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**

AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENT BY THE AMERICAN CANCER SOCIETY CANCER ACTION NETWORK ET AL.

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

The American Cancer Society, the American Cancer Society Cancer Action Network, the American Diabetes Association, The AIDS Institute, the Cystic Fibrosis Foundation, the Epilepsy Foundation, the Hemophilia Federation of America, the Leukemia & Lymphoma Society, the National Multiple Sclerosis Society, the National Patient Advocate Foundation, the National Organization for Rare Disorders, and WomenHeart (collectively, "*Amici*") represent millions of patients and consumers across the country facing serious, acute, and chronic diseases and health conditions. These organizations fight to prevent, treat, and cure some of the most serious, debilitating, and deadly diseases and conditions, and the millions of Americans that *Amici* represent would be among those negatively impacted should this Court, despite decades of well-supported precedent, find that aggrieved Medicaid beneficiaries cannot bring claims under 42 U.S.C. § 1983 to enforce their rights. This outcome would inevitably gut Medicaid benefits in many instances, and drastically reduce access to care among individuals with lower incomes.

Because extensive scientific research has established a strong link between access to Medicaid and improving health outcomes and reducing the financial burdens accompanying medical treatment, *Amici* advocate to protect an individual's right to sue under Section 1983 as an enforcement mechanism to protect

---

[1] Counsel of record for Petitioners and Respondent have submitted blanket consents to the filing of amicus briefs in this case. Pursuant to S. Ct. Rule 37.6, ACS CAN certifies that this brief was authored in whole by counsel for ACS CAN and that no part of the brief was authored by any attorney for a party. No party, nor any other person or entity, made any monetary contribution to the preparation or submission of this brief.

Medicaid rights. Such rights remain critical for these individuals as a means of redress to hold state-administered programs, entities, or actors accountable, and to ensure patients receive the benefits to which they are entitled under federal law. Otherwise, these Medicaid beneficiaries, who include America's most vulnerable populations, would in many cases have no other means available to redress violations of their rights and have "their day in court." This deprivation would inevitably reduce access to care among individuals with limited incomes.

As organizations that fight to prevent, treat, and cure some of the most serious, debilitating, and deadly diseases and conditions, *Amici* are uniquely able to assist the Court in understanding the direct link between Medicaid availability and the beneficial effects to health access, health status, and reduction of socioeconomic disparities in health care access. An individual's private right of action under Section 1983 as an enforcement mechanism is critical for millions of patients, survivors, and their families to ensure continued health care access when state-administered programs, entities, or actors fail to comply with federal mandates to provide specific benefits under the Medicaid Act.

The American Cancer Society's mission is to save lives and lead the fight for a world without cancer.

The American Cancer Society Cancer Action Network ("ACS CAN"), the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public

policy changed as well as legislative and regulatory solutions that will reduce the cancer burden.

The American Diabetes Association is a nationwide, nonprofit, voluntary health organization with a mission to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

The AIDS Institute is a leading national nonpartisan, nonprofit patient advocacy organization working to end the HIV and viral hepatitis epidemics by increasing access to health care for people living with and at risk for infectious disease and chronic illness. The Institute promotes action for social change through public policy, research, advocacy, and education.

The Cystic Fibrosis Foundation's mission is to cure cystic fibrosis (CF) and to provide all people with CF the opportunity to lead long, fulfilling lives by funding research and drug development, partnering with the CF community, and advancing high-quality, specialized care.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of more than 3.4 million Americans with epilepsy and seizures. Nearly 1 million people with epilepsy rely on Medicaid and delays in access to care and treatment increase the likelihood of breakthrough seizures and related complications including injury, disability and even death.

The Hemophilia Federation of America is a community-based, grassroots advocacy organization that educates, assists, and advocates on behalf of people with hemophilia, von Willebrand disease, and other rare bleeding disorders.

The Leukemia & Lymphoma Society is the world's largest voluntary health agency dedicated to fighting blood cancer and ensuring that the more than 1.4 million blood cancer patients and survivors in the United States can access the care they need.

The National Multiple Sclerosis Society mobilizes people and resources so that everyone affected by multiple sclerosis ("MS") can live their best lives while the Society works to stop MS in its tracks, restore what has been lost and end MS forever.

The National Organization for Rare Disorders (NORD) is a patient advocacy organization dedicated to the 25-30 million Americans with rare disorders. NORD strives for a world where people living with rare diseases achieve their best health and well-being.

The National Patient Advocate Foundation is the advocacy affiliate of the Patient Advocate Foundation, a national organization that provides direct assistance and support service for families confronting complex, chronic and serious diseases to help reduce distressing financial and other burdens they experience.

WomenHeart: The National Coalition for Women with Heart Disease is the nation's only patient-centered organization focused solely on providing support, education and advocacy to women living with or at risk for heart disease.

