce the federal statutory rights conferred under social welfare programs. *Id.* at 422.

In yet another AFDC case, *Thiboutot*, the Court endorsed use of Section 1983 suits to challenge statutory violations involving federal-state grant-in-aid programs. Among other things, "analysis in several § 1983 cases involving Social Security Act (SSA) claims has relied on the availability of a § 1983 cause of action for statutory claims." 448 U.S. at 5. The Court explained that cases such as *Rosado* had resolved "any doubt" as to whether "the § 1983 remedy broadly encompasses violations of federal statutory" law. 448 U.S. at 4.

The AFDC cases are relevant here. Both AFDC and Medicaid were created under the Social Security Act as federal-state grant-in-aid programs that call for state plans that must conform to federal requirements. And both created an individual right to benefits, in the case of AFDC to cash assistance, in the

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[9] The Court amplified this point:

> Whether HEW could provide a mechanism by which welfare recipients could theoretically get relief is immaterial. It has not done so, which means there is no basis for the refusal of federal courts to adjudicate the merits of these claims.

Id. at 406 n.8. In another case decided a few weeks before *Rosado*, the Court characterized AFDC benefits as "a matter of statutory entitlement for persons qualified to receive them." *Goldberg v. Kelly*, 397 U.S. 254, 261–62 (1970).

case of Medicaid to medical assistance. In essence, Medicaid and AFDC are "twin" programs.[10]

Apart from AFDC cases, the lower courts handled a number of cases beneficiaries brought against state agencies to enforce provisions of the Medicaid statute. In 1971 alone, at least five district courts issued decisions addressing such claims.[11] After many more years in which lower courts issued decisions enforcing provisions of the Medicaid statute, this Court confirmed in *Wilder* that Section 1983 could be used to pursue such enforcement.[12]

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[10] Other currently effective Social Security Act programs with this sort of state plan structure are Title IV-D, child support enforcement, at issue in *Blessing* and Title IV-E, adoption assistance and child welfare, at issue in *Suter*.

[11] *See Schaak v. Schmidt,* 344 F. Supp. 99 (E.D. Wis. 1971) ($7500 limit on equity value of home violates HEW regulation implementing medically needy part of Medicaid Act); *Bass v. Richardson,* 338 F. Supp. 478 (S.D.N.Y. 1971) (holding that even if reduction in Medicaid eligibility and services receives federal approval, it still violates then-existing 42 U.S.C. § 1396b(e)); *Boisvert v. Zeiller,* 334 F. Supp. 403 (D. N.H. 1971) (denying Medicaid to person who would be eligible for aid to the permanently and totally disabled program except for her income violates the medically needy statute, 42 U.S.C. § 1396a(a)(10)(B)(i)); *Triplett v. Cobb,* 331 F. Supp. 652 (N.D. Miss. 1971) (policy of denying Medicaid to AFDC caretaker relatives violates 42 U.S.C. §§ 1396a(a)(8) and (10)); *Wilczynski v. Harder,* 323 F. Supp. 509 (D. Conn. 1971) (policy of valuing insurance at face value as opposed to cash-surrender value violates reasonable standards requirement of 42 U.S.C. § 1396a(a)(17)).

[12] Petitioners focus on *Wilder*, a case that involved a now-repealed Medicaid provision (the Boren Amendment) that had distinctive features that played a role in the decision. *Wilder*'s primary significance at this point is that it confirmed that the Medicaid statute's defunding provisions (42 U.S.C. § 1396c) did

Against this backdrop of decisions enforcing rights conferred under the Medicaid statute and other Social Security Act provisions, Congress expanded the scope of the Medicaid program, extending the individual entitlement to new groups and adding more benefits.

For example:

- ***Elders and people with disabilities.*** In 1972, Congress provided that Supplemental Security Income (SSI) beneficiaries in most States would qualify for Medicaid, and set up a spend-down process to protect people who might otherwise be over-income in States that chose not to provide Medicaid for all SSI beneficiaries. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 209(b), 86 Stat. 1329, 1381-82 (1972).
- ***Waivers for at-home services.*** In 1981, Congress set up the first long-term care waiver system, helping Medicaid beneficiaries who would have qualified for nursing home care to receive in-home care. *See* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2176, 95 Stat. 357, 812-13 (1981).
- ***Children and pregnant women.*** Between 1984 and 1990, Congress created Medicaid options and mandatory eligibility categories that eventually required participating States to cover children under age six and pregnant women with family income at or below 133% of the poverty line, and to cover older children with

