NOTE

A Judicial Solution to the Medicaid Gap: Using Section 1983 to Do What the Federal Government Cannot

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ABSTRACT

The effect of the decision in National Federation of Independent Business v. Sebelius *(*"NFIB"*), can be felt most directly in the eighteen states that refused to expand their Medicaid programs under the Patient Protection and Affordable Care Act. The pertinent legal ramifications of* NFIB *can be summarized as the establishment of an "Anti-Leveraging Principle" that provides a limit on the power of the Spending Clause. The real-world consequences, however, are much more important. The fact that states can now opt out of expanding Medicaid has left a gap in coverage for about three million citizens—those who are neither covered by their state's Medicaid program, nor qualify for subsidies in the state or federally run Health Insurance Marketplaces. This gap can only be filled through a judicial solution that circumvents the inability of the federal government to force the Medicaid expansion itself. Roberts's opinion in* NFIB *left intact the mandatory language of the act creating a new eligibility category covering all nonelderly low-income persons. This is the kind of strong language that, in providing a right directly to individuals and families, survives the recent restrictions on private enforcement of Spending Clause statutes under the* Gonzaga-Blessing *paradigm. Therefore, potential beneficiaries should be able to utilize 42 USC § 1983 to enforce this right-creating language. This Note explores how this predicament developed,*

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explains the § 1983 claim in relation to the Medicaid Act, and elucidates how the language added by the Affordable Care Act can be enforced just as previous Medicaid provisions have been—by class actions seeking injunctions.

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INTRODUCTION

Meet two middle-aged American men living in Alabama. Ernest Maiden is a single fifty-seven year old diabetic, working as a hair stylist and earning about $200 per week—just over $10,400 a year.[1] Cal Morris is a thirty-seven year old man suffering from severe psoriasis, working two jobs to support his family of five on $35,000 a year.[2] Neither is eligible for Alabama's Medicaid program despite their relative poverty.[3] Alabama's Medicaid program does cover the Morris children,[4] but only because the state is required by federal statute to cover categorically eligible persons—those who are both very poor and members of specifically defined categories, such as pregnant women, children, parents of dependent children, the blind, the elderly, or

1 *See* Christopher Weaver, *Millions Trapped in Health-Law Coverage Gap*, WALL ST. J. (Feb. 18, 2014, 3:39 PM), http://www.wsj.com/articles/SB10001424052702304851104579363621009670740.

2 *Id.*

3 *Id.*

4 *Id.*

the disabled.[5] These categories of people have been long-standing beneficiaries under Medicaid.[6] The Medicaid program, however, will not cover either the Morris parents or Mr. Maiden because Alabama did not expand its Medicaid program under the Patient Protection and Affordable Care Act ("ACA")[7] to cover all nonelderly persons below 133% of the Federal Poverty Level ("FPL").[8]

The ACA provides for an alternative coverage option—subsidized private insurance bought on state or federal Health Insurance Marketplaces[9]—for adults between 100% and 400% of the FPL.[10] For the Morrises, who live above the FPL,[11] a subsidy of almost $440 a month is available.[12] This allows them to purchase a Blue Cross plan for themselves for about $80 per month, while the children can continue to be covered by Medicaid.[13] However, Mr. Maiden, who lives

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5 *See* 42 U.S.C. § 1396a(a)(10) (2012); Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2601 (2012) (noting that states almost universally do not cover childless adults and rarely cover any but the most at-risk parents of dependent children).

6 *See NFIB*, 132 S. Ct. at 2601.

7 Pub. L. No. 111-148, § 2002, 124 Stat. 119, 279–82 (2010).

8 *See* Weaver, *supra* note 1. There is some confusion in the scholarship over whether Medicaid was expanded to cover those below 133% of the FPL or those below 138%. The text of § 1396a(a)(10)(A)(i)(VIII) uses the number "133." However, this section was modified by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2002(a)(14)(A), 124 Stat. 119, 279 (codified as amended at 42 U.S.C. § 1396a(e)(14)(A)) (effective January 1, 2014). Section 1396a(e) includes two subsections numbered "(14)"; the second of these two subsections clarifies that "income" will be determined by "Modified Gross Income" ("MGI"). MGI is then defined by § 1396a(e)(14)(I)(i) (as amended), which explains that the government will increase the upper limit of income eligibility measurements by five percentage points. Therefore, the 133% figure of § 1396a(a)(10)(A)(i)(VIII) functionally becomes 138% under § 1396a(e)(14)(I)(i). This confusion is reflected in scholarship and court opinions, which cite both figures without explanation. *Compare NFIB*, 132 S. Ct. at 2582 (citing the 133% figure), *and* Samuel R. Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After* NFIB, 101 GEO. L.J. 861, 863 (2013) (same), *with* Weaver, *supra* note 1 (citing the 138% figure), *and* RACHEL GARFIELD & ANTHONY DAMICO, KAISER COMM'N ON MEDICAID & UNINSURED, The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid—An Update 1 (2016), https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8659-04-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid.pdf (same). This Note uses the 133% figure in deference to the Supreme Court.

9 Alabama also declined to establish its own Marketplace. *See State Health Insurance Marketplace Types, 2016*, HENRY J. KAISER FAM. FOUND., http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/ (last visited Feb. 10, 2016).

10 26 U.S.C. § 36B(c)(1) (2012).

11 *See* Weaver, *supra* note 1 (stating the Morris family's annual income as "about $35,000"). The FPL for a family of five in 2014 was $27,910. *See* Annual Update of the HHS Poverty Guidelines, 79 Fed. Reg. 3593, 3593 (Jan. 22, 2014).

12 Weaver, *supra* note 1.

13 *Id.*

below the FPL,[14] qualifies for no subsidy whatsoever. Even to purchase the cheapest plan available on the exchange, he would have to spend $437 per month in premiums and his coverage would be subject to a $6,350 deductible.[15] Therefore, Mr. Maiden would owe almost $11,600 annually for his coverage to even kick in,[16] which is $1,200 more than he was set to make last year.[17] If Mr. Maiden made $1,300 more per year, he would actually be eligible for subsidies that would all but eliminate his premiums and reduce his cost sharing dramatically.[18]

So, although Mr. and Mrs. Morris have a position of wealth relative to Mr. Maiden, their family will receive affordable health insurance and Mr. Maiden will not.[19] Mr. Maiden, instead, falls into what the Kaiser Commission on Medicaid and the Uninsured has termed the "coverage gap"—a hole in the safety net between unexpanded Medicaid programs and the new ACA Marketplaces.[20] This gap is not isolated to Alabama; rather, it extends to all sixteen states that show no signs of expanding their Medicaid programs.[21]

This paradox is a consequence of the Supreme Court decision in *National Federation of Independent Business v. Sebelius* ("*NFIB*").[22] Before *NFIB*, the ACA sought to ensure universal insurance coverage by expanding Medicaid from covering just a few categorical groups in extreme poverty to covering all Americans living below 133% of the FPL[23] and providing subsidies for private insurance for individuals

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14 In 2014, the FPL was $11,670 for a single individual. Annual Update of the HHS Poverty Guidelines, 79 Fed. Reg. at 3593.

15 Weaver, *supra* note 1.

16 *Id.*

17 *See id.*

18 *Id.*

19 *See id.*

20 GARFIELD & DAMICO, *supra* note 8, at 1.

21 *See id.*; *see also* Dr. Sanjay Gupta, *Obamacare's Coverage Gap: The Poor Caught in Between*, CNN (Oct. 4, 2013, 6:42 AM), http://www.cnn.com/2013/10/03/health/obamacare-medicaid-gap-gupta/ (explaining a similar situation for a woman in South Carolina). As of January 12, 2016, thirty-one states and the District of Columbia have adopted the Medicaid expansion, sixteen states have decided not to expand Medicaid coverage, and three states—South Dakota, Virginia, and Wyoming—are still discussing the possibility of expansion. *See Status of State Action on the Medicaid Expansion Decision*, HENRY J. KAISER FAM. FOUND., http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ (last updated Jan. 12, 2016); *see also* Dana Ferguson, *Medicaid Expansion Plan Gets Initial 'Go Ahead' in D.C.*, ARGUS LEADER (Sept. 29, 2015, 10:06 PM), http://www.argusleader.com/story/news/2015/09/29/medicaid-expansion-plan-gets-initial-go-ahead-dc/73067220/ (discussing South Dakota's expansion plan).