In this brief, *Amici* will demonstrate how an individual's right to bring suit under Section 1983 to redress violations of the rights of Medicaid beneficiaries is critical to: (i) promote health access, improve health outcomes, and reduce socioeconomic disparities in health care access to continue to prevent, treat, and cure the diseases that *Amici's* constituents fight every day and (ii) hold state-administered programs,

entities, and actors accountable if they fail to provide Medicaid benefits or coverage to qualifying individuals as required under federal mandate.

SUMMARY OF ARGUMENT

The Medicaid Act, which provides rights to individual beneficiaries through its health-benefit programs, is critically important to improving health outcomes and to reducing the financial burdens accompanying medical treatment. Medicaid has dramatically increased access to medical care among individuals with lower incomes by covering millions of such individuals who otherwise lack health insurance. Medicaid also increases access to and use of health services. Having access to Medicaid dramatically improves health outcomes, particularly for persons with serious, life-threatening diseases, in many cases by providing specific rights to certain types of care. Accessible health care is essential in managing chronic diseases, including cancer, cardiovascular disease, diabetes, and other conditions. Studies confirm that access to Medicaid reduces socioeconomic disparities in health care access.

For many decades, Section 1983 has served as the primary mechanism for enforcing Medicaid rights. Congress has modified the availability of Section 1983 enforcement for certain Medicaid provisions but has otherwise permitted Section 1983 to remain available to enforce individual Medicaid rights. Courts have permitted aggrieved Medicaid beneficiaries to sue under Section 1983 since Medicaid's enactment. Neither this Court nor any of the courts of appeals has ever held that Medicaid rights are *per se* unenforceable by means of Section 1983 because Congress enacted Medicaid under its Spending Clause authority.

Stripping Medicaid beneficiaries of access to court under Section 1983 as a means of redressing Medicaid rights violations would gut Medicaid enforcement and drastically reduce access to care among individuals with low income. Section 1983 provides a well-established, comprehensive and appropriately limited means for enforcing statutory rights under Medicaid. Any decision to abruptly jettison the availability of Section 1983 to enforce Medicaid rights should be left to Congress.

ARGUMENT

I. THE MEDICAID ACT IS CRITICALLY IMPORTANT TO IMPROVING HEALTH OUTCOMES AND TO REDUCING THE FINANCIAL BURDENS ACCOMPANYING MEDICAL TREATMENT.

The effects of Medicaid availability in the United States have been heavily studied, with researchers often highlighting the drastic variation between Medicaid expansion and non-expansion states as a "natural experiment" that underscores the importance of Medicaid coverage. The research findings are highly consistent: Medicaid availability has increased health care coverage and improved access to and use of necessary services. This increased access has in turn improved certain health outcomes and reduced the financial burdens of health care and a range of health disparities. Those same studies illustrate the urgent need for Medicaid availability in producing beneficial health outcomes and reducing healthcare inequities. Several of these research findings are described below.

A. Medicaid has dramatically increased access to medical care among individuals with lower incomes by reducing the number of people without health insurance.

In a review of over 600 studies conducted between January 2014 and March 2021, the Kaiser Family Foundation found that Medicaid expansion is linked to gains in coverage, and consequently, to improvements in access to care, financial security, and certain health outcomes. *See* Madeline Guth *et al.*, Kaiser Family Found., *The Effects of Medicaid Expansion Under the ACA*: *Studies from January 2014 to January 2020* (2020), https://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansionunder-the-ACA-Updated-Findings-from-a-Literature-Review.pdf; Madeline Guth & Meghana Ammula, Kaiser Family Found., *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021* (2021), https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/. Similar findings were made by the U.S. Department of Health and Human Services in 2017. *See* U.S. Dep't of Health & Human Servs., Office of the Assistant Sec'y for Planning & Evaluation, *Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care* (2017), https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf.

In the states that have expanded Medicaid availability, there was a sharp uptick in insurance coverage, especially among individuals with lower incomes, directly attributable to the expansion. Guth *et al.*, *supra*, at 5-6. Studies also found larger coverage gain, Guth *et al.*, *supra*, at 5-6, in expansion states

among certain high-risk populations, including cancer patients, individuals with substance abuse disorders, people with HIV, people with a history of cardiovascular disease, and adults with diabetes. *Id*. at 6; Xuesong Han, *et al*., *Comparison of Insurance Status and Diagnosis Stage Among Patients With Newly Diagnosed Cancer Before vs After Implementation of the Patient Protection and Affordable Care Act*, JAMA Oncology, 2018 (4)(12): 1713-1720, https://jamanetwork.com/journals/jamaoncology/fullarticle/2697226?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamaoncol.2018.3467; A. Jemal, *et al.*, *Changes in Insurance Coverage and Stage at Diagnosis Among Nonelderly Patients With Cancer After the Affordable Care Act*, Journal of Clinical Oncology, 2017 35:3906-3915, https://pubmed.ncbi.nlm.nih.gov/28885865/; Cystic Fibrosis Foundation, *2021 Cystic Fibrosis Foundation Patient Registry Highlights*, https://www.cff.org/media/26631/download (last visited Sept, 22, 2022) (noting that 42 percent of all people with cystic fibrosis are enrolled in Medicaid, including 52 percent of children under 10 years old fighting the disease); The Aids Institute, *Closing the Health Coverage Gap is the Key to Ending the HIV and Hepatitis C Epidemics* (2021), https://aidsinstitute.net/documents/Coverage-Gap-Issue-Brief_draft-V7.pdf (noting that only 6 percent of people living with HIV are uninsured in Medicaid expansion states compared to 20 percent in non-expansion states).

