No. 23-1275

IN THE
Supreme Court of the United States

EUNICE MEDINA, IN HER OFFICIAL CAPACITY AS INTERIM DIRECTOR, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.,

Respondents.

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

BRIEF OF AMICI CURIAE HEALTH POLICY SCHOLARS IN SUPPORT OF RESPONDENTS

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March 12, 2025

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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 that serves over 80 million beneficiaries—as an individual entitlement for the benefit of low-income people. The brief also provides context on Congress's addition of 42 U.S.C. § 1396a(a)(23) (hereinafter, (a)(23)), the provision at issue in this case, which confers an individual entitlement for Medicaid beneficiaries to choose their health care providers.

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 this Court's decisions in cases such as *King v. Smith*, 392 U.S. 309 (1968), *Rosado v. Wyman*, 397 U.S. 397 (1970), and *Maine v. Thiboutot*, 448 U.S. 1 (1980), as well as a number of lower federal court decisions, 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 described in this

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[1] The amici are listed in the Appendix to this brief. *See infra* App. 1a–3a. Pursuant to Rule 37.6, 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.

brief confirms that Congress has protected and enhanced beneficiaries' ability to bring such suits and that private enforcement of individual rights under 42 U.S.C. § 1983 (hereinafter, Section 1983) has become an integral part of Medicaid's structure.

INTRODUCTION AND SUMMARY OF ARGUMENT

This brief reviews the history showing that Congress created, maintained, and defended Medicaid as an individual entitlement program. Section (a)(23) of the Medicaid statute,[2] which confers on beneficiaries the right to obtain health care from providers of their choice, reflects Congress's intent to create an individual entitlement that beneficiaries may enforce through a Section 1983 suit.

The history of Medicaid as an individual entitlement program starts in the 1960s, when Congress enacted the Medicaid statute, establishing specific health care rights for beneficiaries. A few years later, in the face of efforts by some States to limit beneficiaries' choice of providers, Congress added (a)(23), establishing the individual right of beneficiaries to choose their providers. Congress subsequently took additional steps to ensure in particular that beneficiaries could choose their providers when receiving family planning services.

The history continues through the 1970s, with federal government recognition of the importance of

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[2] "Medicaid statute" refers to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq*.

the Medicaid entitlement and its status as part of health insurance coverage for Americans. It 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 of beneficiaries. Congress chose instead to retain the individual Medicaid entitlement, as well as the companion entitlement of States to matching funds, reflecting its commitment to continuing the program's focus on benefits and rights for individual beneficiaries.

In the 1990s, some Members of Congress proposed changes to Medicaid that would have transformed the beneficiary-focused entitlement program into a state-focused, block grant program. Congress passed that bill, but after President Clinton vetoed it Congress did not override the veto, and Medicaid continued as an individual entitlement program.

A 1994 congressional enactment (overruling in part this Court's decision in *Suter v. Artist M.*, 503 U.S. 347 (1992)) confirms Congress's intent that beneficiaries may bring private actions under Section 1983 to enforce certain provisions of laws enacted under the Spending Clause. Through that 1994 enactment, Congress expressly confirmed that some provisions of the Social Security Act are privately enforceable, ratifying a long line of cases that had so held.

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.

This history makes clear that Congress designed Medicaid with a focus on the rights of individual beneficiaries, and has maintained that focus by repeatedly rejecting or abandoning efforts to eliminate the individual entitlement.

At the same time, 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.

Beginning in the late 1960s and through the 1970s, federal courts (including this Court in *King v. Smith*, *Rosado v. Wyman*, *and Maine v. Thiboutot*[3]) began to recognize the right of beneficiaries to enforce provisions of the Social Security Act (including the Medicaid statute). At various points, Congress rejected or abandoned proposals to eliminate beneficiaries' right to enforce such provisions in federal court. And over the decades, Congress has continued to expand Medicaid against the backdrop of *King v. Smith*, *Rosado v. Wyman*, *Maine v. Thiboutot*, and a number of lower court decisions confirming that beneficiaries of Social Security Act programs on whom Congress conferred rights have a federal court forum to protect those rights.

Congress plainly intended (a)(23) to confer on beneficiaries an individual right enforceable through

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[3] *King v. Smith*, 392 U.S. 309 (1968); *Rosado v. Wyman*, 397 U.S. 397 (1970); and *Maine v. Thiboutot*, 448 U.S. 1 (1980).

