

NOTES

“MAKING MEDICAL ASSISTANCE AVAILABLE”: ENFORCING THE MEDICAID ACT’S AVAILABILITY PROVISION THROUGH § 1983 LITIGATION

Devi M. Rao

This Note examines the § 1983 enforceability of the Medicaid Act’s “availability provision,” which requires states to “make[] medical assistance available” to all individuals who qualify for benefits. Although traditionally courts have found the availability provision enforceable through § 1983, two recent changes may cause courts to reexamine this question. First, in Gonzaga University v. Doe, the Supreme Court articulated a new and more stringent test for § 1983 enforceability that turns on congressional intent to confer an enforceable right. As a result of Gonzaga, two Medicaid provisions have been found unenforceable in a majority of circuits that have addressed the question. Second, the Deficit Reduction Act (DRA) amended the Medicaid Act to allow states more flexibility in their delivery of benefits to certain groups, which, some argue, may indicate that Congress did not intend beneficiaries to have a right enforceable through § 1983. This Note argues that despite Gonzaga and the DRA, the availability provision continues to confer individual rights enforceable through § 1983.

INTRODUCTION

Medicaid is a medical assistance program for low-income individuals¹ that insures more than one in seven Americans.² Congress established Medicaid in 1965 under Title XIX of the Social Security Act,³ also known as the Medicaid Act.⁴ The Medicaid program is jointly funded by the federal government and the states,⁵ and although the federal govern-

1. 42 U.S.C. §§ 1396–1396v (2006). Medicaid’s general introductory statement provides that the Act is “[f]or the purpose of enabling each State . . . to furnish . . . medical assistance on behalf of families . . . [and] individuals, whose income and resources are insufficient to meet the costs of necessary services.” *Id.* § 1396.

2. Andy Schneider et al., *The Kaiser Comm’n on Medicaid and the Uninsured, The Medicaid Resource Book*, at i (2002), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14266> (on file with the *Columbia Law Review*).

3. For a history of Medicaid and its amendments, see Omar N. Ahmad, *Medicaid Eligibility Rules for the Elderly Long-Term Care Applicant: History and Developments, 1964–1998*, 20 *J. Legal Med.* 251, 252–65 (1999) (discussing initial passage and amendments regarding spousal impoverishment); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 *J. Health Care L. & Pol’y* 5, 8–24 (2006) (discussing Medicaid’s legislative roots, basic structure, and history).

4. *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 182 (3d Cir. 2004).

5. Jane Perkins & Sarah Somers, *Nat’l Health Law Program, An Advocate’s Guide to the Medicaid Program* § 1.1 (2001).

ment establishes broad guidelines that states must follow in administering Medicaid, the exact contours of the program are established by each state.⁶ Medicaid does not provide care and services to every low-income individual, and eligibility depends on an individual's state of residence.⁷ For individuals that meet the state's eligibility requirement, the Medicaid Act's basic availability provision, § 1396a(a)(10)(A) ("the availability provision"), requires that "[a] State Plan . . . *must provide* for making medical assistance available . . . *to all individuals*" who are eligible.⁸ Another section of the Act describes the minimum services that a state must provide.⁹ But what if a state fails to provide the relevant medical services to individuals that qualify?¹⁰

In the past, individuals have sued under 42 U.S.C. § 1983 when the state failed to provide them with the Medicaid services for which they were eligible. In the facts of one successful § 1983 suit, for instance, Pennsylvania had left mentally disabled individuals who qualified for Medicaid "languish[ing] on waiting lists for years, unable to obtain . . . services."¹¹ Oregon responded to a budget crisis by revoking the eligibility of seniors and disabled individuals for nursing home facilities, and plaintiffs sued alleging that the state's actions violated the availability provision.¹² Similarly, a plaintiff sued when Louisiana refused to pay for his medically prescribed incontinence underwear, which were necessary as a result of his spina bifida.¹³ Michigan failed to provide early and periodic screening, diagnosis, and treatment ("EPSDT") services to eligible children who requested them,¹⁴ and Texas's EPSDT program did not ensure eligible children received the care required by Medicaid.¹⁵

6. Ctr. for Medicaid & State Operations, Dep't of Health and Human Servs., Medicaid At-a-Glance 2005: A Medicaid Information Source 1 (2005), available at <http://www.cms.hhs.gov/MedicaidGenInfo/downloads/MedicaidAtAGlance2005.pdf> (on file with the *Columbia Law Review*).

7. *Id.*

8. 42 U.S.C. § 1396a(a)(10)(A)(i) (2006) (emphasis added).

9. *Id.* § 1396d(a).

10. This problem may be even more pressing because of the current recession. Faced with budget deficits, many states are "slicing into their social safety nets." Erik Eckholm, *States Slashing Social Programs for Vulnerable*, N.Y. Times, Apr. 12, 2009, at A1. For example, "California has ended dental coverage for adults on Medicaid, all but guaranteeing future medical problems." *Id.*

11. *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 182 (3d Cir. 2004).

12. *Watson v. Weeks*, 436 F.3d 1152, 1154 (9th Cir. 2006).

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

14. *Westside Mothers v. Olszewski*, 454 F.3d 532, 535 (6th Cir. 2006). The Medicaid Act's EPSDT provisions are children-specific and are among the enumerated services that a state program must provide. See Frederick H. Cohen, *An Unfulfilled Promise of the Medicaid Act: Enforcing Medicaid Recipients' Right to Health Care*, 17 *Loy. Consumer L. Rev.* 375, 381–83, 391–93 (2005) (describing EPSDT provisions and their enforceability through § 1983).

15. *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 434 (2004). This case was brought, not under the availability provision, but under 42 U.S.C. § 1396a(a)(43)(B)–(C), which requires states to "provid[e] or arrang[e] for the provision of . . . screening services in all

Two recent changes have thrown into question the continued enforceability of the availability provision through § 1983 litigation. First, in 2002, the Supreme Court's decision in *Gonzaga University v. Doe* created more stringent requirements for the enforcement of federal statutes through § 1983 by requiring a showing of explicit congressional intent within the statute to confer an enforceable individual right.¹⁶ As a result of *Gonzaga*, two other Medicaid provisions, the "equal access" provision in § 1396a(a)(30),¹⁷ and the "reasonable standards" provision in § 1396a(a)(17), have been rendered unenforceable in a majority of circuits that have addressed the question.¹⁸ Second, the Deficit Reduction Act of 2005 (DRA) ushered in a number of changes to the overall Medicaid scheme that allow states flexibility in the way they provide benefits to certain groups. Before the DRA, the Act enumerated a list of benefits that a state must provide for *all* qualifying individuals.¹⁹ The DRA, however, allows states to enroll some individuals in specified types of pre-existing non-Medicaid health plans, without specifically requiring that the plan cover particular services.²⁰ In *Gonzaga*, the Court implied that, despite clear and unambiguous rights-creating language in a provision, the *structure* of an Act as a whole may indicate Congress did not intend for a plaintiff to have a right enforceable through § 1983.²¹ Thus, the argument goes, the DRA has dramatically altered the structure of the Medicaid Act so as to render the availability provision unenforceable

cases where they are requested" and arrange for "corrective treatment." A Texas district court had issued a consent decree, and in *Hawkins* the Court held that enforcing the consent decree does not violate the Eleventh Amendment. *Hawkins*, 540 U.S. at 439.

16. 536 U.S. 273, 283–86 (2002).

17. See Andrew R. Gardella, Note, The Equal Access Illusion: A Growing Majority of Federal Courts Erroneously Foreclose Private Enforcement of § 1396a(a)(30) of the Medicaid Act Using 42 U.S.C. § 1983, 38 U. Mem. L. Rev. 697, 706 (2008) (noting majority of circuits that examined § 1396a(a)(30) found it unenforceable under *Gonzaga* analysis). The "equal access" provision of the Medicaid Act states that "[a] State plan for medical assistance must . . . provide such methods and procedures . . . so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A) (2006).

18. The Eighth and Ninth Circuits have held § 1396a(a)(17) unenforceable through § 1983. See *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006) ("As the statute sets forth only broad, general goals, . . . plaintiffs do not have a private right of action to enforce Medicaid's reasonable-standards provision under section 1983."); *Watson v. Weeks*, 436 F.3d 1152, 1155 (9th Cir. 2006) ("We . . . hold that section 1396a(a)(17) does not create . . . an individual right [under § 1983]."). Section 1396a(a)(17) provides that a state Medicaid plan must "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan." § 1396a(a)(17).

19. The availability provision requires that states make "medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) [of the Act]." § 1396a(a)(10). Among the services included in the referenced subsection are inpatient and outpatient hospital services, laboratory and X-ray services, nursing facility services, EPSDT services, and physician or nursing care. § 1396d(a).

20. § 1396u-7.

21. *Gonzaga*, 536 U.S. at 286.

through § 1983.²² Currently under the availability provision, if a state chooses to participate in Medicaid it must “make[] medical assistance available” for all eligible individuals.²³ If this section of the Medicaid Act is rendered unenforceable, the traditional method by which individuals can sue noncompliant states, § 1983, will be foreclosed.²⁴

This Note argues that the availability provision still confers individual rights enforceable through § 1983, despite *Gonzaga*'s heightening of the enforceability standard and the DRA's changing of the content of these rights. Part I describes the cases that delineate which rights are enforceable under § 1983, and discusses the Court's seminal *Gonzaga* decision. In addition, Part I outlines two of the DRA's most significant changes to the Medicaid Act. Part II builds on this foundation by discussing post-*Gonzaga* circuit and district court cases that address the availability provision's enforceability through § 1983, but do not discuss the DRA's changes to the Act. Furthermore, Part II introduces the problem of whether the DRA sufficiently changed the structure of the Medicaid Act so as to render the availability provision unenforceable. It also outlines other recent developments that may affect how courts answer this question. Part III then applies the reasoning of the post-*Gonzaga* cases discussed in Part II to the “new” post-DRA Medicaid Act. It concludes that despite the DRA's significant changes to the Medicaid scheme, it has not sufficiently altered the structure of the Act to negate the availability provision's strong rights-creating language.

22. See Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. Davis L. Rev. 413, 418 (2008) (arguing DRA “change[s] Medicaid from a program of promised care and benefits into one of no enforceable promises”); Jon Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 Yale L.J. 1498, 1523 (2008) (“The fact that states under the DRA have the option of fundamentally restructuring Medicaid's basic benefit packages severely undercuts any claim to enforceability through § 1983.”).

23. § 1396a(a)(10).

24. A number of commentators have noted that bringing a preemption suit based on the Supremacy Clause is a viable alternative to § 1983 suits. See, e.g., Lauren K. Saunders, *Preemption as an Alternative to Section 1983*, Clearinghouse Rev. J. Poverty L. & Pol'y, Mar.–Apr. 2005, at 705 (discussing how preemption cause of action can be used by public interest advocates); David Sloss, *Constitutional Remedies for Statutory Violations*, 89 Iowa L. Rev. 355, 361 (2004) (noting possibility of preemption cause of action “assumes added significance in light of the Court's recent decision in *Gonzaga University v. Doe*”); Harper Jean Tobin & Rochelle Bobroff, *The Continuing Viability of Medicaid Rights After the Deficit Reduction Act of 2005*, 118 Yale L.J. Pocket Part 147, 149–51 (2009), at <http://the-pocketpart.org/2009/02/09/tobinbobroff.html> (on file with the *Columbia Law Review*) (arguing preemption as best alternative to § 1983 in availability provision context). No federal courts have addressed whether the availability provision can preempt a state Medicaid plan. This question, while interesting, is outside the scope of this Note.