In addition, research suggests that Medicaid availability has helped to reduce disparities in access to health care coverage. Guth, *et al., supra*, at 6 (noting that studies have found expansion helped decrease disparities in coverage "by age, marital status, disability status, and in some studies, race/ethnicity"). Han, *et al., supra*; Jemal, *et al., supra*; The Aids Institute,

supra (finding that in expansion states, Black and Hispanic residents have seen the greatest declines in uninsured rates concerning HIV and hepatitis C diagnoses). A 2017 study found that the gap in coverage between households with an annual income below $25,000 and those above $75,000 fell from 31 percent to 17 percent (a relative reduction of 46 percent) in Medicaid expansion states, twice the relative reduction in non-expansion states. Kevin Griffith *et al.*, *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, 36 Health Aff. 1503, 1507–08 (2017), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0083?journalCode=hlthaff.

Increasing Medicaid coverage for adults also led to increased coverage for children. *See* Genevieve M. Kenney *et al.*, Urban Inst., *Children's Coverage Climb Continues: Uninsurance and Medicaid / CHIP Eligibility and Participation Under the ACA*, 7 (2016), https://www.urban.org/sites/default/files/alfresco/publicationpdfs/2000787-Childrens-Coverage-Climb-Continues-Uninsurance-and-Medicaid-CHIP-Eligibility-and-Participation-Under-the-ACA.pdf; *see also* Maya Venkataramani *et al.*, *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, 140 Pediatrics e20170953 (2017), https://pediatrics.aappublications.org/content/pediatrics/140/6/e20170953.full.pdf (finding that when a parent is enrolled in Medicaid, their children are 29 percent more likely to receive an annual well child visit); X. Ji, *et al.*, *Narrowing Insurance Disparities Among Children and Adolescents with Cancer Following the Affordable Care Act*, JNCI Cancer Spectrum, Volume 6, Issue 1 (February 2022), https://doi.org/10.1093/jncics/pkac006. Other studies have shown that access to Medicaid coverage provided both short- and long-term benefits for children's health, educational achievement, and long-term earnings. *See* Alisa

Chest & Joan Alker, Georgetown Univ. Health Pol. Inst., Ctr. for Children and Families, *Medicaid at 50*: *A Look at the Long-Term Benefits of Childhood Medicaid* 1 (2015), https://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf.

B. Medicaid increases access to and use of health services.

Medicaid availability is associated with improved access to care and increased utilization of health care services. *See*, *e.g.*, Guth *et al.*, supra, at 8-9; Benjamin D. Sommers *et al.*, *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, 36 Health Aff. 1119, 1124 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0293 (finding that Medicaid expansion "was associated with significant improvements in access to primary care and medications, affordability of care, preventive visits, screening tests, and self-reported health"). This trend is not surprising, as research evaluating the effects of Medicaid coverage even prior to expansion found that enrollment in Medicaid led to greater access to care. *See, e.g.*, Andrea S. Christopher *et al.*, *Access to Care and Chronic Disease Outcomes Among Medicaid-Insured Persons Versus the Uninsured*, 106 Am. J. Pub. Health 63, 63–69 (2015), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302925 (finding that, compared with uninsured individuals, individuals enrolled in Medicaid are more likely to have at least one outpatient physician visit annually); Katherine Baicker & Amy Finkelstein, *The Effects of Medicaid Coverage–Learning from the Oregon Experiment*, 365 New Eng. J. Med. 683 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3321578/pdf/nihms-366643 (finding that Medicaid coverage raised the probability of using

outpatient care by 35 percent and prescription drugs by 15 percent).

Numerous studies have found that Medicaid availability is associated with increased utilization of a variety of preventive services, and, in turn, increased diagnoses of diseases and health conditions. *See* Guth *et al.*, *supra*, at 8-9. In one study, the improvement in screening rates for colorectal cancer (CRC) translated to an additional 236,573 low-income adults receiving recent CRC screening in 2016. Stacey A. Fedewa *et al.*, *Changes in Breast and Colorectal Cancer Screening After Medicaid Expansion Under the Affordable Care Act*, 57 Am. J. Preventive Med. 1, 3 (2019). If the same absolute increases were experienced in non-expansion states, 355,184 more low-income adults would have had CRC screening as of 2019. *Id.*

Similarly, compared with non-expansion states, states that implemented the expansion saw greater improvement in breast cancer screening rates among lower-income women. Yoshiko Toyoda *et al.*, *Affordable Care Act State-Specific Medicaid Expansion: Impact on Health Insurance Coverage and Breast Cancer Screening Rates*, 230 J. Am. Coll. Surg. 5 (2020), https://www.journalacs.org/article/S1072-7515(20)30213-1/fulltext. *See also* Nicolas Ajkay *et al.*, *Early Impact of Medicaid Expansion and Quality of Breast Cancer Care in Kentucky*, 226 J. Am. Coll. Surg. 498 (2018), https://doi.org/10.1016/j.jamcollsurg.2017.12.041 (finding that Medicaid expansion in Kentucky led to a higher incidence of early detection and treatment).