Section 1983. This provision easily satisfies the criteria this Court set forth in *Gonzaga University v. Doe,* 536 U.S. 273 (2002), and *Health & Hospital Corp. of Marion County v. Talevski*, 599 U.S. 166 (2023). The text of (a)(23) speaks in terms of individual beneficiaries, and the context of its enactment confirms that in adding this provision Congress unambiguously intended that Medicaid beneficiaries would be entitled to enforce their choice of providers through a Section 1983 suit.

ARGUMENT

In *Health & Hosp. Corp. of Marion Cnty. v. Talevski* this Court held that rights created by statutes enacted pursuant to the Spending Clause could be enforced through a suit under Section 1983 where congressional intent to confer an enforceable individual right is clear. This result was consistent with a long line of Supreme Court and lower federal court decisions involving enforcement of Social Security Act provisions, dating back more than 50 years.

For the Medicaid statute, provisions of which were at issue in *Talevski*, the Court's holding was fully consistent with Congress's creation and preservation of Medicaid as an individual entitlement program since its inception. While not all parts of the Medicaid statute confer an individual entitlement supporting enforcement under Section 1983, the text and the context of some provisions clearly indicate Congress's intent to confer enforceable individual rights. Consideration of both the language and context of (a)(23), against the backdrop of Congress's long

history of treating Medicaid as an individual entitlement, makes clear that the right of beneficiaries to choose a provider embodied in (a)(23) is enforceable through Section 1983 suits.

I. Congress Created Medicaid as an Entitlement Program Providing Rights for Individual Beneficiaries, and Has Repeatedly Protected Medicaid's Status as an Individual Entitlement.

Nearly sixty 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 *individual* entitlements to 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—rather than individuals—to cover certain medical costs for the elderly poor. Pub. L. No. 86-778, 74 Stat. 924 (1960). However, Congress soon recognized that the law was ill-suited for that aim. *See* Staff of the S. Spec. Comm. on Aging, 87th Cong., *Performance of the States: Eighteen Months of Experience with the Medical Assistance for the Aged (Kerr-Mills) Program* at III, 1 (Comm. Print 1962) ("Kerr-Mills Report") (finding "weaknesses inherent in this legislative approach which prevent it from being a significant weapon in meeting the medical requirements of America's elderly," and describing "persistent areas of confusion" including administrative complexity and inadequate and hard-to-understand benefits).

A. Congress Created Medicaid as an Entitlement for Individuals.

The Medicaid statute, enacted in 1965, created two distinct sets of rights. It first created a limited number of specific rights in individuals who meet state and federal eligibility requirements. *See, e.g.*, Pub. L. No. 89-97, § 1902(a)(8), 79 Stat. 286, 344 (1965) (medical assistance "shall be furnished with reasonable promptness to all eligible individuals"). A few additional rights have since been added, including the right of beneficiaries to choose their health care providers, as described below. The second set of rights is the entitlement of each State to receive federal matching funds—subject to certain federal requirements—for a statutorily set percentage of the amount "expended . . . as medical assistance under the State plan." *Id.,* § 1903(a)(1), 76 Stat. 286, 349.

Although States have rights under Medicaid, Congress designed Medicaid as an individual entitlement program. State participation is voluntary, but States electing to participate must submit—and have approved by the U.S. Secretary of Health and Human Services (HHS, and originally Health, Education and Welfare)—a plan to provide certain medical assistance benefits for "all individuals" eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A), 1396d(a).

In the years following establishment of the Medicaid program, government leaders understood that the program created a right for individual beneficiaries, as 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 AFDC program because a family member had found work would lose its "entitlement to Medicaid").

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.[4] And several years later, a Commerce Department report referred to "Medicaid health insurance."[5]

B. Section (a)(23) is a Key Element in Congress's Long-Standing Maintenance of Medicaid as an Individual Entitlement.

Throughout the existence of the Medicaid program, Congress has acted in various ways to protect and enhance Medicaid's status as an individual entitlement. Section (a)(23), enacted not long after the Medicaid statute was initially passed, is

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[4] *See* Nat'l Ctr. for Health Stats., *Current Estimates from the Health Interview Survey, United States-1976*, at 70, 80 (1977), 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.