I. THE ENFORCEABILITY OF FEDERAL STATUTES THROUGH § 1983

Section 1983 allows a plaintiff to sue in federal court for a deprivation of her civil rights.²⁵ Specifically, she may sue under § 1983 for the “deprivation of any rights, privileges, or immunities secured by the Constitution *and laws*.”²⁶ Though the text of the statute clearly seems to provide a remedy for the deprivation of rights created by federal law, the Supreme Court has limited the type of federal statutes that can be enforced through § 1983. Part I.A surveys the early doctrine in this area, setting out the various restrictions that the Court placed on enforcing federal statutory rights through § 1983. Part I.B then discusses *Gonzaga University v. Doe*,²⁷ which sets the new standard in § 1983 jurisprudence. This background will provide a crucial foundation for Part II, which discusses post-*Gonzaga* case law that has addressed the § 1983 enforceability of the availability provision. Finally, Part I.C outlines two of the DRA’s most important changes to the Medicaid Act. These changes will set the stage for Part III, where this Note discusses the extent to which the DRA affected the overall structure of the Act, and concludes that the availability provision remains enforceable through § 1983 despite these changes.

A. *Pre-Gonzaga Enforceability of Federal Statutes Under § 1983*

1. *History of § 1983*. — Congress enacted § 1983 as part of the Civil Rights Act of 1871²⁸ in response to two concerns. First, Congress passed the Civil Rights Act, also known as the Ku Klux Klan Act,²⁹ as a reaction to the lawlessness of the South at the time, and many state governments’ inability, or unwillingness, to deal with it.³⁰ Specifically, what motivated Congress was “not the unavailability of state remedies but the failure of certain States to enforce the laws with an equal hand.”³¹ Second, in addition to preventing constitutional violations, § 1983 was designed to provide a remedy to plaintiffs for the deprivation of their federal rights by state government actors.³²

Despite congressional intent, § 1983 lay dormant for many years³³ and did not become a driving force in civil rights law until the 1961 case

25. See Liam J. Montgomery, Note, The Unrealized Promise of Section 1983 Method-of-Execution Challenges, 94 Va. L. Rev. 1987, 1988 (2008) (describing § 1983 as “the central cause of action in federal civil rights litigation”).

26. § 1983 (emphasis added).

27. 536 U.S. 273 (2002).

28. Ch. 22, 17 Stat. 13. Congress passed the Act using its Section 5 enforcement powers of the Fourteenth Amendment. *Monroe v. Pape*, 365 U.S. 167, 171 (1961), overruled in part by *Monell v. Dep’t of Soc. Servs.*, 436 U.S. 658 (1978).

29. Sheldon H. Nahmod et al., *Constitutional Torts* 3 (LexisNexis 2d ed. 2004).

30. *Monroe*, 365 U.S. at 174–75.

31. *Id.* at 174.

32. Nahmod, *supra* note 29, at 3 (citing *Carey v. Piphus*, 435 U.S. 247 (1978)).

33. See *id.* at 4 (noting that restrictive application of state action doctrine, narrow reading of Fourteenth Amendment’s Privileges and Immunities Clause, and Supreme

of *Monroe v. Pape*,³⁴ which recognized § 1983 as “afford[ing] a federal right in federal courts” for civil rights abuses.³⁵ *Monroe* resuscitated § 1983 in two distinct ways when it determined that plaintiffs had a right to sue based on an unconstitutional search and seizure of their home by a group of thirteen Chicago police officers.³⁶ First, the Court determined that the policemen were acting “under color of state law,” even though they “abuse[d]” their positions of power when they broke into petitioners’ apartment in violation of the Constitution and Illinois state law.³⁷ Second, the Court rejected the argument that § 1983 embraced only the then-narrow set of rights based on national citizenship—such as the prohibition against ex post facto laws³⁸—and not the broader set of rights derived from state citizenship.³⁹ As a result of these important holdings,

Court’s initial refusal to completely incorporate the Bill of Rights all contributed to § 1983’s dormancy).

34. 365 U.S. 167, 167 (1961); see also Note, Limiting the Section 1983 Action in the Wake of *Monroe v. Pape*, 82 Harv. L. Rev. 1486, 1486–87 (1969) (noting that incorporation of Bill of Rights through Fourteenth Amendment, *Monroe*, and Supreme Court decisions holding exhaustion of state remedies is not necessary to maintain § 1983 action all “significantly broadened the applicability of section 1983”).

35. *Monroe*, 365 U.S. at 180. To understand the scale of this decision, consider that in 1961, the year *Monroe* was decided, there were approximately 150 nonprisoner § 1983 cases filed. By 1986, there were approximately 10,000. Louise Weinberg, *The Monroe Mystery Solved: Beyond the “Unhappy History” Theory of Civil Rights Litigation*, 1991 BYU L. Rev. 737, 738 n.9; see also Richard H. Fallon, Jr. et al., *Hart and Wechsler’s The Federal Courts and The Federal System* 955 (6th ed. 2009) (listing over 20,000 civil rights suits by nonprisoners, including cases not filed under § 1983).

36. *Monroe*, 365 U.S. at 169–71. The group of police broke into petitioners’ home without an arrest warrant in the early morning and forced them to stand naked in the living room while they ransacked the house. They then took Mr. Monroe to the police station and detained him for ten hours without allowing him to call his family or attorney. Afterwards, they released Monroe without charging him with any crime. *Id.* at 169.

37. *Id.* at 171–72. The Court here followed its decisions in prior cases having to do with the criminal counterparts to § 1983. In *United States v. Classic*, 313 U.S. 299, 326 (1941), then-Associate Justice Stone noted that “[m]isuse of power, possessed by virtue of state law and made possible only because the wrongdoer is clothed with the authority of state law, is action taken under color of state law.” This meaning of “under color of state law” was reaffirmed in *Screws v. United States*, 325 U.S. 91, 108–13 (1945), where the Court noted that reading “under color of state law” more restrictively would “emasculate an Act of Congress designed to secure individuals their constitutional rights by finely spun distinctions concerning the precise scope of the authority of officers of the law”; see also David Achtenberg, *A “Milder Measure of Villainy”: The Unknown History of 42 U.S.C. § 1983 and the Meaning of “Under Color of” Law*, 1999 Utah L. Rev. 1, 5 (detailing legislative history of § 1983 that “should dispel the remarkably persistent myth that the Forty-second Congress never intended the provision to cover constitutional wrongs unless those wrongs were actually authorized by state law”).

38. See *Slaughter-House Cases*, 83 U.S. 36, 76–77 (1872) (providing examples of “the very few express limitations which the Federal Constitution imposed upon the States”).

39. *Monroe*, 365 U.S. at 170. Prior cases had construed Reconstruction-era laws as covering only “federal” rights. See, e.g., *United States v. Williams*, 341 U.S. 70, 73 (1951) (holding statute criminalizing any “conspiracy against rights” covered only conduct that interfered with rights “arising from the substantive powers of the Federal Government”). At the time, the Court’s understanding of state citizenship was expansive, as opposed to its

§ 1983 has served as a tool for plaintiffs bringing actions in federal court alleging violations of constitutional rights by persons acting under color of state law, whether or not they are acting outside of their authority, or depriving what had traditionally been seen as “federal” rights.⁴⁰

In 1871, when § 1983 was originally passed, it did not provide a remedy for federal statutory violations. In other words, it provided only remedies for *constitutional* violations.⁴¹ Three years later, in 1874, Congress amended the Act to insert the phrase “and laws” when it reorganized and recodified all federal statutes.⁴² Congress did not intend this recodification to amend any existing law—only to clarify and simplify the law on the books—and there was no discussion on the floor of Congress regarding the “and laws” addition.⁴³ The opaque origin of § 1983’s “and laws” provision eventually forced the Supreme Court to address the issue of *what* laws were enforceable through § 1983.

2. *Early Cases Dealing with the Enforceability of Federal Statutes Through § 1983.* — Not all federal laws are enforceable through § 1983. Section 1983 contains no substantive rights: It is only a vehicle to get into court for the deprivation of rights enumerated elsewhere.⁴⁴ Thus, as a threshold matter, to make out a claim under § 1983, plaintiffs must assert a violation of an appropriate right.⁴⁵ Although since the 1874 recodifica-

restrictive view of federal citizenship under the *Slaughter-House Cases*, 83 U.S. at 76 (noting privileges and immunities of state citizenship “are *fundamental*; which belong of right to the citizens of all free governments, and which have at all times been enjoyed by citizens of the several States which compose this union” (quoting *Corfield v. Coryell*, 6 F. Cas. 546, 551 (C.C.E.D. Pa. 1823) (No. 3230))).

40. Section 1983 is limited to the deprivations of rights by “[e]very person who, *under color of any statute, ordinance, regulation, custom, or usage, of any State or the District of Columbia*, subjects, or causes to be subjected . . . [any person] to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws.” 42 U.S.C. § 1983 (2006) (emphasis added). Under certain conditions, private parties, as well as state actors, can be sued under § 1983. However, examining the “under color of state law” test is outside the scope of this Note.

41. Civil Rights Act of 1871, ch. 22, 17 Stat. 13.

42. 1 Rev. Stat. 348 (1875); see also Lisa E. Key, *Private Enforcement of Federal Funding Conditions Under § 1983: The Supreme Court’s Failure to Adhere to the Doctrine of Separation of Powers*, 29 U.C. Davis L. Rev. 283, 304 (1996) (detailing early history of § 1983).

43. Key, *supra* note 42, at 304–05. There are three main theories regarding this change. The “Consistency Theory” and the “No Modification Theory” both assert that the revisers intended “and laws” to mean “and laws providing for equal rights,” limiting the use of § 1983 to violations of federal laws providing for equal rights. In contrast, the “Plain Meaning Theory” does not advocate such a restriction of § 1983, instead suggesting that “and laws” should be given its literal meaning and apply to all federal statutes. For a more thorough discussion of these theories, see *id.* at 306–13.

44. The Court has noted that “one cannot go into court and claim a ‘violation of § 1983’—for § 1983 by itself does not protect anyone against anything.” *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 617 (1979).