22 Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566 (2012).

23 *See id.* at 2581–82.

and families from 100% to 400% of the FPL.[24] The law simply did not contemplate that states could opt out of the Medicaid expansion.[25] When the Supreme Court concluded that the Medicaid expansion had to be voluntary,[26] twenty-four states exercised this new right and decided not to expand.[27] Although eight states expanded later and three are still discussing the possibility of expansion, leaving a total of sixteen nonexpansion states as of January 2016.[28] Thus, a sizable coverage gap emerged between the pre-ACA reach of Medicaid and the post-ACA reach of subsidies.[29]

It is absolutely necessary that this gap be filled in order to attain near-universal coverage. Disproportionately impoverished and minority populations are caught with the surprise that the promised universal coverage does not apply to them because their state governments decided not to expand Medicaid and the ACA has no fallback plan.[30] Although the Secretary of Health and Human Services ("HHS") has worked with some states to expand their coverage through alternative models,[31] many states show no signs of expanding, leaving the vast majority of those in the gap stuck there for the foreseeable future.[32]

The legal issue here rests with determining exactly what the Supreme Court prohibited in the *NFIB* decision. This Note explores the

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24 26 U.S.C. § 36B(c)(1)(A) (2012) (defining "applicable taxpayer" for the ACA tax credit as "a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved").

25 *See NFIB*, 132 S. Ct. at 2608.

26 *See id.* at 2607; Bagenstos, *supra* note 8, at 863.

27 *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID 1 (2014), http://www.nhchc.org/wp-content/uploads/2013/01/kff-march-2014-the-coverage-gap_uninsured-poor-adults-in-states-that-do-not-expand-medicaid.pdf.

28 *See Status of State Action on the Medicaid Expansion Decision*, *supra* note 21. This number is, of course, subject to change.

29 *See generally* GARFIELD & DAMICO, *supra* note 8.

30 *See* SAMANTHA ARTIGA ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, The Impact of the Coverage Gap in States Not Expanding Medicaid by Race and Ethnicity 4 (2015), http://files.kff.org/attachment/issue-brief-the-impact-of-the-coverage-gap-for-adults-in-states-not-expanding-medicaid-by-race-and-ethnicity.

31 *See* ROBIN RUDOWITZ ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, The ACA and Recent Section 1115 Medicaid Demonstration Waivers 2 (2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/02/8551-the-aca-and-recent-section-1115-medicaid-demonstration-waivers.pdf; *see also* Reid Wilson, *North Carolina Governor Weighing Medicaid Expansion*, WASH. POST (Oct. 31, 2014), http://www.washingtonpost.com/blogs/govbeat/wp/2014/10/31/north-carolina-governor-weighing-medicaid-expansion/.

32 *See* GARFIELD & DAMICO, *supra* note 8, at 1–6.

legal predicament, explains its practical result, and demonstrates that a solution is available in the form of state-by-state class actions filed under 42 U.S.C. § 1983, which provides a private right of action to enforce "right- or duty-creating language"[33] in any statute. To provide context for this strategy, Part I of this Note gives background on the Medicaid program and the ACA. Part II deconstructs and analyzes the *NFIB* decision, showing that although the Supreme Court eliminated the power of the federal government to enforce the Medicaid expansion, sufficient legally binding language remains to support a § 1983 action. Part III then explores the Medicaid gap as the practical effect of *NFIB* and illustrates the immediate need for intervention. Finally, Part IV demonstrates the viability of the proposed § 1983 solution.

I. Background on Medicaid and the Affordable Care Act

The Medicaid and Medicare programs began in the mid-1960s, providing health insurance coverage to the most vulnerable members of society.[34] In 2010, President Barack Obama and a Democratic Congress sought to accomplish universal coverage by passing the ACA—a multifaceted statutory overhaul of the insurance market.[35]

A. Medicaid

In 1965, President Lyndon Johnson signed Medicaid into law.[36] This program provides payment for medical care for traditional beneficiary groups and was limited to very poor children and their parents, the blind, the indigent elderly, and the disabled.[37] Over time, Medicaid expanded to include low-income children and pregnant women as distinct beneficiary categories.[38] Although Medicaid does include an optional coverage provision for parents of covered children and some states made limited attempts to cover that group, Medicaid never in-

33 Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 526 (1990) (Rehnquist, C.J., dissenting) (quoting Cannon v. Univ. of Chi., 441 U.S. 677, 690 n.13 (1979)).

34 *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (creating Medicare and Medicaid); Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2581 (2012).

35 *See NFIB*, 132 S. Ct. at 2580.

36 *See id.* at 2581; *see also History*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/History/ (last visited Feb. 10, 2016).

37 *NFIB*, 132 S. Ct. at 2631 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

38 *See id.* at 2630–31 (noting that these changes were authorized by a clause that expressly gives the federal government "the 'right to alter, amend, or repeal' any provision of the Medicaid Act") (citing 42 U.S.C. § 1304 (2012)).

cluded childless adults, let alone all persons below a particular income level.[39] Therefore, states that do provide coverage for adults with children only cover those in the most extreme poverty—an average threshold of less than thirty-seven percent of the FPL for unemployed parents and sixty-three percent of the FPL level for employed parents.[40]

This complicated program has become a hallmark of cooperative federalism. State participation is voluntary, although every state joined the program by 1982.[41] The federal government sets eligibility requirements, determines what medical services will be covered, and establishes reimbursement standards.[42] Within those parameters, states agree to administer the program and set reimbursement rates, receiving funds from the federal government to reimburse providers.[43] The federal government matches state funds at rates ranging from fifty percent to eighty-three percent of state expenses.[44] The combined federal and state funds account for over twenty percent of individual state budgets, with the federal matching funds alone accounting for over ten percent of most states' total revenue.[45] In total, these expenses are projected to cost the federal government $3.3 trillion from 2010–2019—not including the cost of the expansions under the ACA.[46]

In the past, states have used special waivers under section 1115 of the Social Security Act[47] to conduct "demonstrations" outside the normal confines of the Medicaid program.[48] These demonstrations waive the normal federal requirements of Medicaid and allow the use of federal matching funds outside normal channels. Thus, states can create coverage programs that would otherwise be impermissible. Demonstration waivers are issued when the Secretary of HHS approves a

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39 *See id.* at 2601 (Roberts, C.J., majority opinion).

40 *Id.*

41 *Id.* at 2581.

42 *See id.*

43 *See id.* at 2631–32 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

44 *See id.* at 2604 (Roberts, C.J., majority opinion).

45 *See id.* at 2581, 2604.

46 *See id.* at 2604.

47 Social Security Act § 1115, 42 U.S.C. § 1315a (2012).

48 ROBIN RUDOWITZ ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, A LOOK AT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS UNDER THE ACA: A FOCUS ON CHILDLESS ADULTS 3 (2013), https://kaiserfamilyfoundation.files.wordpress.com/2013/10/8499-a-look-at-section-1115-medicaid-demonstration-waivers.pdf.

budget-neutral experimental plan from the state.[49] Historically, states utilized these waivers to increase enrollment of parents of dependent children, add adults without dependent children, charge higher fees to beneficiaries, and implement premium assistance programs for the purchase of private insurance.[50]

B. The Affordable Care Act

Forty-five years after Medicaid was introduced, President Barack Obama signed the ACA into law.[51] The stated goal of the ACA was to expand health insurance coverage for millions of Americans.[52] To fulfill this goal, the ACA created the individual mandate, established insurance exchanges with subsidies, and expanded Medicaid.[53]

The ACA Medicaid expansion was intended to cover all individuals earning below 133% of the FPL.[54] The federal government committed to pay the cost of covering newly eligible individuals in full from 2014 through 2016, and thereafter to pay a decreasing percentage until 2020 when the federal commitment would remain at ninety percent.[55] Specifically, the ACA added a new mandatory eligibility group to Medicaid by inserting a clause that required a state Medicaid program to cover all individuals who are not otherwise eligible for public insurance and whose income does not exceed 133% of the

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49 *See id.* (explaining that the budget-neutral requirement is a long-standing informal requirement imposed by the Secretary and that it is not a statutory requirement).