[5] U.S. Dep't of Com., *Characteristics of Households and Persons Receiving Selected Noncash Benefits 1980*, at 1 (1982), https://tinyurl.com/commercereport1982.

an important expression of Congress's intent to confer individual rights on beneficiaries.

As described above, Congress's dissatisfaction with the predecessor Kerr-Mills program led it to create Medicaid. One problem Congress identified with Kerr-Mills was the failure to give individual beneficiaries the right to choose their providers. Some localities were placing the elderly poor into government institutions or otherwise restricting their choice of providers.

- California limited patients to using a county hospital during their first 30 days of "confinement." Kerr-Mills Report, *supra*, at 35.

- Hawaii allowed only "government doctors" to provide outpatient care and dispense drugs. *Id.*

- Pennsylvania limited nursing home care to homes operated by counties. *Id.*

- Louisiana required patients to notify the welfare department and wait for a new card to see a new doctor. Staff of the S. Subcomm. on Health of the Elderly to the Spec. Comm. on Aging, 88th Cong., *Medical Assistance for the Aged: The Kerr-Mills Program 1960–1963*, at 51 (Comm. Print 1963).

- Washington, D.C. restricted care to specific hospitals under contracts with the D.C. Department of Health, while also limiting nursing home care to one public facility. *Id.*

- Puerto Rico offered hospital and outpatient care only in government facilities. Kerr-Mills Report at 35.

When it considered the original Medicaid legislation, Congress discussed adding provisions granting beneficiaries their choice of providers. *See* 111 Cong. Rec. 505 (1965) (statement of Rep. Pelley); 111 Cong. Rec. 16085 (1965) (statement of Sen. Cooper). Congress did not initially include such a provision in the Medicaid statute, but it was aware that some localities were continuing to restrict patients' choice of providers. For instance, in 1967 Medicaid recipients in Puerto Rico were still "forced" to receive care in government facilities. *President's Proposals for Revision of the Social Security System: Hearings before the H. Comm. Ways & Means on H.R. 5710*, 90th Cong. 2273 (1967).

In early 1968, Congress amended the Medicaid statute by adding (a)(23) to ensure that beneficiaries could choose their providers. *See* Pub. L. No. 90-248, § 227, 81 Stat. 821, 903–04 (1968). New section (a)(23) stated that—in order for a State to receive federal funding for Medicaid—its state plan must:

> provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services.

Id.

The Senate Finance Committee and House Ways and Means Committee Reports made clear that Congress was focused on individual rights in enacting (a)(23): "Under this provision, an individual is to have a choice from among qualified providers." S. Rep. No. 90-744, at 183 (1967); H.R. Rep. No. 90-544, at 122 (1967). In the same passage, the Committee Reports tie the "qualified provider" term *not* to some arbitrary exclusion of disfavored providers, but to the Medicaid statute's requirement for States to "set certain standards for the provision of care." *Id.* In other words, (a)(23) requires States to establish a standard for healthcare, but does not grant States unilateral authority to exclude politically disfavored health care services.

Following the enactment of (a)(23), Congress several times reinforced individuals' freedom-of-choice rights, specifically in the context of family planning services.[6] First, in 1972, Congress made sure that beneficiaries needing family planning services could receive care in *all* Medicaid-participating States, with the federal government providing 90 percent of the funds. *See* Pub. L. No. 92-603, § 299E(b), (e), 86 Stat. 1329, 1462 (1972). In 1981,

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[6] Congress has amended (a)(23) seven times, consistently preserving the "any individual" language. Pub. L. No. 92-603, § 240, 86 Stat. 1329, 1418 (1972); Pub. L. No. 94-48, § 2, 89 Stat. 247, 247 (1975); Pub. L. No. 95-210, § 2, 91 Stat. 1485, 1488 (1977); Pub. L. No. 97-35, § 2175, 95 Stat. 357, 809 (1981); Pub. L. No. 100-203, § 4112, 100 Stat. 1330, 1330-148 (1987); Pub. L. No. 105-33, §§ 4701, 4724, 111 Stat. 251, 493, 517 (1997); Pub. L. No. 111-309, § 205, 124 Stat. 3285, 3290 (2010).