45. See *Nahmod et al.*, *supra* note 29, at 101 (“The availability of a cause of action only gets the plaintiff into the courthouse. In order to prevail, the plaintiff must prove a substantive constitutional (or, in certain circumstances, a statutory) violation.”).

tion § 1983 had provided a remedy for violations of rights under the Constitution “and laws,” it was not until 1980 that the Supreme Court first addressed, at any length, the question of whether federal statutes were enforceable through § 1983.⁴⁶

In *Maine v. Thiboutot*, the Court addressed the meaning of “and laws.” The question was whether the phrase “means what it says” or whether only particular laws are enforceable through § 1983.⁴⁷ Justice Brennan, writing for the Court, first looked to the text of § 1983. He determined that its plain language “undoubtedly embraces” violations of both federal statutory and constitutional law.⁴⁸ The Court also briefly addressed the legislative history of the “and laws” addition in 1874, but found that it did not offer a clear answer.⁴⁹ Ultimately, the Court remained convinced that in the absence of definitive contrary congressional intent, the “plain language” of § 1983 prevails, and it applies to both constitutional and statutory rights.⁵⁰

Despite *Thiboutot*'s broad language, not all federal statutes are enforceable through § 1983. Soon after *Thiboutot*, the Court began to articulate the types of federal statutes that give rise to enforceable rights. First, then-Associate Justice Rehnquist, who had dissented in *Thiboutot*, limited the scope of Justice Brennan's opinion: In *Pennhurst State School and Hospital v. Halderman*, the Court held that the Developmentally Disabled Assistance and Bill of Rights Act of 1975 does not create judicially enforceable substantive rights for the disabled.⁵¹ When addressing if the Act creates enforceable rights, the Court asked “whether Congress . . . imposed an *obligation* on the States . . . or whether it spoke merely in *precatory* terms.”⁵² Ultimately, the Court found that neither the text of the statute nor its legislative history demonstrate that Congress intended to impose a binding obligation on the states to provide better services to the developmentally disabled.⁵³

In the Court's next case addressing the enforceability of federal statutes under § 1983, it found Congress had indeed intended to create an enforceable right. In *Wright v. City of Roanoke Redevelopment and Housing*

46. The Court did briefly address the “and laws” issue in dicta in *Holt v. Indiana Manufacturing Co.*, 176 U.S. 68 (1900). While deciding whether a circuit court had jurisdiction to hear the case, the Court drew an analogy between the statute at issue and § 1983, noting that “it is sufficient to say that [both statutes] refer to civil rights only, and are inapplicable here.” *Id.* at 72. Though the dissent in *Maine v. Thiboutot*, 448 U.S. 1, 27–28 (1980) (Powell, J., dissenting), cites to *Holt*, the Court did not adopt *Holt*'s attempt to cabin the enforceability of statutory rights under § 1983.

47. 448 U.S. at 4.

48. *Id.*

49. *Id.* at 7.

50. *Id.* at 7–8.

51. See 451 U.S. 1, 18 (1981) (“There is virtually no support for the lower court's conclusion that Congress created rights and obligations pursuant to its power to enforce the Fourteenth Amendment.”).

52. *Id.* (emphasis added).

53. *Id.* at 19.

Authority, the Court held that the Brooke Amendment to the Housing Act of 1937—providing that a state cannot charge low-income families more than thirty percent of their adjusted income for affordable housing⁵⁴—creates enforceable rights.⁵⁵ Using the mandatory/precatory distinction articulated in *Pennhurst*, the Court concluded that because the statute at issue created a binding, as opposed to suggestive, limitation on the states regarding maximum allowable rent, it provides a right enforceable through § 1983.⁵⁶

3. *The Court's Three-Part Test for Determining the Enforceability of a Federal Statute.* — In *Wilder v. Virginia Hospital Ass'n*, the Court established a test to determine whether a plaintiff may sue to enforce a particular statute through § 1983.⁵⁷ At issue was whether a health care provider could challenge a state's Medicaid reimbursement scheme under § 1983.⁵⁸ Specifically, the Medicaid Act's Boren Amendment required reimbursement to health care providers at rates that the state finds to be "reasonable and adequate."⁵⁹ In addressing the question of whether the Boren Amendment created a right enforceable through § 1983, the Court established a three-part test.⁶⁰ First, a court must ask whether Congress intended the provision to benefit the plaintiff.⁶¹ If so, the statute creates an enforceable right unless either (1) the provision reflects mere congressional preference, as opposed to imposing a binding obligation on the state,⁶² or, (2) the right asserted "is too vague and amorphous such that it is beyond the competence of the judiciary to enforce."⁶³ The Court then applied the provisions of the Boren Amendment to the test, and concluded that the statute did create enforceable rights.⁶⁴

In *Suter v. Artist M.*,⁶⁵ the Court's next case on the issue, it found the Adoption Assistance and Child Welfare Act of 1980⁶⁶ unenforceable, but did not apply the *Wilder* three-part test.⁶⁷ The Act in question provides for the federal reimbursement of certain state expenses in administering its foster care and adoption services.⁶⁸ It states that in each case, "*reasona-*

54. 42 U.S.C. § 1437a (2006).

55. 479 U.S. 418, 432 (1987).

56. *Id.* at 431–32.

57. 496 U.S. 498, 509 (1990). Like in *Thiboutot*, Justice Brennan wrote the majority opinion. See *id.* at 501. Chief Justice Rehnquist signed on to the dissent in *Thiboutot*; here he wrote the dissenting opinion. See *id.* at 524 (Rehnquist, C.J., dissenting).

58. *Id.* at 501 (majority opinion).

59. 42 U.S.C. § 1396a(a)(13)(A) (1994).

60. *Wilder*, 496 U.S. at 509.

61. *Id.*

62. *Id.*

63. *Id.* (citations omitted) (internal quotation marks omitted).

64. *Id.* at 512.

65. 503 U.S. 347 (1992). By this time, Justice Brennan had retired and Chief Justice Rehnquist wrote for a 7-2 majority. See *id.* at 348.

66. 42 U.S.C. §§ 621–628, 670–679a (2006).

67. *Suter*, 503 U.S. at 363.

68. *Id.* at 350–51.

ble efforts shall be made” before the child is placed in foster care to prevent the need for removal from the home, and after the child is removed from the home to make it possible for the child to return to the home as quickly as possible.⁶⁹ After examining the text and structure of the statute, the Court concluded that the “reasonable efforts” language did not create an unambiguously conferred right enforceable through § 1983 because it appeared “to impose only a rather generalized duty” on the state, which was not intended to be enforced by private individuals.⁷⁰

In response to this holding, Congress enacted the “*Suter* fix”⁷¹ in 1995, which, though it did not overturn *Suter* as applied to the particular provision at issue, negated much of *Suter*’s reasoning.⁷² With the *Suter* fix, Congress passed an amendment to the Medicaid Act, which provides that a statutory provision “is not to be deemed unenforceable because of its inclusion in a section of [the Medicaid Act] requiring a State plan or specifying the required contents of a State plan.”⁷³

The Court reaffirmed its three-part *Wilder* test in *Blessing v. Freestone*.⁷⁴ The respondents in *Blessing* were mothers of children who were eligible to receive child support services from the state under Title IV-D of the Medicaid Act.⁷⁵ The relevant provision authorizes the Secretary of Health and Human Services to penalize a state by reducing its Temporary Assistance for Needy Families (TANF) grant by up to five percent if it fails to “substantially comply” with Title IV-D’s requirements.⁷⁶ The plaintiffs sued under § 1983, asserting that Title IV-D gave them an enforceable right to have the state’s child support program achieve “substantial compliance” with the Title’s requirements.⁷⁷

69. § 671(a)(15) (emphasis added).

70. *Suter*, 503 U.S. at 363.

71. § 1320a-2. The term “*Suter* fix” first appears in the scholarship in 2002, and in the courts in 2006. See Eric E. Thompson, *The Adoption and Safe Families Act: A New Private Right of Action for Children in Foster Care Pursuant to Section 1983*, 6 U.C. Davis J. Juv. L. & Pol’y 123, 127 (2002) (using term as section heading in article); see also Watson v. Weeks, 436 F.3d 1152, 1158 (9th Cir. 2006) (“Congress responded to [*Suter*] by enacting the ‘*Suter* fix,’ 42 U.S.C. § 1320a-2, which blocks any Medicaid Act provision from being deemed unenforceable by an individual merely because the provision contains state plan requirements.”).

72. See Sasha Samberg-Champion, Note, *How to Read Gonzaga: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 Colum. L. Rev. 1838, 1850–51 (2003) (noting *Suter* was first repudiated by lower courts and then by Congress).

73. § 1320a-2.

74. 520 U.S. 329 (1997).

75. *Id.* at 332 (citing §§ 651–669b). Respondents complained that they had applied for child support services, but Arizona’s child support agency failed to take adequate steps to obtain payments from their children’s fathers. *Id.* at 337.

76. § 609(a)(8). Though the program is now referred to as TANF, at the time of *Blessing* it was still known as Aid to Families with Dependent Children (AFDC).

77. *Blessing*, 520 U.S. at 332–33.

Before turning to whether Title IV-D of the Medicaid Act gave rise to a right enforceable through § 1983, the Court reasserted *Wilder's* three-part test:⁷⁸

First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so vague and amorphous that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States.⁷⁹

The Court applied this test to the case before it, and found that plaintiffs did not assert an enforceable right.⁸⁰ The claimed “right” failed the first prong of the test because the “substantial compliance” requirement in the Act was not intended to benefit individual children and custodial parents. Rather, the Secretary was to measure *systemwide* performance, not whether the state had provided adequate services to a particular person.⁸¹ Because it found Title IV-D of the Medicaid Act insufficiently individual-centered, the Court concluded that plaintiffs did not have a federally enforceable right.⁸²

78. The *Blessing* Court articulated the test in a different order than seen in *Wilder*. Subsequently, courts have used the *Blessing* ordering of the prongs. For consistency's sake, this Note uses the *Blessing* ordering as well. In addition, for clarity, this Note refers to this test as the “*Blessing* test.”

79. *Blessing*, 520 U.S. at 340–41 (citations omitted) (internal quotation marks omitted). The Court noted that even if all three prongs of the test are met and a plaintiff can show that a federal statute creates an individual right, this merely establishes a rebuttable presumption of enforceability through § 1983, and if Congress has “specifically foreclosed a remedy under § 1983,” the suit must be dismissed. *Id.* at 341 (quoting *Smith v. Robinson*, 468 U.S. 992, 1005 n.9 (1984)). Congress may do so explicitly in the statute, or implicitly “by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983.” *Id.* (citing *Livadas v. Bradshaw*, 512 U.S. 107, 133 (1994)). It is unclear in precisely what situations an enforcement mechanism will supplant § 1983 enforcement. See, e.g., *Fitzgerald v. Barnstable Sch. Comm.*, 129 S. Ct. 788, 795–96 (2009) (holding because Title IX does not contain express private remedy, neither administrative procedure resulting in withdrawal of federal funding nor implied right of action under Title IX precludes suit under § 1983); *City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 122 (2005) (“The ordinary inference [is] that the remedy provided in the statute is exclusive . . .”); *Middlesex County Sewerage Auth. v. Nat’l Sea Clammers Ass’n*, 453 U.S. 1, 13, 20 (1981) (finding congressional intent to displace § 1983 remedies through “elaborate” and “comprehensive enforcement mechanism[s]”). The Supreme Court has explicitly rejected the argument that “Congress has foreclosed enforcement of the Medicaid Act under § 1983.” *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 520 (1990).

80. *Blessing*, 520 U.S. at 344–45.