Further, states that implemented the expansion saw significantly smaller increases in the rate of cardiovascular mortality for middle-aged adults. Sameed Khatana *et al.*, *Association of Medicaid Expansion*

with Cardiovascular Mortality, JAMA Cardiol. 4(7) 671-679 (2019) https://jamanetwork.com/journals/jamacardiology/fullarticle/2734704 (finding that the counties in expansion states displayed significantly smaller increases in cardiovascular mortality rates among middle-aged adults post-expansion compared with counties in states that did not expand Medicaid).

Medicaid availability has also increased access to and utilization of prescription drugs. Medicaid expansion "is associated with increases in overall prescriptions for, Medicaid-covered prescriptions for, and Medicaid spending on medications to treat opioid use disorder and opioid overdose." Guth *et al.*, *supra*, at 9. More generally, a 2019 study found that within 15 months after Medicaid expansion, Medicaid-paid prescriptions increased 19 percent, with the largest increases in generic drugs for chronic conditions like diabetes and heart disease, suggesting that Medicaid expansion reduced cost barriers that inhibit access to such medications for low-income adults with chronic conditions. *See* Ausmita Ghosh *et al.*, *The Effect of Health Insurance on Prescription Drug Use Among Low-Income Adults: Evidence from Recent Medicaid Expansions*, 63 J. Health Econ. 64 (2019). Research also suggests that the expansion reduced racial disparities in access to medications. *See* Benjamin D. Sommers *et al.*, *Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act* 314 JAMA 366 (2015), https://jamanetwork.com/journals/jama/fullarticle/2411283; Lucy Chen *et al.*, Harvard Univ., *Technical Memo on Coverage Expansion and Low-Income, Reproductive-Age Women* (2020), https://hcp.hms.harvard.edu/technical-memo-coverage-expansion-andlow-income-reproductive-age-women (finding that Medicaid expansion was associated with an

increase of 2.8 prescription refills per year among non-pregnant, low-income women ages 18-44).

C. Access to Medicaid dramatically improves health outcomes, particularly for persons with serious, life-threatening diseases.

By increasing access to and utilization of health care services, Medicaid has led to a range of improved health outcomes. *See* Guth *et al.*, *supra*, at 10-11; Guth & Ammula, *supra*, at 4-8. A 2019 study, updated in January 2021, concluded that near-elderly adults (those between ages 50-62) in expansion states experienced a substantial drop in mortality compared to adults the same age in non-expansion states. *See* Sarah Miller *et al.*, *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data, NBER Working Paper Series No. 26081* (2019), https://www.nber.org/system/files/working_papers/w26081/w26081.pdf. The authors estimated that in the four years following Medicaid expansion, approximately 15,600 deaths could have been averted if Medicaid expansion had been adopted nationwide. *Id.* at 3; 23. Additional research has shown that Medicaid expansion resulted in decreased overall mortality rates and decreased mortality rates associated with specific health conditions such as certain cancers, cardiovascular disease, and liver disease. *See* Guth & Ammula, *supra*, at 5.

1. Cancer

Researchers have found that Medicaid availability is associated with a shift to early stage at diagnosis for cancer patients. *See, e.g.*, Xuesong Han *et al.*, *supra*, *at* 1717; J. Zhao *et al.*, *Health insurance status and cancer stage at diagnosis and survival in the United States*. CA Cancer J Clin. (2022) https://acsjournals.

onlinelibrary.wiley.com/doi/10.3322/caac.21732 (finding that uninsured patients were significantly more likely to be diagnosed with late-stage cancer for all stageable cancers combined); *see also* Ivette Gomez *et al.*, Kaiser Family Found., *Medicaid Coverage for Women* (2022), https://www.kff.org/womens-health-policy/issue-brief/medicaid-coverage-for-women/ (noting that women on Medicaid use primary and preventive health services, such as pap smears and mammograms, at rates comparable to women with private insurance and at higher rates than uninsured women).