50 *See id.* These states included Hawaii, Oregon, and Tennessee in 1994; Delaware and Vermont in 1996; Maryland and Massachusetts in 1997; Arizona and New York in 2001; and Maine, New Mexico, Michigan, Iowa, Indiana, Oklahoma, Utah, and Wisconsin between 2001 and 2010. *Id.* at 4. Before 2001, these expansions provided to childless adults coverage equivalent (or nearly so) to that received by traditional groups under normal Medicaid. *Id.* After 2001, under more lax policies of the Bush Administration embodied in the Health Insurance Flexibility and Accountability ("HIFA") waiver program, coverage often became stricter and more expensive for childless adults. *Id.*

51 *See* Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 46 U.S.C.); *NFIB*, 132 S. Ct. at 2580.

52 *NFIB*, 132 S. Ct. at 2580.

53 *See id.* at 2580–81, 2593–94 (citing 26 U.S.C § 5000A(g)(1) (2012)). The individual mandate and the Health Care Exchanges have been discussed at length in other cases and other works. *See, e.g.*, King v. Burwell, 135 S. Ct. 2480, 2487–96 (2015) (discussing the exchange and subsidy provisions at greater length). For discussion of other programs created by the ACA that do not pertain to this Note, see generally Sallie Thieme Sanford, *Mind the Gap: Basic Health Along the ACA's Coverage Continuum*, 17 J. HEALTH CARE L. & POL'Y 101 (2014).

54 *See NFIB*, 132 S. Ct. at 2582.

55 *See* 42 U.S.C. § 1396d(y)(1)(A)–(E) (2012) (delineating that the federal government would pay 100% of the cost through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and "each year thereafter").

FPL.[56] Congress intended to enforce this expansion clause through 42 U.S.C. § 1396c, which empowered the Secretary of HHS to pull all or part of a state's Medicaid funding if the state fails to comply with any federal rule; however, the Court declared section 1396c unenforceable as applied in *NFIB*.[57]

In order to provide insurance for those not covered by employer-sponsored private insurance, Medicare, and the newly expanded Medicaid, the ACA established Health Insurance Marketplaces,[58] where insurers offer private health plans.[59] Tax credits are available on the Marketplaces to subsidize the cost of premiums and cost sharing in proportion to household income.[60] However, only families earning between 100% and 400% of FPL (for premium assistance) and 100% and 250% of FPL (for cost-sharing assistance) are eligible.[61]

Observers, including the Supreme Court, believe that Congress wrote the ACA with the assumption that every state would participate in the Medicaid expansion.[62] The ACA, therefore, established a coverage continuum wherein persons and families below 133% of the poverty line would be covered by Medicaid, persons from 133% to 400% would buy private insurance on the Marketplaces with the help of federal subsidies, and the remaining individuals and families without employer-provided or Medicare coverage could buy private insurance on the Marketplaces at full price.[63] Through the complexity of the ACA, one thing is clear: these reforms were designed to interweave and create a coherent continuum of universal health insurance coverage.[64]

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56 *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

57 *See NFIB*, 132 S. Ct. at 2601–07.

58 *See* Sanford, *supra* note 53, at 108.

59 *See id.* (qualified plans are required to provide certain "essential health benefits").

60 *See id.* at 111–12. This is calculated by determining the sliding-scale contribution of a family as a percentage of household income, and then making up the difference between that number and the benchmark premium for that Marketplace. *See id.*

61 *See id.* at 108–09.

62 *See NFIB*, 132 S. Ct. at 2608.

63 *See* 26 U.S.C. § 36B(c)(1)(A) (2012) (defining "applicable taxpayer" for the ACA tax credit as "a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved"); *see also* Sanford, *supra* note 53, at 108, 111–12.

64 *See* Sanford, *supra* note 53, at 127.

II. THE *NFIB* DECISION

The *NFIB* decision consists of several interacting opinions.[65] This Note focuses on the opinion by Chief Justice Roberts, especially Part IV, which found that the Medicaid expansion was coercive and therefore unconstitutional as applied because it infringed on the limitations implicit in the Spending Clause and offended the principles of federalism.[66] Writing for the Court, Roberts held that the appropriate remedy was to bar the Secretary of HHS from enforcing the expansion as mandatory upon the states.[67] That opinion did not alter the statutory text in any way or nullify its legal viability, which allowed the expansion to remain as a voluntary program.[68] Justices Breyer and Kagan joined Robert's opinion on this point in full[69] and Justices Ginsburg and Sotomayor concurred in the remedy, despite dissenting from the finding of coerciveness.[70] The joint dissent by Justices Scalia, Kennedy, Thomas, and Alito agreed with the Chief Justice as to the coerciveness on somewhat different reasoning, but preferred a remedy of striking down the entire statute.[71] Therefore, one majority—six Justices and the Chief Justice—agreed that the expansion was coercive and a different majority—four Justices and the Chief Justice—agreed that the appropriate remedy was to prevent the act of coercion by the Secretary of HHS.[72]

A. The Optional Expansion

Centrally, Part IV of the Chief Justice's opinion explained that it was the fact that the federal government *forced* the expansion of

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65 *See NFIB*, 132 S. Ct. at 2577. The court considered the constitutionality of the Affordable Care Act on three separate questions: (1) the authorization of the individual mandate under the Commerce Clause, *id.* at 2585–93; (2) the authorization of the individual mandate under Congress's tax power, *id.* at 2593–600; and (3) the authorization of the Medicaid expansion under the Spending Clause, *id.* at 2601–08.

66 *See id.* at 2601–08.

67 *See id.* at 2607.

68 *See id.* at 2607–08.

69 *See id.* at 2577.

70 *See id.* at 2575.

71 *See* Bagenstos, *supra* note 8, at 866.

72 *See id.* at 866–67; *see also NFIB*, 132 S. Ct. at 2608 (majority opinion); *id.* at 2642 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). Insofar as the reasoning of the Chief Justice and the joint dissenters diverges, the lower courts are more likely to follow the Chief Justice's opinion. Bagenstos, *supra* note 8, at 868; *see also* NCAA v. Governor of N.J., 730 F.3d 208, 244 (3d Cir. 2013) (Vanaskie, J., concurring in part and dissenting in part) (citing the Roberts opinion as the authoritative opinion in consideration of the coerciveness of the Professional and Amateur Sports Protection Act of 1992).

Medicaid upon the states that made the expansion unconstitutional.[73] Roberts began this discussion by introducing the Spending Clause and noting that the Supreme Court has long accepted that Congress may condition grants of federal funds upon actions taken by the states, even if Congress itself would not be otherwise authorized to take those actions, as long as the conditions remain related to the "general Welfare of the United States."[74] But there are two important limits: Congress cannot "commandeer[ ]" a state's legislative or administrative powers, and Congress cannot "coerce" a state into taking the desired action.[75]

In his opinion, Roberts addressed only the coercion limit, outlining a two-step test for unconstitutional spending conditions based on an "anti-leveraging principle."[76] The threshold question under this test is whether the federal government program enacted under the Spending Clause threatens to withhold a "significant independent grant" of funds to pressure the recipient state to accept another program or policy change—if so, such a program demands analysis for coercion.[77] In looking at the Medicaid expansion, Roberts saw pre-ACA Medicaid and post-ACA Medicaid as separate programs,[78] justifying this interpretation by pointing to the substantial changes to eligibility rules, reimbursement rules, and benefits packages, especially insofar as they are different for those beneficiaries enrolled through pre-ACA clauses versus those enrolled through clauses added by the ACA.[79] For example, Roberts contrasted the pre-ACA Medicaid program, which only mandated that states cover certain discrete categories of needy individuals, with expanded, post-ACA Medicaid, which required states to cover all persons below 133% of FPL.[80] Therefore, when the ACA threatened to withhold funding for the pre-ACA

73 *See NFIB*, 132 S. Ct. at 2607–08 (majority opinion).

74 *See id.* at 2601–02 (quoting U.S. CONST. art I, § 8, cl. 1).

75 *See id.* at 2602.

76 *See* Bagenstos, *supra* note 8, at 866.

77 *See id.* at 869 (quoting *NFIB*, 132 S. Ct. at 2604).

78 *See id.* at 870 (citing *NFIB*, 132 S. Ct. at 2606). This is in contrast to Justice Ginsburg who, in her opinion in *NFIB*, treated Medicaid as the same program before and after its expansion. *See NFIB*, 132 S. Ct. at 2635 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

79 *See* Bagenstos, *supra* note 8, at 870.