81. *Id.*

82. *Id.* In his concurring opinion, Justice Scalia raised the possibility that § 1983 never “authorizes the beneficiaries of a federal-state funding and spending agreement—such as Title IV-D—to bring suit.” *Id.* at 349 (Scalia, J., concurring). He noted that such federal-state funding agreements are “‘in the nature of a contract,’” and likened the respondents in the case to third party beneficiaries, “stranger[s] to the contract” with no right to sue under it. *Id.* (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). Justice Scalia continues to assert this argument. See *Pharm. Research & Mfrs. v. Walsh*, 538 U.S. 644, 675 (2003) (Scalia, J., concurring) (“I would reject petitioner’s

In summary, through the late 1990s, individual rights pursuant to federal-state funding programs could be enforced in federal court through § 1983 if the provisions at issue met the three-part test articulated in *Wildier* and *Blessing*. However, this test, and the Court's jurisprudence on the enforceability of statutory rights through § 1983, was thrown into question by the Court's most recent case on this issue.

B. *Gonzaga University v. Doe*—*The New Standard for § 1983 Enforceability*

Gonzaga University v. Doe,⁸³ the Court's most recent decision in its § 1983 enforceability jurisprudence, establishes an important new standard by which all federal statutes have since been measured. According to *Gonzaga*, the crux of the enforceable rights inquiry turns on congressional intent. Admitting that the three-part *Blessing* test may have led to confusion,⁸⁴ the court reiterated that "anything short of an unambigu-

statutory claim on the ground that the remedy for the State's failure to comply with the obligations it has agreed to undertake under the Medicaid Act . . . is set forth in the Act itself: termination of funding by the Secretary of the Department of Health and Human Services."); *Barnes v. Gorman*, 536 U.S. 181, 186–87 (2002) (Scalia, J.) (discussing scope of contract analogy); cf. *Walsh*, 538 U.S. at 683 (Thomas, J., concurring) ("This contract analogy raises serious questions as to whether third parties may sue to enforce Spending Clause legislation . . .").

83. 536 U.S. 273 (2002). Most commentators agree that *Gonzaga* drastically changed the landscape of § 1983 enforcement case law. See, e.g., Brian J. Dunne, Enforcement of the Medicaid Act Under 42 U.S.C. § 1983 After *Gonzaga University v. Doe*. The "Dispassionate Lens" Examined, 74 U. Chi. L. Rev. 991, 999 (2007) (noting *Gonzaga* "marked [a] departure from the more broad-based inquiry into legislative intent demonstrated in *Wildier* and other Court precedent"); Bradford C. Mank, Suing Under § 1983: The Future After *Gonzaga University v. Doe*, 39 Hous. L. Rev. 1417, 1419–20 (2003) [hereinafter Mank, Suing Under § 1983] ("While it does not purportedly change the prevailing three-part enforcement test for § 1983, the *Gonzaga* decision places a heavy and unnecessary burden of proof on plaintiffs . . ." (footnote omitted)); Donenberg, *supra* note 22, at 1520 (noting commentators believe *Gonzaga* "indicates significant hostility toward arguments that Spending Clause legislation confers enforceable rights under § 1983"); Samberg-Champion, *supra* note 72, at 1886 ("*Gonzaga*, if followed to some of its logical (if unstated) conclusions, could radically reshape the legal system."). For an example of *Gonzaga*'s leading the courts to find federal statutes unenforceable, see *supra* notes 17–18 and accompanying text.

84. The *Gonzaga* Court sought to refine and synthesize its prior case law, noting that "our opinions in this area may not be models of clarity." *Gonzaga*, 536 U.S. at 278. However, because the opinion did not seem to follow the three-part *Blessing* test, *Gonzaga* has created confusion among courts as to whether the decision merely clarified the *Blessing* test or supplanted it. Some lower courts think *Gonzaga* speaks only to the first prong of the *Blessing* test, and others now substitute *Gonzaga* for *Blessing*. For examples of the former approach, see, e.g., *Ball v. Rodgers*, 492 F.3d 1094, 1104–06 (9th Cir. 2007); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1146–48 (10th Cir. 2006); *Westside Mothers v. Olszewski (Westside Mothers II)*, 454 F.3d 532, 541–42 (6th Cir. 2006); *Lankford v. Sherman*, 451 F.3d 496, 508–09 (8th Cir. 2006); *Harris v. Olszewski*, 442 F.3d 456, 461, 463 (6th Cir. 2006); *Watson v. Weeks*, 436 F.3d 1152, 1160 (9th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1056–57 (9th Cir. 2005); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602–04 (5th Cir. 2004); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 183, 186–87 (3d Cir. 2004). For examples of the latter approach, see, e.g., *Equal Access for El Paso, Inc. v. Hawkins*, 509

ously conferred right” will not support a § 1983 action.⁸⁵ The *Gonzaga* Court would require Congress to “‘speak[] with a clear voice,’ and manifest[] an ‘unambiguous’ intent to confer individual rights” enforceable through § 1983.⁸⁶

Under *Gonzaga*, both the text and structure of an act are relevant to the § 1983 inquiry. As a threshold matter, the text of a statute must confer individual rights: “For a statute to create such private rights, its *text* must be ‘phrased in terms of the persons benefited.’”⁸⁷ However, under

F.3d 697, 702–04 (5th Cir. 2007); *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456–57 (7th Cir. 2007); *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 73 n.10 (1st Cir. 2005); *Rabin v. Wilson-Coker*, 362 F.3d 190, 201–02 (2d Cir. 2004); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004); *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003).

For discussion in the literature about this confusion, see Deborah N. Archer & Kele S. Williams, Making America “the Land of Second Chances”: Restoring Socioeconomic Rights for Ex-Offenders, 30 N.Y.U. Rev. L. & Soc. Change 527, 557 (2006) (“Interpretation of *Gonzaga* has created widespread disagreement among the lower federal courts.”); Huberfeld, *supra* note 22, at 442 (“*Gonzaga*’s legacy is a hodgepodge of lower court decisions.”); Samberg-Champion, *supra* note 72, at 1839 (“[T]he decision is a murky one and already has led to widespread disagreement in the lower federal courts.”).

85. *Gonzaga*, 536 U.S. at 283. The Court noted that “it is *rights*, not the broader or vaguer ‘benefits’ or ‘interests,’ that may be enforced under the authority of that section.” *Id.*

86. *Id.* at 280 (citing and quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 28 & n.21 (1981)). This “clear statement” requirement is a result of federalism concerns underlying congressional Spending Clause enactments. For a discussion of considerations that should inform judicial decisionmaking regarding Medicaid enforceability—including federalism, the cost of medical treatment, and public health—see Dunne, *supra* note 83, at 1012–21.

87. *Gonzaga*, 536 U.S. at 284 (emphasis added) (quoting *Cannon v. Univ. of Chicago*, 441 U.S. 677, 692 n.13 (1979)).

Gonzaga incorporated the Court’s implied right of action cases—by which a court will infer a remedy into a statute that is silent on the subject—into its § 1983 inquiry. See Richard H. Fallon, Jr. et al., *Hart and Wechsler’s The Federal Courts and The Federal System* 787 (5th ed. 2003) (noting *Gonzaga* “narrowed the gap between implied right of action and § 1983 decisions”). Dissenting in *Gonzaga*, Justice Stevens argued that the majority’s merging of the implied right of action cases into the § 1983 inquiry “is inappropriate” because the former do not distinguish between rights and remedies. *Gonzaga*, 536 U.S. at 301 (Stevens, J., dissenting). “Moreover, by circularly defining a right actionable under § 1983 as, in essence, ‘a right which Congress intended to make enforceable,’ the Court has eroded—if not eviscerated—the long-established principle of presumptive enforceability of rights under § 1983.” *Id.* at 302. Up until this point, these two lines of cases had been distinct and parallel routes by which a plaintiff could find rights enforceable in federal court. The *Gonzaga* Court stated that henceforth, implied right of action cases “should guide the determination of whether a statute confers rights enforceable under § 1983.” *Id.* at 283 (majority opinion). Though the two lines of cases represent different inquiries, they “overlap in one meaningful respect—in either case we must first determine whether Congress *intended to create a federal right*.” *Id.*

A full importation of the implied right of action line of cases into § 1983 jurisprudence may effectively switch the presumption away from enforceable rights. In *Gonzaga*’s § 1983 analysis, the Court explained that a plaintiff need only point to a right that Congress intended to create, but does not need to show that Congress intended to provide a remedy. See *id.* at 284 (“Once a plaintiff demonstrates that a statute confers an

Gonzaga the structure of the act at issue is also relevant; the Court noted that “where the text *and structure* of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit.”⁸⁸

When the *Gonzaga* Court applied its test to the statute at issue, the Family Educational Rights and Privacy Act of 1974 (FERPA),⁸⁹ it found that FERPA does not create enforceable rights.⁹⁰ The relevant portion of FERPA provides that “no funds shall be made available” to an educational institution with “a policy or practice of permitting the release of education records” to unauthorized persons.⁹¹ FERPA also states that funds can only be terminated if the Secretary of Education determines that an institution “is failing to *comply substantially* with any requirement” of FERPA.⁹²

The Court concluded that these provisions were unenforceable for two reasons: they lacked “rights-creating” language and did not focus on the *individuals* protected under FERPA.⁹³ First, the Court contrasted the language in FERPA with that in Title VI of the Civil Rights Act of 1964⁹⁴ and Title IX of the Education Amendments of 1972,⁹⁵ both of which it previously had found to contain an implied right of action.⁹⁶ As opposed

individual right, the right is presumptively enforceable by § 1983.”). Section 1983 itself provides the remedy. See 42 U.S.C. § 1983 (2006) (providing those who violate rights “shall be liable”); see also *Gonzaga*, 536 U.S. at 285 (“[Section 1983] merely provides a mechanism for enforcing individual rights . . . ‘secured by the Constitution and laws’ of the United States.”); *Save Our Valley v. Sound Transit*, 335 F.3d 932, 952 (9th Cir. 2003) (Berzon, J., dissenting) (“Section 1983 . . . undisputably *does* create a right of action. Indeed, that is all it does”); Erwin Chemerinsky, *Federal Jurisdiction* 570 (2007) (“Section 1983 expressly creates a remedy in its authorization for both money damages and injunctive relief.”). In contrast, in *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001), decided just a year before *Gonzaga*, the Court stated that in the implied right of action inquiry “[t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy.” The Court in *Sandoval* focused its implied right of action analysis on whether Congress intended private remedies to enforce the rights created by the regulation. *Id.* at 291. Thus, if lower courts import wholesale *Sandoval*’s analysis into the § 1983 case law, they will require a § 1983 plaintiff to prove Congress intended to create both a right and a remedy, thus undermining the significance of § 1983.

88. *Gonzaga*, 536 U.S. at 286 (emphasis added).

89. 20 U.S.C. § 1232g (2006).

90. *Gonzaga*, 536 U.S. at 290.

91. § 1232g(b)(1).

92. *Id.* § 1234c(a) (emphasis added).

93. *Gonzaga*, 536 U.S. at 287 (quoting *Alexander v. Sandoval*, 532 U.S. 275, 288–89 (2001)).

94. 42 U.S.C. § 2000d (2006).

95. 20 U.S.C. § 1681.