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not rule out relief under § 1983—a point that was reconfirmed in *Blessing*. Private enforcement of beneficiary rights under the Medicaid statute continues to be more fundamentally grounded in the Court's early AFDC cases—*King v. Smith*, *Rosado*, and *Thiboutot*—and their progeny.

family income at or below the poverty line. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4601, 104 Stat. 1388, 1388-166-67 (1990); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2106, 2259 (1989); Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 683, 750–54 (1988); Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4101, 101 Stat. 1330, 1330-140-43 (1987); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401, 100 Stat. 1874, 2050 (1986); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9501, 100 Stat. 82, 201-02 (1986); Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2361(b), 98 Stat. 494, 1104 (1984).

- ***Low-income elders and people with disabilities needing help with Medicare premiums and cost-sharing.*** Between 1986 and 1990, Congress expanded the ways in which Medicaid pays Medicare premiums and cost-sharing amounts, meaning that people over-income for standard Medicaid retain a right to assistance with Medicare obligations. *See* Omnibus Budget Reconciliation Act of 1990, § 4501, 104 Stat. at 1388-164; Medicaid Catastrophic Coverage Act, § 301, 102 Stat. at 748-50; Omnibus Budget Reconciliation Act of 1986, § 9403, 100 Stat. at 2053-56; *see also* Balanced Budget Act of 1997, Pub. L. No. 10-533, § 4732, 111 Stat. 251, 520-22 (1997) (adding "qualified individual" program).
- ***Residents of nursing facilities.*** In 1987, Congress added the Nursing Home Reform Act (NHRA) to the Medicare and Medicaid statutes,

> giving patient rights as against nursing homes. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, §§ 4201–06, 101 Stat. 1330, 1330-160 to 1330-182 (Medicare) (1987); *Id.* §§ 4211–18, 101 Stat. 1330, 1330-182 to 1330-221 (Medicaid). Provisions of the NHRA are at issue in this case.

From 1970 on, these amendments and additions have been made against the backdrop of *Rosado*'s holding that beneficiaries of Social Security Act programs with federal funding conditions may assert their rights in federal court as opposed to having to wait for federal authorities to institute conformity hearings. And from 1980 on, Congress has legislated against the backdrop of *Thiboutot*'s holding that those rights may be asserted under 42 U.S.C. § 1983.

Congress's enactment of these and other expansions of Medicaid coverage against the backdrop of federal court enforcement of Medicaid's individual rights reflects continued acceptance of private enforcement as a complement to federal oversight of state Medicaid programs.

Petitioners repeatedly argue that federal courts should not permit private enforcement unless Congress has expressly provided a private right of action. *E.g.*, Pet. Br. 23–24, 27–30. But when Congress enacted Section 1983, it created an explicit cause of action to vindicate statutory rights, with no exception for the later-created rights set forth in the Social Security Act. There was no need for Congress to include a separate provision in the Medicaid statute authorizing private enforcement: Section 1983 was already on the books.

Several of Petitioners' *amici* argue that States lack notice that they will be sued unless Congress has spelled out an explicit private right of action in the text of the Medicaid statute or other Spending Clause

legislation. *See, e.g.*, Brief of Indiana and 21 Other States as Amici Curiae in Support of Petitioners at 18–19. But Section 1983 had been in place for nearly a century when the Medicaid program came into existence, and the text of the Medicaid statute plainly created individual rights. Furthermore, the backdrop of longstanding court enforcement of rights under the Social Security Act is relevant here. States have been on notice for more than 50 years (since *King v. Smith* and *Rosado* decisions) that they are subject to suit for violations of rights under the Social Security Act and for more than 40 years (since the *Thiboutot* decision) that beneficiaries could invoke Section 1983 to enforce those rights. States have long been aware of these cases (and the text of Section 1983 and the Medicaid statute), and all have chosen to continue to participate in Medicaid. And, as shown below, States have also been on notice thanks to congressional actions over a 35-year period.

IV. Congress Has Repeatedly Protected and Enhanced Medicaid Beneficiaries' Ability to Assert Rights in Federal Court.

In addition to preserving Medicaid as an entitlement program since its enactment, Congress has periodically rejected efforts to eliminate private enforcement of Social Security Act rights. And in some cases, Congress has acted to facilitate beneficiaries' ability to bring suit to enforce rights under Medicaid and other Social Security Act programs.