Among patients with newly diagnosed cancer ages 18-64 years, patients living in states with lower Medicaid income eligibility limits, *i.e.*, in which fewer people qualify for Medicaid, had worse survival rates for most cancers in both early and late stages, compared with those living in states with Medicaid income eligibility limits ≥ 138% of the federal poverty level, *i.e.*, in which more people qualify. J. Zhao *et al., Association of State Medicaid Income Eligibility Limits and Long-Term Survival After Cancer Diagnosis in the United States*, JCO Oncology Pract. (2022), https://pubmed.ncbi.nlm.nih.gov/34995127 (finding that increasing Medicaid income eligibility could improve survival after cancer diagnosis). Further, early mortality among patients discharged from the hospital following lung cancer surgery decreased significantly among patients in Medicaid expansion states, but not in patients living in non-expansion states. L. Nogueira *et al.*, *Association of Medicaid expansion under the Affordable Care Act and early mortality following lung cancer surgery*, Journal of Clinical Oncology 2021 39:28_suppl, 76-76, https://ascopubs.org/doi/abs/10.1200/JCO.2020.39.28_suppl.76 (finding that Medicaid expansion may be an effective strategy for improving

access to care and cancer outcomes among older adults who are not age-eligible for Medicare).

Medicaid availability is also associated with reduced disparities in stage at diagnosis. *See*, *e.g.*, Xu Ji *et al.*, *Association of Medicaid Expansion with Cancer Stage and Disparities in Newly Diagnosed Young Adults*, J. Nat'l Cancer Inst. (2021), https://pubmed.ncbi.nlm.nih.gov/34021352/ (finding a narrowing of rural-urban and Black-white disparities among young adults diagnosed with cancer); Xu Ji *et al.*, *Association between the Affordable Care Act Medicaid Expansion and Survival in Young Adults Newly Diagnosed with Cancer*, Journal of Clinical Oncology 2022 40:16_suppl, 1502-1502, (June 1, 2022), https://ascopubs.org/doi/abs/10.1200/JCO.2022. 40.16_suppl.1502 (finding that cancer survival benefits attributed to Medicaid expansion were notable among racial/ethnic minority patients and patients with high healthcare needs, and by patients' treatment facility type); Jose Wilson B. Mesquita-Neto *et al.*, *Disparities in Access to Cancer Surgery After Medicaid Expansion*, 219 Am. J. Surg. 181 (2020), https://www.americanjournalofsurgery.com/article/S0002-9610(19)30688-9/fulltext (finding that Medicaid expansion was associated with earlier cancer diagnoses and increased access to surgical care, especially among lower-income patients); Xuesong Han *et al.*, *Association Between Medicaid Expansion Under the Affordable Care Act and Survival Among Newly Diagnosed Cancer Patients*, J. Nat'l Cancer Inst. Volume 114, Issue 8, August 2022, 114(8):1176-1185, https://doi.org/10.1093/jnci/djac077 (finding Medicaid expansion was associated with greater increase in 2-year overall survival among newly diagnosed cancer patients, and the increase was prominent among non-Hispanic Blacks and in rural areas).

In addition, a study including over 1.4 million patients with cancer found that those living in states with higher Medicaid income eligibility limits had better long-term survival rates. J. Zhao *et al.*, *supra*, Association *of State Medicaid Income Eligibility Limits and Long-Term Survival After Cancer Diagnosis in the United States*. JCO Oncology Pract. (2022), https://pubmed.ncbi.nlm.nih.gov/34995127.

2. Diabetes

Medicaid availability has also led to improved health outcomes for people with conditions other than cancer. For example, compared with patients with diabetes in non-expansion states, those in expansion states were treated earlier and reported better health outcomes. *See* Harvey W. Kaufman, *Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act*, 38 Diabetes Care 833, 835 (2015), https://care.diabetesjournals.org/content/38/5/833; Jusung Lee, *The Impact of Medicaid Expansion on Diabetes Management*, 43 Diabetes Care 1094, 1097–98 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7171935/pdf/dc191173.pdf.

3. Maternal and infant health

In 2019, women comprised 36% of the overall Medicaid population, and represented the majority of adults in the program. Ivette Gomez *et al.*, *supra*. Research also indicates that Medicaid has led to improved maternal health outcomes and a reduction in maternal and infant health disparities. *Id.* (noting Medicaid is the largest single payer of pregnancy-related services, financing 42% of all U.S. births in 2019).

A recent study found that Medicaid availability is significantly associated with lower maternal mortality, and the effect "was concentrated among non-Hispanic Black mothers, indicating that Medicaid expansion could be contributing to a reduction in the large racial disparity in maternal mortality faced by Black mothers." Erica 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. Similarly, a 2019 study found that expansion was associated with improvements in relative health disparities for Black infants compared with white infants. *See* Clare 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. *See* also Chintan B. Bhatt & Consuelo M. Beck-Sague, *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 (suggesting that expansion may have contributed to a decline in infant mortality rates, especially among African-American infants).