96. *Gonzaga*, 536 U.S. at 284. The Supreme Court recently held that Title IX’s implied right of action does not preempt plaintiffs from bringing constitutional claims under § 1983. See *Fitzgerald v. Barnstable Sch. Comm.*, 129 S. Ct. 788, 796–97 (2009) (“[W]e hold that § 1983 suits based on the Equal Protection Clause remain available to plaintiffs alleging unconstitutional gender discrimination in schools.”). For a discussion of

to the identical rights-creating language contained in those statutes, that “[n]o person . . . shall . . . be subjected to discrimination,”⁹⁷ FERPA provided that “[n]o funds shall be made available” to educational institutions with a prohibited “policy or practice.”⁹⁸ An important difference is the *focus* of the statute’s text: “Statutes that focus on the person regulated rather than the individuals protected create no implication of an intent to confer rights on a particular class of persons.”⁹⁹ In addition, like the unenforceable statute in *Blessing*, FERPA has an “aggregate focus” because it merely requires “substantial compliance,” rather than being concerned with whether an *individual’s* needs are satisfied under the statute.¹⁰⁰

Legislative history is also relevant to the *Gonzaga* inquiry. After discussing the text of the provision and the structure of the entire Act, the *Gonzaga* Court briefly mentioned the legislative history of FERPA, and concluded that “[i]t is implausible to presume . . . Congress . . . intended private suits to be brought.”¹⁰¹

Gonzaga represents a departure from prior case law addressing the enforceability of federal statutes through § 1983.¹⁰² In addition to articulating the more restrictive intent test, the decision implies that despite ambiguous rights-creating language in a specific provision at issue, the overall structure of an act may render rights unenforceable.¹⁰³ Because § 1983 represents “the primary vehicle for redressing civil rights violations in the federal courts,”¹⁰⁴ curtailing this remedy has drastic implications for the enforcement of federal statutes.¹⁰⁵ The enforceability of the

Gonzaga’s importation of the implied right of action jurisprudence into the § 1983 enforceability case law, see *supra* note 87.

97. 42 U.S.C. § 2000d; 20 U.S.C. § 1681.

98. *Gonzaga*, 536 U.S. at 287 (citing 20 U.S.C. § 1232g(b)(1) (2000)).

99. *Id.* (quoting *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001) (internal quotation marks omitted)).

100. *Id.* at 288 (citing *Blessing v. Freestone*, 520 U.S. 329, 343 (1997)). For a discussion of *Blessing’s* holding, see *supra* text accompanying note 82.

101. *Gonzaga*, 536 U.S. at 290.

102. For a sample of commentators’ discussion of the implications of *Gonzaga*, see *supra* notes 83–84.

103. See *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190 (2004) (noting § 1983 enforceability inquiry is “one of those instances in which our inquiry does not end with the plain language of the statute”); *Donenberg*, *supra* note 22, at 1523–26 (arguing DRA’s “serious structural modifications of Medicaid” override rights-creating language of availability provision).

104. Brian J. Sutherland, *Killing Jim Crow and the Undead Nondelegation Doctrine with Privately Enforceable Federal Regulations*, 29 *Seattle U. L. Rev.* 917, 922 n.30 (2006). Justice Blackmun noted that § 1983 stands for “the commitment of our society to be governed by law and to protect the rights of those without power against oppression at the hands of the powerful.” Harry A. Blackmun, *Section 1983 and Federal Protection of Individual Rights—Will the Statute Remain Alive or Fade Away?*, 60 *N.Y.U. L. Rev.* 1, 28 (1985).

105. See *Samberg-Champion*, *supra* note 72, at 1871–72 (noting one interpretation, “seen by some as the logical outgrowth of *Gonzaga*, effectively destroys Section 1983 as an

Medicaid Act, specifically, has been the focus of much of the post-*Gonzaga* litigation.¹⁰⁶

Although Medicaid has been the primary focus of most post-*Gonzaga* enforcement suits, courts have addressed a number of cases regarding such issues as education,¹⁰⁷ housing,¹⁰⁸ child support,¹⁰⁹ and adoption assistance¹¹⁰ under statutes passed using Congress's spending power. These cases show a general trend away from enforceability, and courts may use the reasoning in these cases as precedent for future availability provision suits.¹¹¹

C. Changes to the Medicaid Act Under the DRA

Medicaid is an essential part of health care in America because of its role in paying for the care of low-income, chronically ill, and disabled individuals,¹¹² but its complexity, size, skyrocketing cost, and propensity

independent remedy for statutory violations" (footnote omitted)); cf. Mank, *Suing Under § 1983*, supra note 83, at 1480 ("The *Gonzaga* decision will significantly harm the intended beneficiaries of federal grant-in-aid programs . . .").

106. See infra note 147 and accompanying text.

107. See, e.g., *Newark Parents Ass'n v. Newark Pub. Sch.*, 547 F.3d 199, 214 (3d Cir. 2008) ("Congress did not intend to give individuals a right to enforce the notice and supplemental education services provisions of the [No Child Left Behind] Act.").

108. See, e.g., *Johnson v. City of Detroit*, 446 F.3d 614, 623 (6th Cir. 2006) (finding no enforceable right under pertinent sections of Lead Based Paint Poisoning Prevention Act); *Caswell v. City of Detroit Hous. Comm'n*, 418 F.3d 615, 620 (6th Cir. 2005) (holding recipient did not have viable § 1983 claim under Section 8 of United States Housing Act for defendants' conduct in terminating housing subsidies after landlord initiated eviction proceedings); *Price v. City of Stockton*, 390 F.3d 1105, 1114 (9th Cir. 2004) (finding some provisions of Housing and Community Development Act create rights enforceable under § 1983, but others do not). But see *Johnson v. Hous. Auth.*, 442 F.3d 356, 360, 367 (5th Cir. 2006) (holding Section 8 of United States Housing Act created rights enforceable through § 1983, though noting this result was "a rarity, particularly after *Gonzaga*").

109. See, e.g., *Hughlett v. Romer-Sensky*, 497 F.3d 557, 563-64 (6th Cir. 2006) (holding no § 1983 enforceable right under Title IV-D of Social Security Act for full distribution of received child support payments to custodial parents within two days of receipt by State); *Arrington v. Helms*, 438 F.3d 1336, 1347 (11th Cir. 2006) (holding no enforceable § 1983 right to distribution of child support payments under Title IV-D of Social Security Act); *Walters v. Weiss*, 392 F.3d 306, 313 (8th Cir. 2004) (holding no enforceable § 1983 right under Title IV-D of Social Security Act to be free from administrative costs and fees for collection, distribution, and disbursement of child support payments).

110. See, e.g., *31 Foster Children v. Bush*, 329 F.3d 1255, 1274 (11th Cir. 2003) (holding no enforceable § 1983 right in provisions of Adoption Assistance Act).

111. Jane Perkins, *Nat'l Health Law Program, Fact Sheet: Developments Affecting Medicaid Cases Filed Under 42 U.S.C. § 1983*, at 8 (2008), available at <http://www.healthlaw.org/library/attachment.139385> (on file with the *Columbia Law Review*) [hereinafter Perkins, *Developments*] ("The court's reasoning in these decisions could represent precedent in your jurisdiction that will affect Medicaid.").

112. Rosenbaum, supra note 3, at 6-8. "Medicaid, in short, stands as the nation's central means of compensating for the lack of a unified, population-based system of health care finance, the consequence of which is the total or partial exclusion of tens of millions of persons who tend to be poorer and sicker than the norm." *Id.* at 8.

toward scandals have long made it a likely target for reform.¹¹³ The DRA was the product of several factors. First, the Medicaid Act is “among the most intricate [Acts] ever drafted by Congress,” with “Byzantine construction” that is “almost unintelligible to the uninitiated.”¹¹⁴ Second, the program is the nation’s largest insurer, with enrollment between forty and fifty million people¹¹⁵ and yearly federal and state expenditures of approximately \$333 billion.¹¹⁶ Third, in the beginning of the decade, Medicaid became a symbol of excessive government spending; the cost of the program increased by one-third between 2000 and 2003.¹¹⁷ Finally, Medicaid was plagued by a number of well-publicized scandals in which local governments were essentially embezzling money through the program.¹¹⁸ A number of different reforms were proposed, and the DRA—which allowed states to reduce the costs of their programs through flexible coverage design—emerged from Congress as the answer.¹¹⁹

The DRA, signed into law February 8, 2006 by President Bush,¹²⁰ changed many aspects of the Medicaid Act, including eligibility, scope of benefits, and fraud and abuse prevention.¹²¹ “At its core, the DRA dra-

113. *Id.* at 29. Rosenbaum conducted a Google search for the terms “Medicaid” and “unsustainable” in September 2005 that returned 33,700 hits. Similarly, “Medicaid” and “scam” returned 832,000 hits. *Id.* In July 2009, the same searches yielded, respectively, 184,000 and 259,000 hits.

114. *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting *Friedman v. Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976) (Friendly, J.)).

115. Ctrs. for Medicare and Medicaid Servs., Dep’t of Health & Human Servs., 2008 Actuarial Report on the Financial Outlook for Medicaid, at iii (2008), available at <http://www.cms.hhs.gov/ActuarialStudies/downloads/MedicaidReport2008.pdf> (on file with the *Columbia Law Review*) [hereinafter Ctrs. for Medicare and Medicaid Servs., Actuarial Report]; Carmen DeNavas-Watt et al., U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2007, at tbl.C-1 (2007), available at <http://www.census.gov/prod/2008pubs/p60-235.pdf> (on file with the *Columbia Law Review*).

116. Ctrs. for Medicare and Medicaid Servs., Actuarial Report, *supra* note 117, at iii.

117. Rosenbaum, *supra* note 3, at 24.

118. See *id.* at 27 (describing one particularly egregious case in which facility “was used to return millions of dollars to San Francisco while its 1400 mentally disabled residents were left to endure terrible conditions”).

119. For a thorough comparison of the two competing schools of thought regarding Medicaid reform during this period—that of the Bush Administration and that of state officials—see *id.* at 30–35 (“The two positions bore some similarity, but they also underscored the fundamental differences that flow from the federalism-driven political schism that has characterized the program.”).

120. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006). Congress made a few technical amendments to the DRA with the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, 120 Stat. 2922 (2006). The changes discussed in this Note were instituted with the original DRA.

121. Nat’l Health Law Program, Highlights of Recent Changes to the Medicaid Act 1 (2007), available at http://www.healthlaw.org/library/item.139456-Highlights_of_Recent_Changes_to_the_Medicaid_Act_April_07 (on file with the *Columbia Law Review*) [hereinafter NHeLP, Highlights]. Among the DRA’s changes, § 6011(a) amends 42 U.S.C. § 1396p(c)(1)(B)(i) to require a sixty-month look-back period for asset transfers to determine eligibility, and § 6036 creates a new section of the Medicaid Act that imposes stricter documentation requirements for individuals to prove the citizenship or alien status

matically expanded states' flexibility to operate their Medicaid programs, often by allowing them to make individuals ineligible for Medicaid or limit the scope of Medicaid benefits."¹²² In part because of these benefits restrictions, the DRA was projected to save an estimated \$28 billion over ten years.¹²³ Commentators have noted that the DRA "marks a new chapter in the life of the Medicaid program by introducing certain fundamental changes into program design."¹²⁴

Two particular aspects of the DRA—both allowing states to restrict and condition their Medicaid coverage to qualifying individuals¹²⁵—are relevant to § 1983 enforceability.¹²⁶ First, the DRA gives states the option to provide "benchmark coverage" to certain groups, meaning that a state may enroll a beneficiary in certain non-Medicaid health care plans, such as the plans that cover state or federal employees. This change, in effect, alters the definition of the "medical assistance" that states must provide.¹²⁷ Second, the DRA allows states to implement copayments and premiums, requiring certain beneficiaries to contribute toward their coverage.¹²⁸ These provisions are examined in detail below.

necessary to receive long-term benefits. See 42 U.S.C. § 1396b(x) (2006). For a discussion of these and other changes to long-term care under Medicaid, see generally Gene V. Coffey et al., *Analysis of Changes to Federal Medicaid Laws Under the Deficit Reduction Act of 2005*, 2 Nat'l Acad. of Elder L. Att'ys J. 189 (2006); Morris Klein, *Medicaid Eligibility After the 2005 Deficit Reduction Act*, Md. Bar J., Mar. 2008, at 32; see also Jacob Press, Comment, *Poor Law: The Deficit Reduction Act's Citizenship Documentation Requirement for Medicaid Eligibility*, 8 U. Pa. J. Const. L. 1033, 1034 (2006) (criticizing documentation requirement as "incompatible with constitutionally-mandated norms of justice and equality").