In 1976, for example, in connection with legislation revoking a requirement that States waive Eleventh Amendment immunity for violations of the Medicaid statute, the Senate Finance Committee clarified that the legislation was not intended to prevent Medicaid providers from suing for injunctive relief. *See* S. Rep.

No. 94-1240, at 4 (1976), *reprinted in* 1976 U.S. Code Cong. & Ad. News 5651. The House Committee Report cited similar statements by Administration officials. *See* H.R. Rep. No. 94-1122, at 7 (1976), *reprinted in* 1976 U.S. Code Cong. & Ad. News 5649–51.

Congress again acted to preserve the individual Medicaid entitlement in 1980, repealing the amount-in-controversy requirement for federal question jurisdiction. *See* Pub. L. No. 96-486, 94 Stat. 2369 (1980). This change was motivated in part by Congress's desire to make it easier for beneficiaries to sue state agencies for violations of rights conferred by the Social Security Act. At the House hearing on this legislation, a witness explained:

> Professor Charles Alan Wright has identified several areas for this committee in which the retention of the amount in controversy requirement poses a barrier to the enforcement of federal rights in federal court. One of the most important areas identified by Professor Wright involves cases brought by recipients of public assistance, Medicaid, and other federal benefits to enforce their federal statutory rights. . . .
>
> * * *
>
> . . . . [U]nless section 1331 is amended as proposed in H.R. 2202 to provide jurisdiction over these claims in federal court, there may be no remedy at all for the deliberate violation of many federal statutory rights.

Diversity of Citizenship/Magistrates Reform – 1979, Hearings on H.R. 1046 and H.R. 2202 Before the House Judiciary Subcomm. on Courts, Civil Liberties, and the Administration of Justice of the Comm. on Judiciary,

96th Cong. 122–23, 124–25 (2018) (testimony of Michael B. Trister, Center on Social Welfare Policy and Law). The House Committee report echoed Professor Wright's concern. *See* H.R. Rep. No. 96-1461 (1980), 96th Cong., 2nd Sess. at 2, *reprinted in* 1980 U.S. Code Cong. & Ad. News 5063, 5063–64 ("The $10,000 requirement is particularly troublesome because it tells certain citizens, all too often the poor, that although their federal rights have been violated, their injury is too insignificant to warrant the attention of a federal judge").

Soon after repeal of the amount-in-controversy requirement, Congress rejected repeated efforts by Senator Orrin Hatch to negate the key holding of *Thiboutot* that Section 1983 could be used to enforce Social Security Act rights. The Court had invited Congress to act if it disagreed with the Court's interpretation of Section 1983. *Thiboutot*, 448 U.S. at 8. In 1980, soon after the decision issued, Senator Hatch introduced S. 3114 for this purpose, arguing that Congress should take up the Court's invitation to "modify the statute or limit its application to certain types of statutes." 126 Cong. Rec. 25294–95 (1980) (statement of Sen. Hatch). S. 3114 (which was not enacted) would have inserted in the text of Section 1983 the words "and by any law providing for equal rights" in place of the broad "laws" language. 126 Cong. Rec. 25295.

Senator Hatch subsequently introduced a series of similar bills, all designed to reverse the holding of *Thiboutot*, including S. 584 introduced in 1981, S. 141 introduced in 1983, S. 436 introduced in 1985, and S. 325 introduced in 1987. Congress failed to enact any of these bills.

In 1994, in reaction to a decision of this Court, Congress took a decisive step to preserve private enforcement of both Medicaid and Medicare statutory rights. In *Suter*, the Court had rejected a private suit to enforce a provision of the Social Security Act partly on the ground that the right at issue was a component of a state plan. This holding would have jeopardized a broad range of potential challenges to state Medicaid agency actions. In response, Congress enacted two statutes providing that Medicaid requirements and other provisions of the Social Security Act were not "unenforceable" by private parties simply because the provisions sought to be enforced were required components of a state plan. Pub. L. No. 103-382, § 555, 108 Stat. 3518, 4057 (1994) (codified at 42 U.S.C. § 1320a-2); Pub. L. No. 103-432, § 211, 108 Stat. 4398, 4460 (1994) (codified at 42 U.S.C. § 1320a-10).