4. Mental health

Patients with mental illnesses have also greatly benefited from Medicaid availability. "In states that expanded Medicaid under the Affordable Care Act ("ACA"), the uninsured share of substance use or mental health disorder hospitalizations fell from about 20 percent in the fourth quarter of 2013 to about 5 percent by mid-2015." Continuing Progress on the Opioid Epidemic: The Role of the Affordable Care Act, ASPE ISSUE BRIEF (Jan. 11, 2017), https://aspe.hhs.gov/system/files/pdf/255456/ACAOpioid.pdf. Medicaid expansion increased the rate of health insurance

coverage among nonelderly adults with serious psychological distress and resulted in a reduction of patients choosing to delay or forgo treatment due to the cost of health care. Priscilla Novak *et al.*, *Changes in Health Insurance Coverage and Barriers to Health Care Access Among Individuals with Serious Psychological Distress Following the Affordable Care Act*, 45 ADMIN. POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 924 (2018), https://doi.org/10.1007/s10488-018-0875-9.

D. Access to Medicaid reduces socioeconomic disparities in health care access.

Medicaid availability has been associated with an increase in health care affordability and financial security, as well as a reduction in disparities by income or race across measures of affordability. *See* Guth *et al.*, *supra*, at 13-14; *see also* Sommers *et al.*, *Three-Year Impacts of the Affordable Care Act*, *supra*, at 1124-26 (finding that expansion led to an average of $337 in annual savings on medical out-of-pocket spending among those who gained coverage). Without the benefits of Medicaid, the economic burden of fighting certain diseases can easily become astronomical. *See e.g.,* Lidia M.V.R Moura *et al., Drivers of U.S. healthcare spending for persons with seizures and/or epilepsy*, 63 Epilepsia 8, 2144-2154 (2022), https://doi.org/10.1111/epi.17305 (noting that the average annual health care spending was $15,096 for persons with epilepsy or seizure).

A 2017 study investigated in detail the effects of Medicaid expansion on households' financial health and found direct as well as substantial indirect financial benefits. See Kenneth Brevoort, Daniel Grodzicki, & Martin B. Hackman, *Medicaid and Financial Health*, NBER Working Paper No. 24002 (2017),

https://www.nber.org/system/files/working_papers/w24002/w24002.pdf. During its first two years, expansion not only reduced unpaid medical bills sent to collection by $3.4 billion, it also reduced the likelihood of individuals becoming delinquent on a debt obligation, improved credit scores, prevented about 50,000 bankruptcies among subprime borrowers, and led to better terms for available credit valued at $520 million per year. *Id.* at 3. The study concluded that the financial benefits of Medicaid double when adding these indirect benefits to the direct reduction in out-of-pocket expenditures. *Id.* at 4. *See also* Kyle J. Caswell & Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, 76 Med. Care Res. & Rev. 538, 562 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6716207/pdf/10.1177_10775587177251 64.pdf (finding that Medicaid expansion significantly reduced the likelihood of new medical collections and, more generally, the flow of new and large debt balances).

Other research has concluded that Medicaid expansion helps low-income individuals stay employed and stay in school, further improving their financial security. *See* Krystin Racine, *More Evidence that Medicaid Expansion Linked to Employment and Education Gains*, Geo. U. Health Pol'y Inst., Ctr. for Child. and Families: Say Ahhh! (Mar. 3, 2021), https://ccf.georgetown.edu/2021/03/03/more-evidence-that-medicaid-expansion-linked-to-employment-and-education-gains/. A study in Michigan found that after being enrolled in Medicaid for one year, the proportion of enrollees who were working or in school rose from 54 percent to 60 percent; Black enrollees had even larger gains. *See* Renuka Tipirneni *et al.*, *Association of Medicaid Expansion with Enrollee Employment and Student Status in Michigan*, 3 JAMA Network Open e1920316

(2020). Medicaid expansion has also been linked to lower eviction rates, *see* Heidi L. Allen *et al.*, Can Medicaid Expansion Prevent Housing Evictions? 38 Health Aff. 1451, 1454-56 (2019), https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05071, and fewer payday loans, *see* Heidi Allen *et al.*, *Early Medicaid Expansion Associated with Reduced Payday Borrowing in California*, 36 Health Aff. 1769, 1772-75 (2017), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0369. In sum, greater Medicaid availability has led to increased access to health care and better health outcomes on a wide range of metrics.

II. FOR MANY DECADES, SECTION 1983 HAS SERVED AS A POWERFUL MECHANISM FOR ENFORCING MEDICAID RIGHTS.

A. The Court and the Courts of Appeal have allowed aggrieved Medicaid beneficiaries to sue under Section 1983 since the earliest days of Medicaid.

Medicaid beneficiaries are not merely third-party beneficiaries to a contract, and relegating them to that status ignores clear statutory text and decades of federal precedent. Where, as is the case here, Congress clearly intended to create individually enforceable federal rights, Section 1983 provides a comprehensive scheme for adjudication of those rights.

1. The *Wilder* case.

Petitioner's first issue broadly asks the Court to reexamine whether any Spending Clause legislation is capable of conferring a private right of action enforceable under Section 1983. The Court has already answered that question in the affirmative, and there is no basis to upend Congress's evident, decades-long

satisfaction with that answer with Petitioner's proposed sudden reboot. Although the question in *Wilder* was narrower than those presented in this case, the theme is the same.