80 *See NFIB*, 132 S. Ct. at 2601 (majority opinion) (citing 42 U.S.C. § 1369a(a)(10)(A)(i)(VIII) (2012)). Chief Justice Roberts refused to accept Justice Ginsburg's interpretation that the addition of the less-than-133% category fit within the Social Security Act's explicit clause reserving "[t]he right to alter, amend, or repeal any [of its] provision[s]." *See id.* at 2605. That is, Chief Justice Roberts viewed the Medicaid reforms as "a shift in kind, not merely degree." *Id.*

Medicaid program if a state did not comply with the post-ACA Medicaid program, he believed that it satisfied the threshold question because the federal government was leveraging the grant of money for one independent program (pre-ACA Medicaid) to force the states to accept another (post-ACA Medicaid).[81]

With the threshold question satisfied, Roberts turned to the core question of coercion—whether the threatened loss of funds leaves a real choice for the state, "not merely in theory but in fact."[82] For Roberts, coercion did not turn only on the amount of money at stake.[83] Although a paltry sum of money simply cannot be coercive,[84] a large sum of money is not automatically coercive either.[85] The Chief Justice focused instead on the relative reliance by the state on the preexisting independent grant, roughly measured by the percentage of the state budget that the grant represents.[86] Roberts also noted that it is particularly suspect whenever the grant is attached to an entrenched program like Medicaid.[87]

In the *NFIB* case, Roberts found that the sum of money at stake amounted to a proverbial "gun to the head"[88] because the Medicaid program "accounts for over [twenty] percent of the average State's total budget" and federal funds represent fifty to eighty-three percent of that program.[89] According to Roberts, the threat of losing at least ten percent of a state budget amounted to "economic dragooning," and states were left with no practical choice but to accept the federal government's terms.[90] Therefore, Roberts found the mandatory Medicaid expansion coercive.[91]

B. The Unenforced Expansion

Having established that mandatory expansion was coercive,[92] the Chief Justice's opinion held that the expansion could not therefore be

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81 *See* Bagenstos, *supra* note 8, at 870.

82 *See NFIB*, 132 S. Ct. at 2604 (quoting South Dakota v. Dole, 483 U.S. 203, 211–12 (1987)).

83 *See* Bagenstos, *supra* note 8, at 870.

84 *See id.* at 871.

85 *See id.* at 870.

86 *See id.*

87 *See id.* at 871.

88 Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2604 (2012).

89 *Id.*

90 *Id.* at 2605.

91 *See* Bagenstos, *supra* note 8, at 870.

92 *See id.* at 866.

mandatory.[93] To that end, Roberts held that the language at 42 U.S.C. § 1396c, which authorized the Secretary of HHS to pull funding for Medicaid upon the failure of a state to expand its program, was unconstitutional as applied to the Medicaid expansion.[94] That is, the Chief Justice eliminated the ability of the Secretary to take coercive action. Because Roberts had five votes for this narrow remedy, the expansion was allowed to survive on a voluntary basis.[95]

Roberts further clarified that the language in the statute would remain otherwise fully operable and applicable to other persons or circumstances.[96] Noting that the Social Security Act addressed the issue of possible severability by providing that "[i]f any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby,"[97] Roberts explained that the Court would "follow Congress's explicit textual instruction to leave unaffected 'the remainder of the chapter.'"[98]

The Court left the law in a strange place. The language in the expansion clause that requires state Medicaid programs to cover all persons below 133% of the FPL[99] remains "fully operative as a law."[100] That is, the act of coercion itself is unconstitutional, whereas the change to the program's governing statute apparently is not. This leaves the legal question of how to enforce dangling statutory language when the dedicated enforcement mechanism has been removed. Part IV of this Note resolves this question.

III. The Coverage Gap

The Court's holding in *NFIB* allows states to choose whether or not to expand their Medicaid programs.[101] To date, thirty-one states and the District of Columbia have decided to expand their Medicaid programs, but sixteen states have refused, with expansion in another

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93 *See id.* at 863–64.

94 *See NFIB*, 132 S. Ct. at 2607–08.

95 *See id.*; Bagenstos, *supra* note 8 at 866.

96 *See NFIB*, 132 S. Ct. at 2607–08 ("The other reforms Congress enacted, after all, will remain 'fully operative as a law.'").

97 42 U.S.C. § 1303 (2012).

98 *See NFIB*, 132 S. Ct. at 2607 (alteration in original) (quoting § 1303).

99 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012).

100 *See NFIB*, 132 S. Ct. at 2608.

101 *See id.*

three states uncertain.[102] Poor Americans in these nonexpansion states are left trapped without affordable health insurance because they qualify for neither pre-ACA Medicaid coverage nor ACA Marketplace subsidies that start at 100% of the FPL.[103] Across nonexpansion states, the median threshold for pre-ACA Medicaid coverage for parents of dependent children is forty-four percent of the FPL,[104] while adults without dependent children are not covered whatsoever in most nonexpansion states.[105] Nearly three million poor adults fall into this coverage gap.[106]

Most of those in the coverage gap do not have access to employer-based health insurance.[107] Although approximately half are themselves employed and sixty-two percent are in a family unit with at least one employed adult, employment-based insurance escapes them because they normally either work in businesses with fewer than fifty employees, which are not required to provide insurance coverage under the ACA, or in sectors with historically low insurance rates, like

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102 *See* Ferguson, *supra* note 21; *Status of State Action on the Medicaid Expansion Decision*, *supra* note 21. As of January 12, 2016, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia have expanded. *Status of State Action on the Medicaid Expansion Decision*, *supra* note 21. Arkansas, Indiana, Iowa, Michigan, Montana, New Hampshire, and Pennsylvania have expanded under Section 1115 Waivers, which allow them to use Medicaid funding to purchase private insurance for eligible citizens. *Id.* at n.2. Alabama, Florida, Georgia, Idaho, Kansas, Louisiana, Maine, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, and Wisconsin have not yet expanded, while South Dakota, Virginia, and Wyoming are considering expansion. *See id.*; Ferguson, *supra* note 21. With the election of Matt Bevin as Governor of Kentucky, a reversal or modification of Kentucky's Medicaid expansion can be expected. *See* Sherly Gay Stolberg & Alan Blinder, *Matt Bevin, Republican, Wins Governor's Race in Kentucky*, N.Y. TIMES (Nov. 3, 2015), http://www.nytimes.com/2015/11/04/us/republican-wins-governors-race-in-kentucky.html?_r=0.

103 *See* GARFIELD & DAMICO, *supra* note 8, at 1–2; *see also supra* Part II.A.

104 *See* GARFIELD & DAMICO, *supra* note 8, at 1. In 2015, the FPL for a family of three was $20,160, making the median threshold for coverage approximately $8,870. *See* Annual Update of the HHS Poverty Guidelines, 81 Fed. Reg. 4036, (Jan. 25, 2016). Only one nonexpanding state—Maine—provides coverage to parents of eligible children up to 100% of the FPL. *See* GARFIELD & DAMICO, *supra* note 8, at 3.

105 *See* GARFIELD & DAMICO, *supra* note 8, at 3. The only exception for childless adults is Wisconsin, which under a separate Section 1115 Waiver began providing full Medicaid coverage to adults without dependent children before the Affordable Care Act became law. *See id.* at n.2.

106 *See id.* at 2. The Kaiser Commission's Report includes a helpful table summarizing the number of people within the coverage gap by state. *See id.* at 7.

107 *See id.* at 4.

service and agriculture.[108] Many are also employed part-time and therefore do not usually qualify for health insurance benefits.[109]

Additionally, Americans caught in the coverage gap are disproportionately concentrated in the South and Midwest due to the location of nonexpansion states. A total of ninety-six percent of people in the coverage gap live in those regions, with an overwhelming majority—eighty-nine percent—in the South.[110] Furthermore, some states are individually responsible for a disproportionate percentage of the coverage gap: twenty-six percent of those in the coverage gap live in Texas, twenty percent live in Florida, eleven percent live in Georgia, and eight percent live in North Carolina.[111] The percentage of the "Medicaid-target population"[112] that is caught in the coverage gap varies by state, from forty percent in Alaska to sixty-five percent in Oklahoma.[113] That means that thirteen out of every twenty Oklahomans who would have been eligible for post-ACA Medicaid are ineligible because Oklahoma adheres to its old eligibility rules.