Congress allowed States to seek partial waivers of individuals' freedom-of-choice rights under certain limited circumstances. Pub. L. No. 97-35, § 2175, 95 Stat. 357, 809–11 (1981). After a few years, Congress amended the waiver statute to specify that "[n]o waiver under this subsection may restrict the choice of the individual in receiving services under § 1905(a)(4)(C) [i.e., family planning services]." Pub. L. No. 99-272, § 9508(a), 100 Stat. 82, 211 (1986). As in (a)(23), Congress spoke in terms of *individual* beneficiaries rather than state entitlements.

In 1987, Congress amended (a)(23) by adding subsection (B), which provides that enrollment of a Medicaid beneficiary in a managed care plan would not restrict the individual's choice of provider under § 1905(a)(4)(C) [i.e., family planning services], unless the chosen provider is incompetent or a convicted felon. Pub. L. No. 100-203, § 4113, 101 Stat. 1330, 1330-152 (codified at 42 U.S.C. § 1396a(a)(23)(B)). The House Report that discussed this new subsection focused very explicitly on the individual beneficiary.

> The Committee is concerned that there be no restrictions on access by Medicaid beneficiaries to the family planning providers of their choice, whether or not that restriction occurs in the context of a freedom-of-choice waiver. The Committee amendment would therefore provide that a beneficiary's choice of a qualified family planning provider may not be restricted by that beneficiary's enrollment in a primary care case-management system, an HMO, or similar entity. If a beneficiary, for whatever reason, wants to use a family

> planning provider other than the case manager or HMO, the beneficiary is entitled to have payment made on her behalf to that other provider for covered services.

H.R. Rep. No. 100-391, pt. 1, at 540, *reprinted in* 1987 U.S.C.C.A.N. 2313-360; *see also* Pub. L. No. 105-33, §§ 4701, 4724, 111 Stat. 489–94, 516–18 (1997) (preserving the right to choose a family planning provider if a State elects to follow new managed care option).

Congress's amendment of the waiver statute and its addition of subsection (B) to (a)(23) confirmed and enhanced beneficiaries' individual entitlement to their choice of provider. Through these steps, Congress made clear its view that family planning services in particular are a private right, not an area where States should be choosing a beneficiary's provider.

C. Congress Has Repeatedly Protected and Enhanced Medicaid's Status as an Individual Entitlement.

In the decades following its enactment of (a)(23), Congress continued to protect and reinforce Medicaid's status as an individual entitlement. In 1981, Congress rejected efforts to cap federal Medicaid matching payments to States participating in the program. Capping those payments would have undermined the individual entitlement of Medicaid beneficiaries, which depends on 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 proposal for a cap on annual federal matching payments in favor of the House bill, which instead reduced the percentage of 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).

Through the 1990s, following efforts to replace the individual entitlement with block grants to States, Congress again ultimately retained Medicaid's original design as an individual entitlement program supported by the matching entitlement for States.

In 1995, Congress initially passed a measure that would have converted most of Medicaid into a "MediGrant" block grant program. Under H.R. 2491, federal support for healthcare expenditures would have been limited to a fixed allotment or shifted to block grants to States. In addition, the MediGrant legislation proposed by some House members would have expressly 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.").

However, 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 these presidential vetoes.

In 1996, Congress both rejected proposed legislation providing for Medicaid block grants and passed legislation to preserve the individual entitlement. First, some legislators tried to revive block grant provisions and otherwise restructure Medicaid. *See* Personal Responsibility and Work Opportunity Act of 1996, H.R. 3507, 104th Cong., tit. XV, § 1502 and tit. XI, §§ 2001–2005 ("Restructuring Medicaid"); Welfare and Medicaid Reform Act of 1996, H.R. 3734, 104th Cong., tit. II, §§ 2001–2005. Congress ultimately dropped those provisions. In a separate 1996 bill, Congress enacted a provision *preserving* the Medicaid 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 individual Medicaid entitlements in considering proposals to "repeal and replace" the Affordable Care Act. In 2017, Congress rejected a proposal to restructure Medicaid with either a block grant or a per capita cap, both of which would have replaced the individual entitlement and limited federal Medicaid matching funds. *See* Better Care Reconciliation Act of 2017, 115th Cong., § 132 (1st Sess. 2017), https://www.budget.senate.gov/imo/media/doc/ERN17500.pdf (discussion draft) ("Per Capita Allotment for Medical Assistance"); *id.* § 133 ("Flexible Block Grant Option for States"). 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 individual entitlement feature of Medicaid are highly relevant here. 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)). For the State Children's Health Insurance Program, Congress 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 Medicaid entitlement make sense only if Congress created such an entitlement in the first instance. Despite numerous efforts by some Members to modify the Medicaid program over the years, Congress has repeatedly preserved Medicaid's status as an entitlement for individual beneficiaries, rejecting or abandoning proposals to end the individual entitlement or to introduce alternative funding structures that would have effectively removed the individual entitlement.