In *Wilder*, the Court considered whether a specific subsection (Section 1396a(a)) of the Medicaid Act created a private right of action enforceable under Section § 1983. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 510 (1990). The analysis turned on whether the provision in question was intended to benefit the plaintiff. *Id.* at 509. If so, a Section 1983 right of action would be available unless Congress clearly articulated an intent to the contrary or the interest asserted was so "vague and amorphous" that the judiciary lacked the competence to enforce it. *Id.* The Court concluded that Section 1396a(a), was intended to benefit the plaintiff. The Court also determined that the Medicaid amendments imposed a binding obligation on the states and held that the providers had an enforceable private right for reimbursement at "reasonable and adequate" rates pursuant to Section 1396a(a). *Id.* at 510-12.

2. Neither this Court nor any of the Courts of Appeal have found Medicaid rights unenforceable under Section 1983 solely because Congress enacted Medicaid under its Spending Clause authority

Although some post-*Wilder* cases narrowed the situations in which enforcement is available under Section 1983, none of those cases categorically rejects the notion that individual Medicaid beneficiaries have rights under the Medicaid Act that are enforceable under Section 1983.

For example, *Suter v. Artist M.*, 503 U.S. 347, 360, 112 S. Ct. 1360, 1368 (1992), involving the Adoption

Assistance and Child Welfare Act of 1980, concluded that the Act created no individual guarantees enforceable through Section 1983, and that the Act itself provided no authorization for individuals to sue to enforce its terms. *Id.* Although the Court made passing reference to the fact that the Congress enacted the legislation at issue pursuant to its Spending Clause authority, there was no categorical rejection of Section 1983 remedies in the case of Spending Power legislation. *Id.*

In *Blessing v. Freestone*, 520 U.S. 329, 340 (1997), the Court established a three-pronged, case-by-case test of whether a Section 1983 claim could prevail: (1) whether a particular federal provision in question was intended to benefit an individual plaintiff; (2) whether the provision was sufficiently specific that a court could go about the business of enforcement; and (3) whether the provision created a binding obligation on a state (as opposed to merely a general federal expectation).

In *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283, (2002), the Court focused on the role of Congressional intent that a particular statutory provision benefit a particular plaintiff. Specifically, the Court rejected any notion that its prior rulings "permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983." *Id.* Although the typical remedy for noncompliance with Spending Clause legislation is termination of federal funding, the Court made clear that Spending Clause legislation may give rise to enforceable individual rights when Congress speaks with a "clear voice." *Id.* at 280.

B. Courts have enforced many individual rights created by the Medicaid Act through Section 1983.

Nearly all of the Courts of Appeal have concluded that some provisions of the Medicaid Act confer individual rights enforceable under Section 1983 based on plain statutory language and the Court's precedents. Representative cases include:

1. First Circuit

The Medicaid Act requirement that states adopt methods and procedures which will afford equal access to medical care was held enforceable as an individual right under Section 1983. *Visiting Nurse Ass'n v. Bullen*, 93 F.3d 997, 1005 (1st Cir. 1996); *see also Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002) (holding that beneficiaries may sue under Section 1983 to enforce Medicaid's "reasonable promptness" requirement).

2. Second Circuit

The statutory right to a fair hearing under Section 1396a(a)(3) of the Medicaid Act was held enforceable through a Section 1983 action. *Shakhnes v. Berlin*, 689 F.3d 244, 247 (2d Cir. 2012).

3. Third Circuit

A Medicaid beneficiary's right to receive medical assistance with reasonable promptness was held enforceable under Section 1983. *Lewis v. Alexander*, 685 F.3d 325, 344 (3d Cir. 2012); *see also Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 189 (3d Cir. 2004) (beneficiaries may sue under Section 1983 to enforce Medicaid's requirement that state provide intermediate care facilities for persons with mental disabilities).

4. Fourth Circuit

A claim that South Carolina was not furnishing medical services with reasonable promptness to "all eligible individuals" was held actionable under Section 1983. *Doe v. Kidd*, 501 F.3d 348, 354 (4th Cir. 2007).

5. Fifth Circuit

The Medicaid Act's requirement that the state furnish specified care and services with reasonable promptness was held enforceable under Section 1983. *Romano v. Greenstein*, 721 F.3d 373 (5th Cir. 2013); *see also Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 931 (5th Cir. 2000) (beneficiaries entitled to sue under Section 1983 for violations of Medicaid Act's equal access provision); *S.D. v. Hood*, 391 F.3d 581, 607 (5th Cir. 2004) (beneficiaries entitled to sue under Section 1983 to enforce Medicaid Act right to early and periodic screening, diagnostic, and treatment ("EPSDT") services).

6. Sixth Circuit

The Medicaid Act's freedom-of-choice provision "creates enforceable rights that a Medicaid beneficiary may vindicate through § 1983." *Harris v. Olszewski*, 442 F.3d 456, 461 (6th Cir. 2006).