As the United States explains in its amicus brief, in enacting these statutes Congress not only rejected the specific holding in *Suter* regarding rights defined as state plan components; it expressly ratified the long line of cases in which this Court had held that beneficiaries and providers could privately enforce rights conferred by the Social Security Act. U.S. Br. 15–16.

Over the next few years, Congress considered but ultimately abandoned proposals to cut back or eliminate private enforcement of rights under the Medicaid statute. Bills aimed at converting Medicaid to a block grant program (described in Part II above) also would have eliminated all causes of action by individuals challenging state agencies' failure to comply with MediGrant requirements. *See* Medicaid Transformation Act of 1995, H.R. 2491, 104th Cong., title XVI, § 2117

(1995) at 1461 ("[N]o person (including an applicant, beneficiary, provider, or health plan) shall have a cause of action under Federal law against a State in relation to a State's compliance (or failure to comply) with the provisions of this title or of a MediGrant plan."). The Senate amendment to H.R. 2491 rested the right of action against States for noncompliance exclusively in the HHS Secretary. *See* Balanced Budget Reconciliation Act of 1995, S. 1357, 104th Cong., title VII, ch. 7, § 7191 (1995) at 786–87. In vetoing H.R. 2491, President Clinton noted that eliminating the individual right of action for Medicaid beneficiaries would remove adequate enforcement to ensure protections for elderly nursing home residents and other vulnerable groups. *See* H. Doc. No. 104-141, at 1. Congress did not override the veto.

Several bills considered during the 1995–96 congressional session would also have eliminated the right of beneficiaries to bring suits in federal court to enforce Medicaid requirements. One proposal stated that only the HHS Secretary would be permitted to sue a State to assure provision of Medicaid benefits. *See* Personal Responsibility and Work Opportunity Act of 1996, H.R. 3507, 104th Cong., § 2003 (amending the Social Security Act by inserting title XV, § 1508). Another would have prevented causes of action to enforce Medicaid. *See* H.R. 2491, 104th Cong., title VII, §§ 7002(b)(4) ("No cause of action under title XIX of the Social Security Act which seeks to require a State to establish or maintain minimum payment rates under such title or claim which seeks reimbursement for any period before the date of the enactment of this Act based on the alleged failure of the State to comply with such title and which has not become final as of such date shall be brought or continued."); *see also* Welfare and Medicaid Reform Act of 1996, H.R.

3734, 104th Cong., title II, § 2004. Congress removed these provisions from the legislation before it passed.

More recently, Congress included in the Affordable Care Act a provision protecting private suits to enforce rights under the Medicaid statute against the argument that the statute creates merely a vendor-payment program, not an enforceable entitlement to care. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2304, 124 Stat. 119, 533 (2010). This provision clarified that the term "medical assistance" encompasses "payment of part or all of the cost of the following care and services *or the care and services themselves, or both*. . . ." 42 U.S.C. § 1396d(a) (emphasis added). The change made clear that the statutory requirement that "[medical] assistance shall be furnished with reasonable promptness to all eligible individuals," 42 U.S.C. § 1396a(a)(8), creates an individual entitlement to prompt care and services, rather than merely speaking to the timing of the vendor-payment process. *See* H.R. Rep. No. 111-299, Part 1, § 1781 at 650 (2009) (*technical corrections*, noting that recent legal "opinions have read the term to refer only to payment; this reading makes some aspects of the rest of Title XIX difficult and, in at least one case, absurd," referencing the "reasonable promptness" requirement).

That Congress has never acted to prohibit Medicaid beneficiaries from accessing federal courts, either under the Medicaid statute or under Section 1983, is highly relevant to the question of *stare decisis*. In setting a high bar for overruling its statutory interpretation decisions, the Court has presumed that if Congress disagrees with such rulings it can readily correct any error (as Congress did in response to the *Suter* decision). Here, Congress not only failed for

decades to take action in response to the decisions Petitioners now challenge; it rejected repeatedly proposals to cut off access to federal courts for Social Security Act beneficiaries (and at some points promoted such access).

V. The Court Should Decline to Overrule the Long Line of Cases Holding That Beneficiaries May Use Section 1983 to Enforce Rights Created by Spending Clause Legislation.

Petitioners urge the Court to move beyond the question whether Respondent was entitled to pursue a Section 1983 claim for violation of particular rights under the NHRA under the circumstances of this case. They ask the Court to overrule the long line of cases holding that beneficiaries and providers may use Section 1983 to enforce the terms of Spending Clause statutes, including Medicaid other Social Security Act programs.