II. Congress Has Repeatedly Protected Medicaid Beneficiaries' Rights to Enforce the Medicaid Statute.

A statutory entitlement to benefits means nothing if the entitlement is not enforceable. Without enforcement, individuals would lack assurance that they will receive the benefits Congress conferred on them through the Medicaid program.

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

For decades, private enforcement of rights has been an integral feature of the Medicaid program. The

reason lies in the structure of Social Security Act grant-in-aid programs. Of course, under federal-state programs such as Medicaid and AFDC, the federal government plays a key role in enforcing rights that Congress conferred on beneficiaries and providers. This enforcement can occur through the approval process for state plans and compliance 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 federal-state programs make it practically impossible for the federal agency (the Centers for Medicare & Medicaid Services, in the case of Medicaid) to identify and address all state agency statutory violations through compliance hearings, appeals, judicial review, and withholding of federal funds if the court upholds a non-compliance finding.

The United States has acknowledged, in prior briefing before this Court, that the remedy of withholding federal funds from States that violate Medicaid requirements is draconian and may work against Congress's ultimate aim of ensuring the provision of 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) (noting that "those 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"). In the instant case, the United States has changed its position on this issue (its new position is also inconsistent with the

position it took in *Talevski*). The United States' recent reversal of its earlier position diminishes the persuasiveness of its new view. *See Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016); *cf. Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 386, 410–11 (2024).

In fact, the United States' suggestion in its *Maxwell-Jolly* brief was on target and is entirely consistent with common sense. Private actions with the prospect of injunctive relief can serve as an appropriate complement to federal agency enforcement. An injunction can be an effective vehicle for targeted relief covering just the particular harm at issue.

A Section 1983 suit can seek pinpointed prospective relief to prevent a harm from occurring or continuing, as opposed to the draconian relief of withdrawing some or all 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, with the potential to secure prompt correction of a harm, compared with the delay involved in the cumbersome federal agency compliance process.

In the early years of the Medicaid program, commentators recognized the structural dilemma inherent in federal-state programs under the Social Security Act, such as AFDC and Medicaid. They documented the difficulties resulting from relying exclusively on enforcement by a federal agency to address state statutory violations, citing the exceptionally low number of compliance proceedings held in connection with these programs. *See* Note, *Federal Judicial Review of State Welfare Practices*, 67 Colum. L. Rev. 84, 91 (1967) (reporting that there had been 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.[7] And because the statutory sanction for a State's substantial noncompliance is loss of some or all federal Medicaid payments and consequently loss of benefits for needy individuals, there is a significant disincentive for the federal agency to impose a sanction. *See* Tomlinson & Mashaw, 58 Va. L. Rev. at 631.

Medicaid and similar programs needed a complementary enforcement mechanism, particularly one in which beneficiaries could play a role, and over the years the federal courts have provided it. Not surprisingly, the absence of another private remedy available to beneficiaries under Title IV-D of the

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

Social Security Act was a key factor in this Court's conclusion that the federal agency's limited powers to audit States and withhold federal funding in noncompliance proceedings would not foreclose liability for noncompliance under Section 1983. *See Blessing v. Freestone*, 520 U.S. 329, 346–48 (1997).