The demographics of those trapped in the coverage gap follow those of uninsured persons generally.[114] These Americans are characteristically impoverished and are disproportionately minority.[115] Forty-five percent are white (non-Hispanic), twenty-eight percent are black, and twenty-three percent are Hispanic.[116] This is especially problematic for black Americans because, in 2015, thirty-four percent of all blacks who would qualify for expanded Medicaid also fell below the threshold for subsidies, whereas this was true for only twenty-five percent of Hispanics and twenty-three percent of whites.[117] Because

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108 *See id.*

109 *See id.*

110 *See id.* at 2.

111 *Id.*

112 "Medicaid-target population" ("MTP") reflects those who might be covered by an expanded Medicaid program. *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID 4 (2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/04/8505-the-coverage-gap_uninsured-poor-adults-in-states-that-do-not-expand-medicaid.pdf. A higher percentage of a state's MTP that is in the coverage gap reflects how few people were covered by pre-ACA Medicaid in that state.

113 *Id.* at 4–5.

114 GARFIELD & DAMICO, *supra* note 8, at 2.

115 *See id.*

116 *Id.* For reference, the national composition of the population is approximately sixty-four percent white (non-Hispanic), thirteen percent black, and sixteen percent Hispanic or Latino. KAREN R. HUMES ET AL., U.S. CENSUS BUREAU, OVERVIEW OF RACE AND HISPANIC ORIGIN: 2010, 3–4 (2011), http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.

117 *See* ARTIGA ET AL., *supra* note 30, at 3.

states with relatively large Hispanic populations—like California, New York, and Arizona—have expanded their Medicaid coverage, while states with relatively large black populations—like Florida, Georgia, and Texas—have not, the uninsured rate among black Americans remains higher than among Hispanics within the total adult uninsured population.[118]

Those caught between Medicaid and Marketplace subsidies are unlikely to have any other options for affordable access to care.[119] There is no need to look further than Mr. Maiden for an illustration of this untenable situation. Again, Mr. Maiden lives below the FPL and has no children—he is therefore not covered by Alabama's Medicaid.[120] Private insurance in Alabama, on the federal Marketplace, would cost him $437 per month in premiums and come with a $6,350 deductible.[121] Therefore, of his $10,400 annual income, Mr. Maiden would have to pay approximately $11,600 in annual premiums and cost sharing before his coverage would kick in, something he is clearly unable to do.[122]

IV. Enforcing the Medicaid Expansion With 42 U.S.C. § 1983

Without viable legislative or executive options, those caught in the Medicaid gap could avail themselves of the courts by litigating a series of state-by-state class actions to force expansion of Medicaid without the cooperation of Congress or state governments. Their best legal platform lies with 42 U.S.C. § 1983, which provides each citizen a right of action to remedy deprivations of any constitutional or statutory right by the federal government or a state.[123] Class actions seeking injunctive relief brought under § 1983 to expand state Medicaid programs to cover those eligible under § 1396a(a)(10)(i)(VIII) are a ripe and powerful tool.[124]

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118 Garfield & Damico, *supra* note 8, at 2–3; Artiga et al., *supra* note 30, at 3.

119 *See* Artiga et al., *supra* note 30, at 1.

120 *See* Weaver, *supra* note 1.

121 *Id.*

122 *See id.*

123 42 U.S.C. § 1983 (2012).

124 Class certification for injunctive relief under Federal Rule of Civil Procedure 23 is certainly available for an action under 42 U.S.C § 1983. *See generally* Disability Rights Council of Greater Wash. v. Wash. Metro. Area Transit Auth., 239 F.R.D. 9, 28–29 (D.D.C. 2006) (allowing class certification under § 1983 wherein the class was seeking injunctive relief). Class actions have also been successfully used to enforce Medicaid provisions under § 1983. *See* Binta B. *ex rel.* S.A. v. Gordon, 710 F.3d 608, 613 (6th Cir. 2013) (obtaining consent decree for § 1983 class action).

A. *The Need for a Judicial Solution*

The federal government offers no reprieve for those caught in the coverage gap. Not only can the executive branch no longer force states to expand,[125] but an alternative plan—such as a federal expansion program that avoids the cooperation of the states—is clearly not on the agenda of the Republican-controlled Congress, which does not even wholly support the current health care reforms under the ACA and has proposed no alternatives.[126] Additionally, any exclusively federal supplemental Medicaid program would create a perverse incentive for states to retract their expansions and refuse to expand in the future so that the federal government would step in and pay 100% of the bill.

State governments also offer no solution to the coverage gap problem. Similar to a federal expansion replacement program, it is theoretically possible that the current nonexpansion states could simply change course and opt to expand their programs. Of course, some states did expand after an initial hesitation.[127] Arkansas, Indiana, Iowa, Michigan, New Hampshire, and Pennsylvania have used Section 1115 Demonstration Waivers to implement premium assistance programs after initially refusing, but these states seems to be the exceptions to the rule.[128] South Dakota, Virginia, and Wyoming are said to be considering expansion.[129] However, that leaves sixteen states steadfastly opposed to expansions, and most nonexpansion states have not only retrenched their opposition, but also offered no solution.[130]

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125 *See supra* Part II.A.

126 *See, e.g.*, Alex Rogers, *What is the Republican Alternative to Obamacare?*, TIME (Feb. 3, 2015), http://time.com/3693630/republican-obamacare-alternative/; Avik Roy, *Seven Obamacare Bills That The New GOP Senate Majority Should Pass in 2015*, FORBES (Nov. 5, 2014, 2:29 AM), http://www.forbes.com/sites/theapothecary/2014/11/05/seven-obamacare-bills-that-the-new-gop-senate-majority-should-pass-in-2015/; Deirdre Walsh & Dana Bash, *Boehner: House GOP Files Obamacare Suit*, CNN (Nov. 21, 2014, 1:35 PM), http://www.cnn.com/2014/11/21/politics/house-gop-sue-the-president-over-obamacare/.

127 *See supra* note 102.

128 *Status of State Action on the Medicaid Expansion Decision*, *supra* note 21, at n.2.

129 *See supra* note 21.

130 *See, e.g.*, ANNE DUNKELBERG, CTR. FOR PUB. POLICY PRIORITIES, Closing the Texas Coverage Gap: How Texas Leaders Can Still Help Over 1 Million Texans This Session 1 (2015), http://forabettertexas.org/images/HW_2015_PP_ClosingTXCoverageGap.pdf (noting that Texas and other nonexpansion states "are not in active discussion of any solution"); Jason Millman, *Florida's Republican Governor Says He No Longer Supports Expanding Medicaid*, WASH. POST (Apr. 6, 2015), http://www.washingtonpost.com/blogs/wonkblog/wp/2015/04/06/floridas-republican-governor-just-flip-flopped-on-the-medicaid-expansion/; Rachana Pradhan, *Tennessee Turns Down Obamacare Medicaid Expansion*, POLITICO (Feb. 4, 2015, 5:39 PM), http://www.politico.com/story/2015/02/tennessee-bill-haslam-medicaid-expansion-obamacare-114918; Michelle L.

Without executive or legislative solutions on either the state or federal level and without a statutory enforcement mechanism, the only solution that remains is litigation. Specifically, a series of state-by-state class action lawsuits arising under 42 U.S.C. § 1983 could seek injunctive relief to force the nonexpansion states to abide by the language of 42 U.S.C. § 1396a(a)(10)(A)(i)(VII) and expand their Medicaid programs to cover all individuals and families below 133% of the FPL. Any number of state citizens in Mr. Maiden's situation could serve as class representatives.[131]

B. The § 1983 Framework

Section 1983 offers a general private right of action for any person who is deprived under color of law of any rights established by the Constitution or state or federal laws.[132] This provision is a powerful legal tool that has survived state sovereignty counterarguments, originalist interpretations based on contract law, and persistent adverse lobbying and litigation by states.[133] The modern analytical framework is rooted in *Blessing v. Freestone*,[134] in which the Court supplied a clear three-part test for § 1983 claims.[135] *Blessing* was limited by *Gonzaga University v. Doe*[136] to apply only to "deprivation of 'rights,'"[137] but lower courts have struggled to understand exactly how broadly to apply the *Gonzaga* decision.[138] The majority of courts have interpreted *Gonzaga* to restrict "rights" to *personal* rights that directly apply to individuals and families, as opposed to generalized statutory requirements from which individuals and families might indirectly benefit.[139]

Price, *Governor's Medicaid Expansion Plan May Have Hit Dead End*, WASH. TIMES (Feb. 25, 2015), http://www.washingtontimes.com/news/2015/feb/25/utah-senate-passes-governors-medicaid-expansion-pl/.