For an examination of how the DRA affected Medicaid providers, see Connie A. Raffa, *New Enforcement Powers and Incentives Aimed at Medicaid Fraud Enacted by the DRA*, J. Health Care Compliance, July–Aug. 2008, at 5, 9–10 (discussing new enforcement requirements and suggesting ways provider can protect itself); Andrew E. Bluestein & Stacey L. Gulick, *Deficit Reduction Act Heightens Corporate Compliance Requirements for Medicaid Providers*, N.J. Law., Feb. 2007, at 9, 9–10 (summarizing basic elements of corporate compliance program required under the DRA).

122. NHeLP, *Highlights*, supra note 121, at 1. Because of these dramatic changes to the Medicaid scheme, one commentator has noted that the DRA may signal a tipping point depending on "the extent to which the DRA is considered to be a new vision for Medicaid, no longer as a legally enforceable right to coverage akin to insurance, but as a vast source of federal revenue sharing for states . . . so broad so as to eviscerate any notion of entitlement." Rosenbaum, supra note 3, at 47.

123. Cong. Budget Office, *Cost Estimate, S. 1932, Deficit Reduction Act of 2005*, at 35 (2006), available at <http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf> (on file with the *Columbia Law Review*).

124. Rosenbaum, supra note 3, at 35.

125. See Nat'l Health Law Program, *The Deficit Reduction Act of 2005: Congress Targets Beneficiaries for Cuts*, Health Advocate, Spring 2006, at 2 [hereinafter NHeLP, Health Advocate] ("[S]tates will have unprecedented flexibility to slice and dice Medicaid benefits [and] cost sharing . . . among eligibility groups and parts of the state.").

126. *Id.* For a shorter summary of the DRA's changes, see NHeLP, *Highlights*, supra note 121.

127. 42 U.S.C. § 1396u-7(a) (2006).

128. *Id.* § 1396o-1(a).

1. “*Benchmark Coverage*” and “*Benchmark Equivalent Coverage*.” — The DRA’s new benchmark coverage provision has been described as possibly “the most far-reaching change [to the Medicaid scheme] from a structural and legal perspective.”¹²⁹ Before the DRA, the Medicaid Act mandated that states make certain types of medical assistance available to all qualifying individuals.¹³⁰ These services were provided on a fee-for-service basis: Beneficiaries could simply walk into any provider that accepted Medicaid and the state program would reimburse the provider. The DRA now gives states the option to enroll particular beneficiary groups in specified non-Medicaid preexisting health care plans.¹³¹ This means that these beneficiaries’ utilization of services can be controlled by the plans, for instance through primary care “gatekeepers” or prior authorization requirements.

These plans may be “benchmark coverage” plans, such as those offered to federal and state employees, or the equivalent of those plans, through “benchmark equivalent coverage.”¹³² In the benchmark plan option, the DRA allows states to pay for enrollment in existing health care plans,¹³³ as opposed to providing each individual with an enumerated list of benefits as the pre-DRA Act required.¹³⁴ For a state to enroll individuals in benchmark equivalent health insurance plans, the plan must include an enumerated list of basic services, including inpatient and outpatient hospital services, surgical and medical services, laboratory and x-ray services, well-baby and well-child care, and any “other appropriate preventive services, as designated by the Secretary.”¹³⁵ As a result of these new

129. Rosenbaum, *supra* note 3, at 40.

130. See *supra* note 19 (listing mandated services).

131. The DRA excludes certain categories of individuals from this benchmark coverage including pregnant women, blind or disabled individuals, and terminally ill hospice patients. § 1396u-7(a)(2)(B).

132. “[A] State, at its option . . . may provide for medical assistance under this subchapter to individuals . . . specified by the State through enrollment coverage that provides . . . benchmark coverage . . . or benchmark equivalent coverage.” *Id.* § 1396u-7(a).

133. There are four types of benchmark coverage specified in the DRA. *Id.* § 1396u-7(b)(1). First, states may pay to enroll individuals in an equivalent of the standard Blue Cross/Blue Shield preferred provider Federal Employee Health Benefit Program (FEHBP). For a chart comparing EPSDT benefits covered by the Medicaid program and the FEHBP plan, see Rosenbaum, *supra* note 3, at 43–44. Second, a state may pay to enroll individuals in coverage equivalent to what is available for state employees. Third, states may enroll individuals in coverage equivalent to the largest commercial, non-Medicaid HMO in the state. Finally, the Secretary of Health and Human Services (HHS) may approve a plan that she determines is “appropriate coverage for the population proposed to be provided such coverage.” § 1396u-7(b)(1)(D).

134. See *supra* note 19 for a number of these enumerated benefits.

135. § 1396u-7(b)(2)(A). The Medicaid regulations, which were published in December 2008 and will be effective in December 2009, do not designate any additional services as required under benchmark equivalent coverage. See State Flexibility for Medicaid Benefit Packages, 73 Fed. Reg. 73,694, 73,696 (Dec. 3, 2008) (to be codified at 42 C.F.R. pt. 440) (listing services required under benchmark equivalent coverage); see also

options, states that choose to enroll beneficiaries in benchmark coverage are no longer required to provide the formerly mandatory services to individuals, since enrollment in benchmark plans is not contingent on these plans' offering particular services.¹³⁶ Further, the only services that are mandated in a benchmark equivalent plan are those few listed above.¹³⁷

2. *Copayments and Premiums.* — Before the DRA, the Medicaid Act prohibited copayments, premiums (fees), or other cost sharing mechanisms for particular groups of needy recipients.¹³⁸ For individuals not included in categorically needy groups, Medicaid allowed states to impose “nominal” copayments, between fifty cents and three dollars.¹³⁹ Providers could not deny care based on inability to pay these copayments, and the outstanding amount would then become a legal liability for the individual.¹⁴⁰

The DRA provides states with increased options for imposing cost sharing mechanisms on beneficiaries.¹⁴¹ Without repealing previous sections of the Act,¹⁴² the DRA enables states to “impose premiums and cost sharing [copayments] for any group of individuals . . . and for any type of services” excluding emergency room care and individuals with incomes not exceeding the poverty line.¹⁴³ In addition, under the DRA, states may allow Medicaid providers to condition services on payment of fees and copayments in certain circumstances.¹⁴⁴ One notable part of the provision allows states to “vary such premiums and cost sharing [copy-

State Flexibility for Medicaid Benefit Packages, 74 Fed. Reg. 15,221, 15,221 (Apr. 3, 2009) (reopening comment period and delaying effective date of December 3, 2008 final rule until December 31, 2009); State Flexibility for Medicaid Benefits Packages: Delay of Effective Date, 74 Fed. Reg. 5808, 5809 (Feb. 2, 2009) (delaying effective date of December 3, 2008 final rule until April 3, 2009).

“Benchmark equivalent” coverage must also have an average actuarial value equivalent to a benchmark package, id. § 1396u-7(b)(2)(B), and for prescription drug coverage, mental health services, vision services, and hearing services, the plan must provide at least seventy-five percent of the actuarial value of a benchmark package, id. § 1396u-7(b)(2)(C).

136. NHeLP, Health Advocate, *supra* note 125, at 25–26.

137. See *supra* text accompanying note 135.

138. See § 1396o(a) (prohibiting cost sharing for children, pregnant women, inpatients in hospitals, emergency service, and hospice care).

139. 42 C.F.R. § 447.54 (2008).

140. § 1396o(e).

141. *Id.* § 1396o-1(a)(1).

142. The DRA's premiums and copayment provisions apply “[n]otwithstanding section[] 1396o . . . of this title.” *Id.*

143. *Id.* § 1396o-1(a)(1)–(2).

144. *Id.* § 1396o-1(d). However, providers are not allowed to impose fees or premiums on certain groups of individuals, or on certain services. For instance, a state may not allow a provider to impose premiums on individuals with family income of between 100 and 150 percent of the poverty line, id. § 1396o-1(b)(1), pregnant women, terminally ill individuals receiving hospice care, and disabled children. *Id.* § 1396o-1(b)(3). In addition, a state may not allow providers to impose copayments on preventive services, services to terminally ill individuals receiving hospice care, emergency services, and family planning services and supplies. *Id.*

ments] among such groups or types,” meaning that states are allowed to treat groups differently for the purposes of cost sharing.¹⁴⁵ Thus, the new provisions allow states to increase copayments and premiums, and allows providers to condition care on such payment in certain circumstances.

II. POST-GONZAGA TREATMENT OF THE MEDICAID ACT AND POTENTIAL CHALLENGES TO THE ENFORCEMENT OF THE AVAILABILITY PROVISION

Gonzaga and the DRA have changed the landscape of Medicaid enforceability. Part II.A discusses post-*Gonzaga* decisions that have rendered two key Medicaid provisions—the “equal access” and “reasonable standards” provisions—unenforceable through § 1983. Next, Part II.B addresses the three post-*Gonzaga*—but pre-DRA—availability provision circuit court decisions, all of which found the provision enforceable under § 1983. This Part also discusses a recent district court decision that held that the availability provision is not enforceable, though it did not address the DRA. Part II.C synthesizes commentators’ treatment of the DRA, the trend toward unenforceability of Medicaid and other provisions, and the court decision finding the availability provision unenforceable, illustrating that these forces may converge to invite future challenges to the enforceability of the availability provision.

This Part will establish a foundation for Part III, which argues that the reasoning of the post-*Gonzaga* circuit courts still holds despite the DRA’s changes to Medicaid. This analysis is crucial because no court has directly addressed whether the availability provision remains enforceable through § 1983 since the adoption of the DRA.¹⁴⁶

A. *The Unenforceability of Various Medicaid Provisions Since Gonzaga*

Since *Gonzaga*, the Medicaid Act has been the primary focus of circuit court decisions regarding § 1983 enforceability.¹⁴⁷ These cases tend toward finding sections of the Medicaid Act unenforceable through § 1983.¹⁴⁸ Indeed, *Gonzaga* “probably ended any general presumption of

145. *Id.* § 1396o-1(a)(1).