In the same period when commentators were pointing out the problems with relying only on noncompliance hearings to enforce Social Security Act requirements, this Court and the lower federal courts began to open the door to suits brought by beneficiaries and providers to enforce statutory rights related to Social Security Act programs. *See, e.g.*, *King v. Smith*, 392 U.S. at 333 (holding 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."); *Rosado v. Wyman*, 397 U.S. at 406, 422 (finding no basis for a federal court to refuse to hear AFDC beneficiaries' claims where the regulations provided no procedures by which individual beneficiaries could trigger and participate in the agency's review of the State's program). Lower court cases enforcing provisions of the Medicaid statute date back at least to 1971. *See*, *e.g.*, *Triplett v. Cobb*, 331 F. Supp. 652 (N.D. Miss. 1971) (holding that a policy of denying Medicaid to AFDC caretaker relatives violated 42 U.S.C. §§ 1396a(a)(8), (a)(10)); *Bay Ridge Diagnostic Lab'y, Inc. v. Dumpson*, 400 F. Supp. 1104 (E.D.N.Y. 1975) (enforcing (a)(23)).

In 1980, the Court concluded that suits under Section 1983 are a proper means to challenge statutory violations involving federal-state grant-in-

aid programs. *Maine v. Thiboutot* involved an AFDC beneficiary's claim seeking enforcement of a state plan condition. 448 U.S. at 4–5. The Court reasoned that "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" and explained that cases such as *Rosado v. Wyman* had resolved "any doubt" as to whether "the § 1983 remedy broadly encompasses violations of federal statutory" law.

This Court's AFDC cases (*King v. Smith*, *Rosado v. Wyman*, and *Maine v. Thiboutot*) are relevant to the Medicaid program in light of the similar structure of the two programs. Both 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. Both created an individual entitlement to benefits, in the case of AFDC to cash assistance, in the case of Medicaid to medical assistance. In essence, Medicaid and AFDC are "twin" programs.[8]

Against the backdrop of federal court decisions enforcing entitlements conferred under the Medicaid statute and other Social Security Act provisions, Congress continued to expand the scope of the Medicaid program, extending the individual entitlement to new groups of individuals and adding more benefits. For example, Congress passed

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[8] Two 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 v. Freestone*), and Title IV-E (adoption assistance and child welfare, at issue in *Suter v. Artist M.*).

legislation to extend Medicaid coverage to Supplemental Security Income beneficiaries (1972), to children and pregnant women (in a series of statutes enacted between 1983 and 1990), and to residents of nursing facilities (1987).[9]

From 1970 on, all Medicaid amendments and additions have been made against the backdrop of the holdings—in *King v. Smith* and *Rosado v. Wyman*—that beneficiaries of Social Security Act programs with federal funding conditions may assert certain rights directly in federal court (rather than having to wait for federal authorities to institute conformity hearings). And from 1980 on, Congress has legislated with awareness of this Court's holding in *Maine v. Thiboutot* that those rights may be asserted under Section 1983.

Congress's enactment of these and other expansions of Medicaid coverage, against the backdrop of federal court enforcement of individual rights created by the Medicaid statute, reflects continued acceptance of private enforcement as a complement to federal agency oversight of state Medicaid programs. And, as described below, Congress has gone further periodically, explicitly facilitating private enforcement of Medicaid statutory rights.

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[9] Pub. L. No. 92-603, tit. XVI, 86 Stat. 1329, 1465 (1972). *See al*so, *e.g.,* Pub. L. No. 99-509, § 9401, 100 Stat. 2050 (1986); Pub. L. No. 100-203, § 4101, 101 Stat. 1330, 1330-40 (1987); *id.*, § 4012, 101 Stat. 1330, 1330-60 (1987).

Any argument that federal courts should not permit private enforcement unless Congress has expressly provided a private right of action in the Medicaid statute is incorrect. When Congress enacted Section 1983, it created an explicit cause of action to vindicate rights created by statute, with no exception for the later-created rights set forth in the Social Security Act. As a result, there was no need for Congress to include a separate provision in the Medicaid statute authorizing private enforcement of the rights it had created, or for courts to imply a private right of action. Section 1983 was already on the books. *See Talevski*, 599 U.S. at 180 n.8.

B. 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 rights established by the Social Security Act. And in some cases, Congress has acted affirmatively to facilitate beneficiaries' ability to bring suit in federal court to enforce rights under Medicaid and other Social Security Act programs.

Congress rejected repeated efforts by Senator Orrin Hatch to negate the key holding of this Court in *Maine v. Thiboutot* that Section 1983 could be used to enforce rights grounded in the Social Security Act. 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 Court issued its decision, 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). However, S. 3114—which 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—was not enacted. 126 Cong. Rec. 25295.