This argument is an attack on decisions going back more than 50 years. Petitioners would have the Court overturn *King v. Smith, Rosado*, *Thiboutot*, and hundreds—if not thousands—of their progeny.[13]

Respondent's brief and the amicus brief of the United States lay out several straightforward responses to this audacious assault on longstanding precedent. *First*, the text of Section 1983 states that claims may be brought for "deprivation of any rights . . . secured by the . . . laws." The Social Security Act, including

[13] Neither Petitioners nor any amicus fully on their side of the case acknowledge the reach of their arguments, which imply that they want the Court to overrule a host of longstanding precedents—including *Thiboutot*, *King v. Smith*, and *Rosado*.

its Medicaid provisions, are "laws." As this Court has held repeatedly, there is no indication that Congress intended to categorically exclude the Social Security Act from the term "laws" in Section 1983. *See Edelman v. Jordan*, 415 U.S. 651, 675 (1974) ("It is, of course true that *Rosado v. Wyman*, 397 U.S. 397 (1970), held that suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States."). The plain meaning of the statute forecloses Petitioners' argument.

As the amicus brief of the United States explains at length, Congress's 1994 response to this Court's decision in *Suter* ratified the line of cases anchored by *King v. Smith, Rosado*, and *Thiboutot*, expressly referencing "prior Supreme Court decisions" in the text of the 1994 statute. Pub. L. No. 103-382, § 555(a), 108 Stat. 3518 (1994). In the face of this ratification, the categorical ruling Petitioners seek here would plainly conflict with congressional intent.

Based on these two points alone, the Court should reject Petitioners' argument outright. This brief provides additional reasons why the Court should disregard Petitioners' campaign to undo established precedent.

As described above, Congress created and maintained Medicaid—arguably, the most significant piece of Spending Clause legislation—as an entitlement program characterized by individual rights and benefits, supported by an entitlement in States for federal Medicaid matching funds. Congress has repeatedly rejected or abandoned efforts to transform Medicaid into a different model. And over many decades, Congress protected—and at some points even affirmatively facilitated—the ability of Medicaid beneficiaries to sue in federal court to challenge

violations of the Medicaid statute. Section 1983 suits have proved to be an effective complement to federal agency enforcement of Medicaid statutory requirements, filling gaps created by the limited resources of the federal agency to monitor and address state agencies' compliance failures.

In view of the long history of steadfast congressional support for both the individual and state entitlements in the Medicaid program and for beneficiary access to federal courts, it is far too late in the day to argue that the Court should overrule the long line of decisions that have granted such access.

The doctrine of *stare decisis* has particular relevance in light of this history. This Court has set a high bar for overruling decisions based on statutory interpretation since Congress is free to amend a statute if it disagrees with the Court's interpretation. *See, e.g.*, *Kimble v. Marvel Ent., LLC*, 576 U.S. 446, 456 (2015). In this case, where Petitioners' argument is at odds with the plain language of Section 1983, where Congress in 1994 expressly ratified the line of cases permitting private enforcement (including through use of Section 1983) to challenge violations of Spending Clause statutes, and where the Medicaid history set out in this brief reveals Congress's longstanding support for private enforcement of individual rights under the Medicaid statute, *stare decisis* must prevail.

As the United States explains, the decisions Petitioners seek to erase "have 'effectively become part of the statutory scheme' set out in Section 1983." U.S. Br. 24 (quoting *Kimble*, 576 U.S. at 456). As shown in this brief, these decisions have likewise become part of the fabric of the Medicaid program. Far from "erod[ing] over time," *Kimble*, 576 U.S. at 458, the decisions have been ratified and reinforced by Congress over

many decades. Petitioners' bid to overturn this long line of sound authority should be rejected.

CONCLUSION

For the foregoing reasons, the Court should decline Petitioners' invitation to overrule the many federal court decisions that have permitted beneficiaries to pursue relief for violations of the Medicaid statute and other Spending Clause legislation.

Respectfully submitted,

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September 23, 2022

APPENDIX

APPENDIX

List of *Amici Curiae*

Amici curiae are the following professors and scholars who study, teach, and write about health care policy in the United States.[1]

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[1] *Amici* submit this brief solely on their own behalf and not as representatives of their universities or organizations. *Amici* are listed with institutional affiliations for purposes of identification only.

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