131 *See supra* Introduction. This Note does not address the broader procedural hurdles inherent to a class action.

132 42 U.S.C. § 1983 (2012) ("Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law . . . .").

133 *See* Nicole Huberfeld, *Where There Is a Right, There Must Be a Remedy (Even in Medicaid)*, 102 KY. L.J. 327, 334–37 (2013–2014).

134 Blessing v. Freestone, 520 U.S. 329 (1997).

135 *Id.* at 340–41.

136 Gonzaga Univ. v. Doe, 536 U.S. 273 (2002).

137 *Id.* at 283.

138 *See* Huberfeld, *supra* note 133, at 330–31, 339.

139 *See id.* at 339 ("Some courts ignore the *Gonzaga* modification of *Blessing*, some courts

Under *Blessing*, a plaintiff can successfully bring a § 1983 claim only if they can rest their argument on a mandatory right against the state that is codified in "right- or duty-creating language" within the law being enforced.[140] *Blessing* does not permit § 1983 enforcement of just any mere violation of federal law.[141] Under its three-part test, to establish that a statute provides an actual right enforceable under § 1983, rather than a mere provision of law, the plaintiff must prove that (1) Congress demonstrated an explicit or implicit intent to benefit the plaintiff or a class to which the plaintiff belongs,[142] (2) the right asserted is judicially cognizable, meaning that it is not so "vague and amorphous" that the courts could not understand how to enforce it,[143] and (3) the statute "unambiguously impose[s] a binding obligation" on the federal or state government to provide the right.[144] The plaintiff's case, of course, will not survive if Congress explicitly or implicitly foreclosed private enforcement of that right through other language in the same statute.[145]

Gonzaga clarified that Congress must explicitly confer *personal* rights that vest onto identifiable individuals or classes of individuals and *directly* benefit such persons, rather than create general rights or impose general requirements that only benefit individuals indirectly.[146] Therefore, *Gonzaga* altered *Blessing*'s first prong to be closer to "whether or not Congress intended to confer individual rights upon a class of beneficiaries."[147] *Gonzaga* also indicated that there is a special concern that generalized requirements imposed upon a state government by the federal government in a statute authorized by the Spending Clause not be erroneously interpreted to provide personal rights that could be enforced under § 1983.[148]

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substitute *Gonzaga* for *Blessing*, but most courts see *Gonzaga* as modifying the first part of the *Blessing* test.").

140 Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 526 (1990) (Rehnquist, C.J., dissenting); *accord Blessing*, 520 U.S. at 341.

141 *Gonzaga*, 536 U.S. at 282–83; *Blessing*, 520 U.S. at 340.

142 *Blessing*, 520 U.S. at 340; *Wilder*, 496 U.S. at 509 (stating that a statutory provision intended to benefit a plaintiff "creates an enforceable right unless it reflects merely a 'congressional preference' for a certain kind of conduct").

143 *Blessing*, 520 U.S. at 340–41; *accord Wilder*, 496 U.S. at 509.

144 *Blessing*, 520 U.S. at 341; *Wilder*, 496 U.S. at 509.

145 *Blessing*, 520 U.S. at 341; *Wilder*, 496 U.S. at 508.

146 *See Gonzaga*, 536 U.S. at 285–86.

147 *Id.* at 285.

148 *See id.* at 281–82, 285.

Some observers have noted that the general availability of § 1983 claims has been tightened after *Gonzaga*.[149] This pattern is attributable to the prohibition on enforcement of general clauses by § 1983 that *Gonzaga* imposed.[150] But *Gonzaga* should not discourage the use of § 1983 altogether, given the solid precedent still available for enforcement of provisions that *do* create personal rights. Courts have consistently continued to allow the use of § 1983 when the provision to be enforced refers to "individuals" or "families," while rejecting claims based on more general provisions.[151] That is, *Gonzaga* did not overrule *Blessing*—it simply elucidated that § 1983 does not allow enforcement of indirect benefits by those who merely fell within a statutory provision's zone of interest.[152]

C. Section 1983 and Medicaid

Historically, lawsuits against state Medicaid programs have used 42 U.S.C. § 1983 as a vehicle for their claims because the Medicaid statute lays out the rights of eligible citizens to health care, but does not provide a comprehensive enforcement mechanism of those rights for eligible persons.[153] A clear consensus has developed that § 1983 actions are available for both Medicaid providers and beneficiaries[154]—except in the case of enforcing Medicaid's "equal access provision,"[155] which is irrelevant to enforcement of the Medicaid expansion.

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149 *See* Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 73–74 (2014).

150 *See* Anne M. Dwyer, Note, *Ensuring Equal Access: Rethinking Enforcement of Medicaid's Equal Access Provision*, 97 MINN. L. REV. 2320, 2331–32 (2013).

151 *See id.*; *see also* Equal Access for El Paso, Inc. v. Hawkins, 509 F.3d 697, 702–04 (5th Cir. 2007) (holding that Medicaid's equal access provision does not create an enforceable right under § 1983 because it "speaks only in" general terms); Mandy R. e*x rel.* Mr. & Mrs. R. v. Owens, 464 F.3d 1139, 1148 (10th Cir. 2006) (finding no enforceable right under equal access provision for recipients or providers because provision created no "identifiable class" of beneficiaries); Watson v. Weeks, 436 F.3d 1152, 1159–60 (9th Cir. 2006) (finding that § 1396a(a)(10) of Medicaid statute creates enforceable right under § 1983 because statute "is phrased in terms of the individuals benefitted").

152 *See Gonzaga*, 536 U.S. at 285–86.

153 *See* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 521–22 (1990).

154 *See, e.g.*, S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 607 (5th Cir. 2004); Doe *ex rel.* Doe v. Chiles, 136 F.3d 709, 719 (11th Cir. 1998); *see also* Huberfeld, *supra* note 133, at 337 ("Generally speaking, lower federal courts' approach to Medicaid enforcement actions can be characterized as permissive, with the exception of litigation designed to enforce Boren's successor . . . the . . . '30(A)' provision.").

155 *See* 42 U.S.C. § 1396a(a)(30)(A) (2012).

The application of this right of action to the Medicaid program was exemplified by *Wilder v. Virginia Hospital Ass'n*.[156] There, a nonprofit association of public and private hospitals brought a successful action pursuant to § 1983 to overturn the reimbursement policies of Virginia's Medicaid program, which were implemented to tighten payments in violation of the since-repealed Boren Amendment to the Medicaid Act.[157] More recently, circuits that are populated by nonexpansion states have continued to allow § 1983 enforcement of Medicaid provisions. For example, the U.S. Court of Appeals for the Eleventh Circuit permitted a group of developmentally disabled Medicaid participants to enforce the reasonable promptness requirement of 42 U.S.C. § 1396a(a)(8)[158] against the Florida Medicaid program to demand coverage of intermediate care facilities for the developmentally disabled in *Doe ex rel. Doe v. Chiles*.[159] Additionally, the U.S. Court of Appeals for the Fifth Circuit allowed a sixteen-year-old Medicaid participant to challenge a denial of medical supplies by the Louisiana Medicaid program as a means of enforcing the medical assistance mandate of 42 U.S.C. § 1396d(a)[160] in *S.D. ex rel. Dickson v. Hood*.[161]

Additionally, the Supreme Court has long held that Congress has not foreclosed the enforcement of the Medicaid Act under § 1983 because the Medicaid Act neither expressly excludes its use nor provides such a comprehensive remedial scheme as to imply foreclosure of private enforcement.[162] The *Wilder* Court established that Medicaid's administrative enforcement mechanism, 42 U.S.C. § 1396c, which authorizes the Secretary of HHS to withhold all or part of federal funds to elicit state compliance, is not a sufficient demonstration of congressional intent to foreclose application of § 1983.[163] This was reaffirmed

156 Wilder v. Va. Hosp. Ass'n, 496 U.S. 498 (1990).

157 *See id.* at 502–05, 521–22; *see also* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a), 111 Stat. 251, 507 (repealing the Boren Amendment).

158 42 U.S.C. § 1396a(a)(8) (2012).

159 Doe *ex rel.* Doe v. Chiles, 136 F.3d 709, 711 (11th Cir. 1998).

160 42 U.S.C. § 1396d(a).