Congress also protected the right to bring private actions under Section 1983 by declining to enact similar bills that Senator Hatch subsequently introduced 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.

In 1994, in reaction to a decision of this Court, Congress took a decisive step to preserve the ability of private parties to enforce rights under both the Medicaid and Medicare statutes. In *Suter v. Artist M.*, 503 U.S. 347 (1992), 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).

In enacting these statutes Congress not only rejected the specific holding in *Suter* regarding rights defined as state plan components; it expressly ratified the line of cases in which this Court had held repeatedly that beneficiaries and providers could sue in federal court to enforce rights conferred by the Social Security Act. *See* 42 U.S.C. § 1320a-2 (referencing "prior Supreme Court decisions respecting . . . enforceability [of State plan requirements]").

Over the next few years Congress considered but ultimately abandoned proposals to cut back or eliminate private enforcement of rights under the Medicaid statute. Several of the bills aimed at converting Medicaid to a block grant program (described in Section I.C 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., tit. XVI, § 2117 (1995) ("[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 would have 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., tit. VII, ch. 7, § 7191 (1995). In vetoing H.R. 2491, President Clinton noted

that eliminating the individual right of action for Medicaid beneficiaries would remove adequate protections for vulnerable groups. *See* H.R. Doc. No. 104-141, at 1 (1995). 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. Another would have prevented private causes of action to enforce compliance with provisions of the Medicaid statute. *See* H.R. 2491, 104th Cong., tit. VII, § 7002(b)(4). 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(8), provides individuals with an 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, pt. 1, at 650 (2009).

In sum, Congress has declined to prohibit Medicaid beneficiaries from accessing federal courts, either under the Medicaid statute or under Section 1983. Congress not only declined to take such action for decades; it rejected repeated proposals to cut off access to federal courts for Medicaid beneficiaries (and at some points acted to promote such access).

III. Congress Clearly Intended to Confer on Beneficiaries a Right to Enforce (a)(23) Through a Suit Under Section 1983.

There are multiple reasons to conclude that Congress had an unambiguous intent to confer individual, enforceable rights when it enacted and subsequently amended (a)(23). The historical context of (a)(23) is significant. As described above, Congress created and preserved Medicaid as an individual entitlement to health care benefits. Section (a)(23), with its focus on beneficiaries' right to choose their health care providers, was a key expression of this individual entitlement. Congress thereafter 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.

While some Medicaid provisions do not speak in terms of individual rights, others plainly do – hardly

surprising in light of the history of Medicaid as an individual entitlement. This Court made clear in *Gonzaga* and *Talevski* that the intent of Congress is the determinative factor in whether a statute creates rights that may be enforced under Section 1983. *Talevski* reaffirmed the holdings in *Gonzaga* that a statutory provision is enforceable under Section 1983 when the provision is "phrased in terms of the persons benefited" and contains "rights-creating individual-centric language with an unmistakable focus on the benefited class." 599 U.S. at 183 (quoting *Gonzaga*, 536 U.S. at 284, 287) (internal quotation marks omitted).

The language of (a)(23) speaks clearly in terms of the persons benefited ("any individual eligible for medical assistance"), requiring a State to provide that these individuals may obtain services from any provider qualified to provide the services. This language is unquestionably "phrased in terms of the persons benefited," "rights-creating" and "individual-centric," and it has "an unmistakable focus on the benefited class." The focus of the provision is on the individual beneficiary. In addition to the statutory text, the historical context—what Congress intended to accomplish in enacting (a)(23)—is significant.[10]

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[10] The United States argues that courts must consider the context of a statutory provision in analyzing whether a cause of action is available under Section 1983. US Amicus Br. at 32–36. That is so, but the United States overlooks the most significant context here–the history of Congress's creation and preservation of the Medicaid program as an individual entitlement and the circumstances that led Congress to add (a)(23) to the statute and subsequently expand that provision to confer the freedom to (...continued)

Congress added (a)(23) to the Medicaid statute in response to efforts by States to restrict beneficiaries' choice of providers. With (a)(23) Congress aimed to end these restrictions and to give individual beneficiaries the right to select the providers they believed would best fit their needs, including specifically with respect to family planning services.