7. Seventh Circuit

In a recent opinion evaluating the Medicaid Act, the Seventh Circuit concluded that it was reasonably clear that the rule for prompt payment of providers conferred privately enforceable rights and was not merely a "paper tiger." *Saint Anthony Hosp. v. Eagleson*, 40 F.4th 492, 511 (7th Cir. 2022).

8. Eighth Circuit

The Medicaid Act's equal access provision was found generally analogous to the Boren Amendment examined in *Wilder* and thus supported a private cause of action under Section 1983. *Ark. Med. Soc'y v. Reynolds*, 6 F.3d 519, 525 (8th Cir. 1993); *see also Pediatric Specialty Care, Inc. v. Ark. Dept. of Human Servs*., 293 F.3d 472, 479 (8th Cir. 2002) (beneficiaries have Medicaid Act right to EPSDT services enforceable under Section 1983).

9. Ninth Circuit

"Medicaid beneficiaries enjoy an unambiguously conferred individual right to a free choice of provider under [the Medicaid Act]." *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 968 (9th Cir. 2013).

10. Tenth Circuit

Medicaid's free-choice-of-provider provision was held to confer a private right of action for Medicaid beneficiaries. *Planned Parenthood of Kan. & Mid-Missouri v. Andersen*, 882 F.3d 1205, 1225 (10th Cir. 2018).

11. Eleventh Circuit

Medicaid beneficiaries "have a federal right to reasonably prompt provision of assistance under section 1396a(a)(8) of the Medicaid Act, and . . . this right is enforceable under section 1983." *Doe by & Through Doe v. Chiles*, 136 F.3d 709, 719 (11th Cir. 1998).

C. Congress has not taken any steps to eliminate Section 1983 claims by beneficiaries to redress Medicaid violations.

Even when a plaintiff establishes that a federal law creates an individually enforceable right, there is only a rebuttable presumption that the right is actually enforceable under Section 1983. *City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 120 (2005). A defendant can overcome the rebuttable presumption by "demonstrating that Congress did not intend that remedy for a newly created right." *Id.* As the Court has explained, a defendant successfully rebuts the presumption by demonstrating that Congress expressed its intent to the contrary directly in the statute or inferred it by creating a "comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* (citing *Blessing*, *supra*, at 341 and *Middlesex Cty. Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19-20 (1981)).

Despite numerous amendments and expansions since creating Medicaid, Congress has never revised the law to include a "provision for private judicial or administrative enforcement." *Abrams*, 544 U.S. at 122 (quoting *Wilder*, 496 U.S. at 521). Congress also has been well aware of the extensive litigation involving enforcement of Medicaid rights under Section 1983. Indeed, since *Gonzaga* was decided, the various Circuit Courts of Appeal, with the exception of the DC Circuit, have decided over 50 cases assessing whether a particular Medicaid provision can be privately enforced under Section 1983.[2] Every circuit, other than the Eleventh and the DC Circuit, has affirmatively found

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[2] *See* National Health Law Program Issue Brief (June 30, 2021), file:///C:/Users/Downloads/Fact-Sheet-1983-Enforcement.pdf.

a private right of action, enforceable under Section 1983, for Medicaid beneficiaries in the post-*Gonzaga* era.[3] Despite the significant attention in the courts, Congress has not used any of its opportunities to include language that expresses or implies an intent to foreclose Section 1983 as an avenue for Medicaid beneficiaries to enforce their rights. The bottom line is that the Court has always looked to the remedies available in the statute at issue in determining whether to allow a Section 1983 claim. *Abrams*, 544 U.S. at 121-22. Medicaid does not provide a judicial or administrative remedy, which means that Section 1983 is the only avenue by which beneficiaries can enforce the rights Congress conferred to them via Medicaid. *Id.*

III. STRIPPING MEDICAID BENEFICIARIES OF ACCESS TO COURT VIA SECTION 1983 CLAIMS WOULD GUT MEDICAID ENFORCEMENT AND REDUCE ACCESS TO CARE AMONG INDIVIDUALS WITH LOW INCOMES.

In 2022, nearly 82 million people were enrolled in Medicaid, making it the nation's largest public health insurer. Centers for Medicare & Medicaid Services, May 2022 Medicaid & CHIP Enrollment Data Highlights (2022), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. The above survey of case law illustrates that Section 1983 has been a vital mechanism for enforcing rights-granting provisions of the Medicaid Act. For decades, lower courts have entertained Section 1983 actions to enforce key

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[3] *Id.*

provisions of Medicaid, creating significant reliance interests among aggrieved Medicaid beneficiaries. These private rights of action under Section 1983 play a vital role in ensuring Medicaid provides access to health care as intended. Eliminating Section 1983 as an enforcement mechanism would leave millions of Medicaid beneficiaries, who are by definition individuals with low incomes, without any effective remedy for deprivations of access to health care.

CONCLUSION

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

Respectfully submitted,

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