161 S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 584–86 (5th Cir. 2004).

162 *See Wilder*, 496 U.S. at 520–23. The Court in *Wilder* noted that it had only found a sufficiently comprehensive remedial scheme under two statutes—the Federal Water Pollution Control Act, which granted the Environmental Protection Agency broad enforcement power including orders, lawsuits, and criminal charges in addition to two citizen-suit provisions, and the Education of the Handicapped Act, which included a review mechanism that began with a local administrative process and ended with judicial review. *See id.* at 521. In contrast, the Court found that power to withhold federal funds and to disapprove of state plans was an insufficient remedial scheme. *See id.* at 521–22.

163 *See id.* at 521–22.

in *Virginia Office for Protection & Advocacy v. Stewart*,[164] where the Court noted that the ability of the federal government to administer a statute enacted under the Spending Clause by withholding or withdrawing funds does not prove that Congress intended to foreclose private enforcement.[165]

While the Supreme Court has foreclosed private enforcement of the "equal access provision," that analysis cannot be analogized to this case. Most recently, the Supreme Court held in *Armstrong v. Exceptional Child Center*[166] that private enforcement in equity of Medicaid's equal access provision is implicitly foreclosed by the existence of the enforcement mechanism at 42 U.S.C. § 1396c *combined with* the judicially unmanageable text of the equal access provision.[167] For two reasons the *Armstrong* decision does not apply in this case. First, whereas the equal access provision has been found to be judicially unmanageable for purposes of both implied equity[168] and § 1983,[169] the language of the expansion clause is not judicially unmanageable,[170] and the *Armstrong* Court recognized that § 1396c by itself is not sufficient for implied foreclosure of private enforcement.[171] Second, the existence of the enforcement mechanism in § 1396c is irrelevant to the question of foreclosure under the Medicaid expansion provision because the *NFIB* decision found it unconstitutional as applied to that provision.[172]

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164 Va. Office for Prot. & Advocacy v. Stewart, 563 U.S. 247 (2011).

165 *See id.* at 256 n.3 (analyzing implied foreclosure in the context of enforcement of the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001–15115 (2012)).

166 Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378 (2015).

167 *See id.* at 1385.

168 *See Armstrong*, 135 S. Ct. at 1385. The narrow reasoning of the decision should limit its precedential value to only the section at issue—42 U.S.C. § 1396a(a)(30)(A). *See* Steve Vladeck, Armstrong*: Is Utterly Disingenuous Statutory Interpretation Ever Worth It?*, PrawfsBlawg (Mar. 31, 2015, 8:27 PM), http://prawfsblawg.blogs.com/prawfsblawg/2015/03/armstrong-is-utterly-disingenuous-statutory-interpretation-ever-worth-it.html ("[T]he hyper-specific focus on the equal access provision in both Justice Scalia's majority opinion and Justice Breyer's concurrence almost certainly reduces the precedential effect of today's decision.").

169 *See* Huberfeld, *supra* note 133, at 337.

170 *See infra* notes 192–93, 196, and accompanying text.

171 *See Armstrong*, 135 S. Ct. at 1385 (citing Va. Office for Prot. & Advocacy v. Stewart, 563 U.S. 247, 256 n.3 (2011)).

172 *See* Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2607–08 (2012). Even if a court does not agree that *NFIB*'s finding that § 1396c is unconstitutional would affect the interpretation of Congress's intent to foreclose a private right of action, the first reason to distinguish *Armstrong* is still sufficient because the *Armstrong* court itself recognized that § 1396c alone is not sufficient to find foreclosure.

More broadly, whereas the *Armstrong* decision shows some hostility to private enforcement of some sections of Medicaid, the ACA itself does nothing to restrict private enforcement or displace § 1983 actions that otherwise survive the *Blessing-Gonzaga* test.[173] Even in *Gonzaga*, where the Court also disfavored private enforcement in the context of Spending Clause frameworks, the Court nonetheless cited *Wilder* favorably.[174] Therefore, as a general proposition, the availability of § 1983 to enforce Medicaid rights remains well established.

D. Applying the Blessing-Gonzaga *Test*

The statutory language of the expansion clause clearly satisfies the *Blessing-Gonzaga* test. The analyses by both the Eleventh Circuit in *Chiles*[175] and the Fifth Circuit in *Dickson*[176] of § 1983 enforceability of similar Medicaid provisions support this conclusion. In *Chiles*, the Eleventh Circuit found that § 1396a(a)(8), which requires that a state Medicaid program act with "reasonable promptness" to provide access to intermediate care facilities for the mentally disabled, was fully enforceable under § 1983.[177] The court established that this promptness requirement was (1) intended to benefit Medicaid-eligible individuals,[178] (2) sufficiently specific to be enforced by the court,[179] and (3) formed a binding obligation upon the state because it was "undoubtedly cast in mandatory rather than precatory terms."[180] In *Dickson*, the Fifth Circuit applied a similar analysis to allow private enforcement of § 1396a(a)(10)(A)(i),[181] which requires that a state Medicaid program provide, among other mandatory services, "early and periodic screening, diagnostic, and treatment services," known in the medical field as EPSDT.[182] It must be noted that the Eleventh Circuit includes the nonexpansion states of Florida, Georgia, and Ala-

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173 *See* Huberfeld, *supra* note 133, at 346–47.

174 *See Armstrong*, 135 S. Ct. at 1386 n.* (noting that although *Gonzaga* constricts *Wilder*, the latter is still a source for § 1983 claims if the statute "unambiguously confer[s a] right"); Gonzaga Univ. v. Doe, 536 U.S. 273, 274 (2002) ("Since *Pennhurst*, the Court has found that spending legislation gave rise to rights enforceable under § 1983 only in *Wright v. Roanoke Redevelopment and Housing Authority* and *Wilder v. Virginia Hospital Assn.*") (citations omitted)).

175 *See* Doe *ex rel.* Doe v. Chiles, 136 F.3d 709, 713–18 (11th Cir. 1998).

176 *See* S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 602–03 (5th Cir. 2004).

177 *Chiles*, 136 F.3d at 718.

178 *Id.* at 715.

179 *See id.* at 716–18.

180 *Id.* at 718.

181 *See Dickson*, 391 F.3d at 602–07 (applying the *Blessing* three-factor test to find 42 U.S.C. § 1396a(a)(10)(A)(i) (2012) enforceable via § 1983).

182 *Id.* at 584.

bama, and that the Fifth Circuit includes the nonexpansion states of Texas, Louisiana, and Mississippi. Therefore, the *Chiles* and *Dickson* decisions are directly binding on six nonexpansion states, three of which include some of the largest percentages of those caught in the coverage gap—twenty-six percent live in Texas; twenty percent in Florida, and eleven percent in Georgia.[183]

The Medicaid expansion clause clearly survives a similar analysis. Turning to *Blessing*'s first prong, the expansion clause most certainly demonstrates a congressional intent to confer rights upon a class of individuals. Just as the promptness requirement at issue in *Chiles* was clearly intended to benefit "eligible individuals," the expansion clause is clearly intended to extend health insurance coverage to persons living below 133% of the FPL by providing them mandatory access to Medicaid.[184] The benefit attaches directly to a class of persons defined by five specific requirements: (1) individuals who (2) are under 65 years of age, (3) are not pregnant, (4) are not otherwise covered by pre-ACA Medicaid, and (5) have income that "does not exceed 133 percent of the [FPL]" that applies to their family.[185]

There can be no clearer delineation of a *personal* right satisfying the limitation imposed by *Gonzaga*. The expansion clause does not merely establish a general statutory requirement from which people might indirectly benefit—it establishes a clearly defined class of individuals who are guaranteed the direct benefit of access to Medicaid coverage.[186] This clause is also analogous to the Brooke Amendment to the Housing Act of 1937,[187] which was found to be enforceable under § 1983 in *Wright v. Roanoke Redevelopment & Housing Authority*[188] because both provisions confer mandatory rights on individuals on the basis of family income.[189] Conversely, the expansion clause is distinguishable from the nondisclosure provisions of the Family Educational Rights and Privacy Act ("FERPA")[190] that were found to be unenforceable under § 1983 in *Gonzaga* because FERPA

183 *See* GARFIELD & DAMICO, *supra* note 8, at 2.

184 *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

185 *Id.*

186 *See id.*

187 Housing and Urban Development Act of 1969, Pub. L. No. 91-152, § 213, 83 Stat. 379, 389 (amending United States Housing Act of 1937, § 305(g)).