South Carolina and some of its amici point to the fact that the word "right" does not appear in the text of (a)(23). *E.g.*, Pet. Br. at 20. But this Court has never required use of this word when analyzing whether a statutory provision is enforceable under Section 1983. Instead, the Court has used the term "rights-creating language." *Talevski*, 599 U.S. at 183; *Gonzaga*, 536 U.S. at 273, 274. Significantly, the statutory provisions this Court considered in affirming enforcement under Section 1983 in its early cases—*King v. Smith*, *Rosado v. Wyman*, and *Maine v. Thiboutot*—did not include the word "right."

South Carolina and some of its amici further argue that States were not on notice that beneficiaries could use Section 1983 to enforce (a)(23). *E.g.*, Pet. Br. at 43. But Section 1983 had been in place for nearly a century by the time the Medicaid program came into existence, and the text of (a)(23) plainly refers to individual rights. States have been on notice for more than 50 years (since *King v. Smith* and *Rosado v. Wyman*) that they are subject to suit for violations of rights under the Social Security Act, and for more than 40 years (since *Maine v. Thiboutot*) that

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choose a provider for family planning services provided in a managed care context.

beneficiaries could invoke Section 1983 to enforce those rights. States have long been aware of these and similar lower court decisions, as well as of Congress's repeated protection of Medicaid's individual entitlement and of beneficiaries' rights to enforce provisions containing individual-centric rights.

In view of the "individual-centric," "rights-creating" text of (a)(23), States cannot credibly claim that they lacked notice regarding Congress's intention for (a)(23) to confer an individual, enforceable entitlement. The subject of (a)(23) is not some administrative process or aggregate directive, but rather an individual beneficiary's sensitive, highly personal decision about which providers will provide health care (including family planning services) to the individual. To date, five circuits (the Fourth, Sixth, Seventh, Ninth, and Tenth) have concluded that beneficiaries may pursue private enforcement of (a)(23) under Section 1983.[11] *See Planned P'hood of So. Atl. v. Baker*, 941 F.3d 687, 700 (4th Cir. 2019), *cert. denied*, 141 S. Ct. 550 (2020); *Harris v. Olszewski*, 442 F.3d 456, 461 (6th Cir. 2006); *Planned P'hood of Ind., Inc. v. Comm'r of Ind. State Dep't Health*, 699

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[11] Two circuits, the Fifth and the Eighth, have concluded that (a)(23) may not be enforced through a Section 1983 suit. *See Planned P'hood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman*, 981 F.3d 347, 368 (5th Cir. 2020); *Does v. Gillespie*, 867 F.3d 1034, 1046 (8th Cir. 2017). These decisions give insufficient weight to Congress's response to the *Suter v. Artist M.* decision (*see supra* p. 26) and to this Court's conclusion in *Blessing v. Freestone*, 520 U.S. at 346–48, that a federal agency's power to withhold federal funding from States in noncompliance proceedings would not foreclose liability under Section 1983.

F.3d 962, 977 (7th Cir. 2012); *Planned P'hood of Ariz. v. Betlach*, 727 F.3d 960 (9th Cir. 2013), *cert. denie*d, 571 U.S. 1198 (2014); *Planned P'hood of Kan. v. Andersen*, 882 F.3d 1205, 1224 (10th Cir. 2018).

South Carolina and some of its amici argue that placement of (a)(23) in a long list of state plan requirements suggests it was not meant to confer an individual right enforceable under Section 1983. Congress's passage of 42 U.S.C. § 1320a-10 in response to the *Suter v. Artist M.* decision precludes any such argument. Obviously, the language, structure, and context of individual state plan requirements vary widely. Some–like (a)(23)—are "phrased in terms of the persons benefited" and contain "rights-creating," "individual-centric language" with an "unmistakable focus on the benefited class." *Gonzaga*, 536 U.S. at 284, 287 (emphasis and internal quotation marks deleted), and some do not.

Both the text of (a)(23) and the history summarized in this brief support the conclusions of the courts below: in enacting (a)(23), Congress unambiguously intended to confer an individual right enforceable through a Section 1983 suit.

CONCLUSION

For the foregoing reasons, the Court should affirm the decision below.

Respectfully submitted,

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March 12, 2025

APPENDIX

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APPENDIX

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