146. See Donenberg, *supra* note 22, at 1521–22 (noting that states, as yet, have “failed to contest the applicability of § 1983 in light of the statutory modifications occasioned by the DRA”).

147. See Jane Perkins, Nat’l Health Law Program, Issue Brief: Update on § 1983 Enforcement of the Medicaid Act 2 (2007), available at <http://www.healthlaw.org/library/attachment.94516> (on file with the *Columbia Law Review*) (“[T]he Medicaid Act has received the vast bulk of courts’ post-*Gonzaga* attention.”). As of January 2007, there were over fifty published cases that cite *Gonzaga* and discuss whether the Medicaid Act is enforceable under § 1983. *Id.*

148. See Rochelle Bobroff, Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes, 10 *Loy. J. Pub. Int. L.* 27, 63 (2008) (noting that post-*Gonzaga*, “circuit courts have generally rejected the enforceability of Medicaid provisions that contain broad directives, including several provisions that had been deemed

§ 1983 enforceability of substantive Medicaid Act requirements that may have lingered from *Wilder*, and may even have created the opposite presumption.”¹⁴⁹ One commentator has gone so far as to assert that “[t]he Medicaid Act lacks the language necessary to create an enforceable private right” post-*Gonzaga*.¹⁵⁰ Although this may overstate the point,¹⁵¹ courts have indeed found various Medicaid provisions unenforceable.¹⁵²

1. *Medicaid’s Equal Access Provision, § 1396a(a)(30)*. — *Gonzaga* has already led to the unenforceability of Medicaid’s “equal access” provision through § 1983. The equal access provision, § 1396a(a)(30), requires that a state plan provide “methods and procedures” to ensure that care under the plan is comparable to what is available to the general population in the geographic area.¹⁵³ Before *Gonzaga*, courts had generally found the equal access provision enforceable through § 1983 for Medicaid recipients.¹⁵⁴ After *Gonzaga*, however, a majority of the circuits that

unenforceable prior to *Gonzaga*”); Dunne, *supra* note 83, at 1003 (“After *Gonzaga*, the overall trend in Medicaid Act cases has been towards a narrowed § 1983 enforcement right in an aggregate sense.”).

149. Dunne, *supra* note 83, at 1004.

150. Mark Andrew Ison, Note, Two Wrongs Don’t Make a Right: Medicaid, Section 1983 and the Cost of an Enforceable Right to Health Care, 56 Vand. L. Rev. 1479, 1508 (2003).

151. See *infra* Part III.A.3; see also *Harris v. Olszewki*, 442 F.3d 456, 461 (6th Cir. 2006) (holding Medicaid’s “freedom of choice” provision, 42 U.S.C. § 1396a(a)(23) (2006), created right enforceable through § 1983); *G. ex rel. K. v. Haw. Dep’t of Human Servs.*, Civ. Nos. 08-00551 ACK-BMK, 09-00044 ACK-BMK, 2009 WL 1322354, at *11–*12 (D. Haw. May 11, 2009) (following *Harris* and finding enforceable right through § 1983 for Medicaid’s freedom of choice provision).

152. The Supreme Court remains actively interested in § 1983 enforcement of the Medicaid Act. For example, under the Fifth Circuit held that individuals had no rights enforceable through § 1983 under Medicaid’s “equal access” provision, *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007) (examining 42 U.S.C. § 1396a(a)(30)(A)), the plaintiffs petitioned for certiorari. Petition for a Writ of Certiorari, *Equal Access for El Paso, Inc. v. Hawkins*, 129 S. Ct. 34 (2008) (No. 07-1160). Because there was no circuit split on the question of the provision’s enforceability—all circuits had found it unenforceable—there seemed little chance that the Supreme Court would grant the petition. *Perkins, Developments, supra* note 111, at 8. The Court, however, requested that the State file a response to the petition for certiorari. *Id.* at 9. Although the Court ultimately denied the petition, 129 S. Ct. 34, the Court’s request for a response from the State signaled that the Court remains interested in this area. See *Perkins, Developments, supra* note 111, at 9 (noting Court’s “unusual step” of requesting response to petition).

153. 42 U.S.C. § 1396a(a)(30) (2006).

154. See, e.g., *Pa. Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 543–44 (3d Cir. 2002); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 932 (5th Cir. 2000) (en banc); *Visiting Nurse Ass’n of N. Shore v. Bullen*, 93 F.3d 997, 1004 n.7 (1st Cir. 1996); *Ark. Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993). The courts were split, however, on whether the equal access provision created an enforceable right for Medicaid providers. The First, Seventh, and Eighth Circuits found an enforceable right for providers. See *Bullen*, 93 F.3d at 1005; *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Ark. Med. Soc’y*, 6 F.3d at 528. The Third and Fifth Circuits, however, found that § 1396a(a)(30) did not create an enforceable right for Medicaid providers. See *Pa.*

have examined (or re-examined) the equal access provision have found that it does not provide Medicaid recipients with enforceable rights under § 1983.¹⁵⁵ These holdings are premised on aggregate, rather than individual, focus of the “methods and procedures” language of § 1396a(a)(30).¹⁵⁶ The text of the equal access provision has not changed. Rather, the courts are quite clear: The equal access provision is no longer enforceable as a result of *Gonzaga*’s new test.¹⁵⁷

2. *Medicaid’s Reasonable Standards Provision, § 1396a(a)(17)*. — Courts have found another Medicaid provision, § 1396a(a)(17), unenforceable post-*Gonzaga*.¹⁵⁸ Section 1396a(a)(17) provides that a state Medicaid plan “must . . . include reasonable standards” for determining eligibility for Medicaid and the extent of medical assistance under the plan.¹⁵⁹ The Eighth and Ninth circuits, relying heavily on the *Gonzaga* test in their analysis, have found insufficient evidence of congressional intent to infer a § 1983 right under the “reasonable standards” provision.¹⁶⁰

Pharmacists Ass’n, 283 F.3d at 543; *Walgreen Co. v. Hood*, 275 F.3d 475, 478 (5th Cir. 2001); *Evergreen*, 235 F.3d at 929.

155. See *Equal Access for El Paso*, 509 F.3d at 703 (“[T]he Medicaid Act’s Equal Access provision . . . does not confer individual private rights that are enforceable under § 1983.”); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006) (finding no enforceable rights for recipients); *Westside Mothers v. Olszewski (Westside Mothers II)*, 454 F.3d 532, 543 (6th Cir. 2006) (no enforceable rights for recipients or providers); *Sanchez ex rel. Hoebel v. Johnson*, 416 F.3d 1051, 1059–60 (9th Cir. 2005) (same); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004) (no enforceable rights for providers). But see *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005, 1015–16 (8th Cir. 2006) (finding enforceable rights for recipients and providers). For a thorough discussion of these cases and an argument for finding that the equal access provision creates individual rights, see Gardella, *supra* note 17, at 733–55.

156. See, e.g., *Westside Mothers II*, 454 F.3d at 542–43 (“[Section] 1396a(a)(30) has an aggregate focus rather than an individual focus that would evince congressional intent to confer an individually enforceable right.”).

157. See, e.g., *Long Term Care Pharmacy Alliance*, 362 F.3d at 57 (noting *Gonzaga* “compels us to reexamine” the Circuit’s previous holding that found equal access provision created enforceable right).

158. It does not appear that any circuits addressed the enforceability of this provision before *Gonzaga*. See *Watson v. Weeks*, 436 F.3d 1152, 1162 (9th Cir. 2006) (“We are the first federal circuit to address whether section 1396a(a)(17) creates a section 1983 right.”).

159. 42 U.S.C. § 1396a(a)(17) (2006).

160. *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006) (noting provision “is not phrased in terms of the individuals it intends to benefit” and focuses on aggregate practices as opposed to individual entitlements); *Watson*, 436 F.3d at 1162 (“[S]ection 1396a(a)(17) is not framed in terms of the individuals benefited, which is fatal under *Gonzaga* to the existence of a section 1983 right.”); see also *Mundell v. Bd. of County Comm’rs*, No. Civ.A05CV00585REBMJW, 2005 WL 2124842, at *2 (D. Colo. Sept. 2, 2005) (finding reasonable standards provision did not create enforceable right under *Gonzaga* analysis); *Sanders ex rel. Rayl v. Kan. Dep’t of Soc. and Rehab. Servs.*, 317 F. Supp. 2d 1233, 1250 (D. Kan. 2004) (same). But see *Mendez v. Brown*, 311 F. Supp. 2d 134, 140 (D. Mass. 2004) (finding plaintiffs have enforceable right of action for violations of § 1396a(a)(17)); *Kerr v. Holsinger*, No. Civ.A.03-68-H, 2004 WL 882203, at *5 (E.D. Ky. Mar. 25, 2004) (same).

B. Courts' Post-Gonzaga Treatment of Medicaid's Availability Provision

The circuits that have addressed the question of the availability provision—the focus of this Note—post-*Gonzaga* have all found it does contain rights enforceable under § 1983.¹⁶¹ Since the DRA went into effect in early 2006, no court has directly addressed whether the availability provision retains its § 1983 enforceability. As a result, one commentator has noted that these post-*Gonzaga* cases “provide [] little insight into whether or not federal courts will ultimately read the DRA as rendering the provision unenforceable” because the courts were not briefed on this issue.¹⁶² The following section examines the post-*Gonzaga* circuit court case law to establish a framework with which this Note will analyze whether the DRA's changes affect the enforceability of the availability provision through § 1983.

1. *The Third Circuit's Decision of Sabree ex rel. Sabree v. Richman.* — The Third Circuit, the first to address the availability provision after *Gonzaga*, found that it was enforceable through § 1983. In *Sabree ex rel. Sabree v. Richman*, a class of mentally disabled adults in need of intermediate care facilities sued Pennsylvania, which had failed to provide them with services.¹⁶³ The court noted that, as is customary for Spending Clause legislation, “[w]hen Congress offers money to the states, it often imposes conditions on acceptance.”¹⁶⁴ This case presented the question of what happens when a state, by failing to provide services to eligible individuals, does not live up to federally mandated conditions.¹⁶⁵ Pennsylvania argued that the sole remedy for the state's noncompliance would

The Ninth Circuit's decision, in particular, has been criticized by at least one commentator, who notes that § 1396a(a)(17) needs to be read in conjunction with § 1396a(a)(10), because these provisions, “read together, guarantee that ‘reasonable’ treatment will be made ‘available.’ . . . Thus, millions of Medicaid beneficiaries in our nation's largest judicial circuit are no longer guaranteed treatment not specifically enumerated [in particular subsections of the Act] no matter how many physicians certify this treatment as medically necessary.” Dunne, *supra* note 83, at 1011 (emphasis omitted).

161. *Watson*, 436 F.3d 1152 (discussed *infra* Part II.B.3); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004) (discussed *infra* Part II.B.2); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004) (discussed *infra* Part II.B.1). These decisions are generally consistent with circuit cases prior to *Gonzaga*, in which three circuits had held that the availability provision contained rights enforceable through § 1983. See *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir. 2002); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir. 2002); *Miller ex rel. Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993).

162. Donenberg, *supra* note 22, at 1522 (“In short, the question of how the new statutory provisions affect the operation of prior Medicaid law has not yet been squarely presented to a federal appellate court.”).