188 Wright v. Roanoke Redevelopment & Hous. Auth., 479 U.S. 418, 429 (1987). This case was cited favorably by *Gonzaga*. *See* Gonzaga Univ. v. Doe, 536 U.S. 273, 280 (2002).

189 *See Wright*, 479 U.S. at 420 (noting that the Brooke Amendment "provides that a low-income family 'shall pay as rent' a specified percentage of its income").

190 20 U.S.C. § 1232g (2012).

spoke only in terms of school policy and practice and did not provide an individual entitlement to any direct benefit.[191]

Blessing's second prong is also easily satisfied because the coverage of people that fit the expansion clause's five-part test is not too vague for the court to enforce. In *Chiles*, the Eleventh Circuit found that it could enforce the reasonableness of waiting lists requirement for intermediate care facilities.[192] In *Dickson*, the Fifth Circuit found that it could enforce individuals' right to received mandatory EPSDT services.[193] In contrast, in *Armstrong*, the Supreme Court found the equal access provision[194] of Medicaid to be "judicially unadministrable" because the Court could not "imagine a requirement broader and less specific than" the equal access provision's requirement that states set prices that are "consistent with efficiency, economy, and quality of care, all the while safeguarding against unnecessary utilization of care and services."[195] The expansion clause is nothing like the equal access provision's amorphous multifactor balancing scheme. To enforce the expansion clause, a court would only be required to determine that the complainant's age is less than sixty-five years, that their income is less than 133% of the FPL, and that they are not pregnant or otherwise eligible for Medicaid.[196] In fact, enforcing the expansion clause under § 1983 would require less subjective judgment than the enforcement of a reasonableness standard, which the Eleventh Circuit found cognizable in *Chiles*.[197] Therefore, the expansion clause is well within the competence of the courts to enforce.

Under *Blessing*'s third prong, there is no doubt that the expansion clause is a binding obligation on the states.[198] The *Gonzaga* court noted that the "no person . . . shall" language of Title VI of the Civil Rights Act of 1964[199] and Title IX of the Education Amendments of 1972[200] was prototypical rights-creating language.[201] The Third Cir-

191 *See Gonzaga*, 536 U.S. at 287.

192 Doe *ex rel.* Doe v. Chiles, 136 F.3d 709, 716–18 (11th Cir. 1998).

193 S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 605 (5th Cir. 2004).

194 42 U.S.C. § 1396a (2012).

195 Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378, 1385 (2015) (internal quotations, brackets, and ellipses omitted).

196 *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

197 *Chiles*, 136 F.3d at 711.

198 *Compare* 42 U.S.C. § 1396a(a)(8), *and* 42 U.S.C. § 1396a(a)(10)(A)(i), *with* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

199 42 U.S.C § 2000d (2012).

200 20 U.S.C. § 1681(a) (2012).

201 *See* Gonzaga Univ. v. Doe, 536 U.S. 273, 284 & n.3 (2002).

cuit, in *Sabree v. Richman*,[202] established that § 1396a(a)'s "[a] State plan . . . must" language is not materially different than the language exalted by the *Gonzaga* court.[203] The *Dickson* court cited *Sabree* for the same proposition and added that the only potential difference was the fact that § 1396's provisions have to be actualized through a state plan in contrast to Title VI and Title IX.[204] However, the Fifth Circuit held that this fact was not dispositive because the Medicaid framework itself declares that when a provision of the chapter is being enforced in court, the fact that the provision is designed to be enforced by a state plan does not undermine enforcement of said provision.[205]

Furthermore, due to the structure of § 1396a(a), all of its internal provisions begin with the exact same words—"[a] State plan . . . must."[206] The expansion clause added by the ACA begins with that same language, as do the promptness requirement in *Chiles* and the EPDST clause in *Dickson*.[207] Under *Bragdon v. Abbott*,[208] when previous "'judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute' is presumed to incorporate that interpretation."[209] By placing the added language within § 1396a, Congress effectively repeated the "[a] State plan . . . must" language and accepted the prevailing interpretation of those words by the courts.[210] This further supports the binding nature of the expansion clause for § 1983 purposes. But even without applying the *Bragdon* analysis,[211] in addition to being a personal right

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202 Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180 (3d Cir. 2004).

203 *See id.* at 190.

204 S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 603 (5th Cir. 2004).

205 *Id.*

206 42 U.S.C. § 1396a (2012).

207 *See* 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10)(A)(i)(VIII), 1396a(a)(10)(A)(i). *See generally supra* Part II.B. It is important to note that *Gonzaga* was decided in 2002 and *Dickson* was decided in 2004—so the § 1396 language was held binding even after the Court tightened the *Blessing* test.

208 Bragdon v. Abbott, 524 U.S. 624 (1998).

209 Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378, 1386 (2015) (quoting *Bragdon*, 524 U.S. at 645).

210 *See* Huberfeld, *supra* note 133, at 332–33 (explaining that Congress "knew of and expected" private enforcement when it used the language "must" in the Boren Amendment that was litigated in *Wilder*). Just as in 1980, Congress in 2008 understood that using the "must" language would "open the courthouse doors to Medicaid litigation against the states." *See id.* at 333.

211 The Supreme Court has implied that prevailing circuit precedent does not "settle" the meaning of a statutory term in lieu of a Supreme Court decision on the same, at least when the language is not identical (like it is in this case). *See generally Armstrong*, 135 S. Ct. at 1386–87 (stating that a question on statutory interpretation remained "unsettled" during the pendency of the case before the Court).

and judicially administrable, the expansion clause is undoubtedly an obligation binding on the states. Therefore, the *Blessing-Gonzaga* test for § 1983 enforceability is satisfied and the expansion clause is eligible for a § 1983 action.

E. Null Effect of NFIB *on § 1983 Medicaid Actions*

No court should interpret the *NFIB* decision as barring a cause of action brought under § 1983 to enforce the Medicaid expansion. Although the Court declared the Medicaid enforcement provision unconstitutional as applied to the ACA Medicaid expansion, Chief Justice Roberts explicitly clarified that the *NFIB* decision would not affect the enforcement of the rest of the ACA or the application of the expansion clause in other situations.[212] It bears repeating that in doing so, Roberts quoted "Congress's explicit textual instruction" that a court decision finding one Medicaid provision invalid does not undermine the validity of the rest of the Medicaid program.[213]

Furthermore, the *NFIB* majority, disjointed as it was, only took issue with the leverage of federal money to enforce a policy change.[214] The coercion would occur when the Secretary of HHS leveraged a significant independent grant of money to force a state to comply with the federal rule.[215] Therefore, the Court only removed the capacity of the Secretary to coerce the states.[216] Private enforcement under § 1983 by potential beneficiaries against the states does not bring up a Spending Clause coercion problem and therefore *NFIB* does not apply. Accordingly, there is no reason to fear that recent Supreme Court decisions interfere with this potential cause of action.

Conclusion

The *NFIB* decision created a profound problem—a coverage gap that has left almost three million Americans trapped without access to affordable health insurance. However, a resolution to this coverage crisis exists in § 1983 private actions. Although the *NFIB* decision clearly eliminated the capacity of the federal government to coerce

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212 *See* Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2607–08 (2012) ("We . . . leave unaffected the remainder of the chapter, and the application of the challenged provision to other persons or circumstances." (internal quotations and alterations omitted)).

213 *Id.* at 2607 (citing 42 U.S.C. § 1303 (2012)).

214 *See id.* at 2606–07 (noting that Congress "may not simply 'conscript state [agencies] into the national bureaucratic army'") (quoting FERC v. Mississippi, 456 U.S. 742, 775 (1982) (O'Connor, J., concurring in judgment in part and dissenting in part).

215 *See id.* at 2607.

216 *Id.*

the state governments to accept the ACA Medicaid expansion, it did not eliminate the expansion clause itself. In fact, Chief Justice Roberts took the time to highlight that the ACA's enforcement in all other circumstances is not undermined by the Court's narrow holding. Applying the *Blessing-Gonzaga* § 1983 framework to the preserved expansion clause demonstrates that the language creates a personal right that is judicially cognizable and binding upon the states. Moreover, neither the *Armstrong* nor the *NFIB* decision support the argument that private enforcement has been implicitly foreclosed by Congress. Potential beneficiaries cannot wait on the federal or state governments to solve this problem. Instead, persons who fall in the Medicaid Gap should come together in and press their statutory right to healthcare before the courts. Using § 1983 offers a very powerful and historically successful avenue for Medicaid-eligible individuals to enforce their rights.