163. 367 F.3d at 181. After discussing the facts of the case, the court noted: “That plaintiffs merit sympathy does not escape our notice, but neither does it govern our reasoning.” *Id.* at 183.

164. *Id.* at 181.

165. *Id.*

be congressional revocation of funding.¹⁶⁶ The Third Circuit disagreed and allowed the plaintiffs to sue under § 1983 for monetary and injunctive relief.¹⁶⁷

Before starting its analysis, the court remarked on the difficulty of applying the *Gonzaga* test.¹⁶⁸ It noted that, while the *Gonzaga* inquiry is whether Congress unambiguously conferred a right, it cannot require a clear statement from Congress because “to do so would effectively repeal § 1983.”¹⁶⁹ The court seemed to acknowledge that the *Gonzaga* inquiry walked a fine line between cabining the types of cases that can be enforced through § 1983 and rendering § 1983 meaningless.¹⁷⁰

As the *Gonzaga* Court had done, the Third Circuit in *Sabree* started its analysis by examining the text of the availability provision. The court found that the language of the statute was “clear and unambiguous” in its creation of binding obligations on the states.¹⁷¹ However, these binding obligations did not answer the question of whether the provision conferred *rights* to individuals, enforceable through § 1983.¹⁷² After noting that the provision passed the traditional three-part *Blessing* test,¹⁷³ the court looked to the statute for the type of rights-creating language newly mandated by *Gonzaga*.¹⁷⁴ The court compared the language of the availability provision—“A State plan . . . must provide”¹⁷⁵—to the “no person shall” language of Titles VI and IX, those identified by *Gonzaga* as the paradigmatic examples of rights-creating language.¹⁷⁶ The *Sabree* court found the two phrases linguistically similar.¹⁷⁷ First, all three provisions contain “mandatory rather than precatory” language.¹⁷⁸ Second, all of

166. *Id.*; cf. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981) (“In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.”). Indeed, a state that fails to comply with its Medicaid plan runs the risk of having its funding revoked by the Secretary of Health and Human Services. See 42 U.S.C. § 1396c (2006) (noting Secretary shall, after reasonable notice and hearing, “notify such State agency that further payments will not be made to the State” as long as it is found in noncompliance).

167. *Sabree*, 367 F.3d at 181.

168. See *id.* at 183 (“This analysis, . . . as will become clear, is assuredly not for the timid . . .”).

169. *Id.* at 183 n.7.

170. See *supra* notes 107–111.

171. *Sabree*, 367 F.3d at 189.

172. *Id.*

173. See *supra* notes 80–84 and accompanying text.

174. *Sabree*, 367 F.3d at 189–90.

175. 42 U.S.C. § 1396a(a) (2006).

176. *Sabree*, 367 F.3d at 190.

177. *Id.* (noting it is “difficult, if not impossible, as a linguistic matter, to distinguish” the relevant language).

178. *Id.* (quoting *Blessing v. Freestone*, 520 U.S. 329, 341 (1997)).

the provisions are unmistakably individual-focused,¹⁷⁹ as opposed to focused on the regulated entity.¹⁸⁰

Next, as the *Gonzaga* Court had done, the Third Circuit turned to the structure of the Medicaid Act as a whole.¹⁸¹ The court found clear rights-creating language in the text of the statute, but because of the Act's broader structure, the court was hesitant to declare congressional intent to create enforceable rights. The court noted that "[t]urning our sights beyond the narrow provisions invoked by the plaintiffs gives us some pause."¹⁸² The Medicaid Act's introductory statement, § 1396, notes that Medicaid was enacted "[f]or the purpose of enabling each State . . . to furnish . . . medical assistance."¹⁸³ However, as opposed to the rights-creating language of the availability provision, the court noted that Medicaid's introductory statement speaks in the language of the federal-state relationship.¹⁸⁴ In addition, the court examined § 1396c, which gives the Secretary of Health and Human Services the power to suspend payments to any state that fails to "comply substantially" with the requirements of its Medicaid Plan,¹⁸⁵ and found it similarly lacking in rights-creating language.¹⁸⁶ The *Sabree* court noted that this language not only reconfirms that Medicaid is a federal-state partnership, but is also reminiscent of the "comply substantially" language in *Gonzaga* and *Blessing* that the Court found failed to create enforceable rights.¹⁸⁷ In summary, the court looked to the structural characteristics of the Act by examining its introductory sections, 1396 and 1396c.¹⁸⁸ Although the court found

179. *Id.* (noting availability provision "enumerate[s] the entitlements available to 'all eligible individuals'" (quoting 42 U.S.C. § 1396a(a)(8) (2000))).

180. *Id.* (quoting *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001)).

181. *Id.* at 191. The court noted that "[o]ur judicial function is limited to recognizing those rights which Congress unambiguously confers, and in doing so we would be remiss if we did not consider the whole of Congress's voice on the matter—the statute in its entirety." *Id.* (internal quotation marks omitted). As a result, the court turned to the Act's structure. Although as a general rule when the text of the statute is unambiguous, judicial inquiry need not proceed, "[g]eneral' rules . . . are susceptible to exceptions," and determining whether a statute confers enforceable rights is an "instance[] in which [the] inquiry does not end with the plain language of the statute." *Id.* at 190.

The *Sabree* court found that because the text unambiguously conferred individual rights, it was unnecessary to examine the statute's legislative history: "Where, as here, the plain meaning of the text is evident, we need not look further to determine congressional intent." *Id.* ("Recourse to the legislative history . . . is unnecessary in light of the plain meaning of the statutory text." (citing and quoting *Darby v. Cisneros*, 509 U.S. 137, 147 (1993))).

182. *Id.* at 191.

183. 42 U.S.C. § 1396 (2006).

184. *Sabree*, 367 F.3d at 191.

185. § 1396c.

186. *Sabree*, 367 F.3d at 191–92.

187. *Id.* (citing *Gonzaga Univ. v. Doe*, 536 U.S. 273, 288–89 (2002), and *Blessing v. Freestone*, 520 U.S. 329, 343 (1997)).

188. *Id.*

these provisions did not contain rights-creating language,¹⁸⁹ it held the provisions insufficient to “neutralize the rights-creating language” of the availability provision, which it declared enforceable through § 1983.¹⁹⁰ Thus, despite structural features to the contrary, the Third Circuit found the text of the availability provision similar enough to the language of Titles VI and IX to determine that Congress intended to create an enforceable right. Under *Sabree*, both the text of a particular provision and structure of an Act as a whole are relevant to determine whether an individual may enforce a right through § 1983.

2. *The Fifth Circuit’s Decision in S.D. ex rel. Dickson v. Hood.* — In *S.D. ex rel. Dickson v. Hood*, the Fifth Circuit found that the plaintiff, who suffered from spina bifida and had been denied medically prescribed treatment, could sue Louisiana through § 1983 to enforce his rights under the availability provision.¹⁹¹ First, the court held that the availability provision’s language created enforceable individual rights.¹⁹² Second, it found that the statute conferred the right to enumerated types of health care upon an identifiable class, since it requires that the state “provide such care and services ‘to all individuals’ who meet the plan eligibility requirements.”¹⁹³

Turning to the Medicaid Act’s structure, the court noted that the Act’s focus on states’ obligations was not fatal to the availability provision’s creation of enforceable individual rights. It compared the structure of the Medicaid Act with that of Titles VI and IX and found only one relevant difference: The former required state action (“a state plan for medical assistance must . . . provide”¹⁹⁴), while the latter did not (“No person . . . shall . . . be subjected to discrimination”¹⁹⁵). The court held that this difference was not determinative of whether a statute created rights enforceable through § 1983.¹⁹⁶ It pointed to the *Suter* fix,¹⁹⁷ which specifically provided that a statute “requiring a State plan or specifying the required contents of a State plan” is not per se unenforceable.¹⁹⁸

189. *Id.*

190. *Id.* at 192.

191. 391 F.3d 581, 607 (5th Cir. 2004). The plaintiff claimed that Louisiana had unlawfully denied his claim for EPSDT under Medicaid when it refused to pay for the disposable incontinence underwear that a doctor prescribed as necessary to ameliorate his mental and physical conditions. *Id.* at 584. For a brief discussion of EPSDT, see *supra* note 14.

192. *Dickson*, 391 F.3d at 603. The court noted that the provision contains “precisely the sort of rights-creating language identified in *Gonzaga* as critical to demonstrating a congressional intent to establish a new right.” *Id.* (internal quotation marks omitted).

193. *Id.* (quoting 42 U.S.C. § 1396a(10)(A) (2000)).

194. 42 U.S.C. § 1396a (2006).

195. *Id.* § 2000d; 20 U.S.C. § 1681 (2006).

196. *Dickson*, 391 F.3d at 603.

197. See *supra* notes 71–73 and accompanying text (describing *Suter* fix).

198. *Dickson*, 391 F.3d at 603 (quoting 42 U.S.C. § 1320a-2 (2000)); see also *Harris v. James*, 127 F.3d 993, 1003 (11th Cir. 1997) (“[I]n light of [the *Suter* fix], it is clear that the

Thus, the *Dickson* court built upon *Sabree's* textual analysis in two ways: first, by holding that conferral of rights upon a class of individuals is evidence of congressional intent to confer enforceable rights, and, second, by noting that as a result of the *Suter* fix, the requirement of a state plan is not fatal to enforceable rights.

3. *The Ninth Circuit's Decision in Watson v. Weeks.* — In *Watson v. Weeks*, the Ninth Circuit joined the Third and Fifth Circuits in holding that the availability provision created an individual right that can be enforced through § 1983.¹⁹⁹ The plaintiffs in *Watson* were a group of seven Medicaid-eligible seniors and disabled individuals who sued the state when it failed to provide them with nursing facility services to which they alleged they were entitled.²⁰⁰ The Ninth Circuit, like the Fifth Circuit, focused on the term “all individuals” in the availability provision. First, the court found that the phrase was evidence of congressional intent to confer an enforceable right.²⁰¹ In addition, it found that because the availability provision required states to provide enumerated benefits to defined types of individuals, it passed the second and third prongs of the *Blessing* test because it was neither “vague and amorphous” nor would it “strain judicial competence” to enforce.²⁰² In short, the Ninth Circuit's *Watson* treatment reinforces the argument that a statute can be individual-focused under *Gonzaga* even if focused on groups or types of individuals.²⁰³

4. *Casillas v. Daines: A Signal of Things to Come? Or An Aberration?* — In the recent case of *Casillas v. Daines*, a district court found that the plaintiff did not have an enforceable right under the availability provi-

mere fact that an obligation is couched in a requirement that the State file a plan is not itself sufficient grounds for finding the obligation unenforceable under § 1983.”).

199. 436 F.3d 1152, 1159 (9th Cir. 2006).

200. *Id.* at 1154.

201. *Id.* at 1161.

202. *Id.* at 1158, 1161.

203. Since the DRA took effect, most courts have continued to find the availability provision enforceable through § 1983. For example, although the Ninth Circuit decided *Watson* before the DRA's changes went into effect, it has continued to find that the availability provision is enforceable, even though it has not addressed directly the changes to Medicaid as a result of the DRA. See *Spry v. Thompson*, 487 F.3d 1272, 1275–76 (9th Cir. 2007) (“We do not see a sound basis for distinguishing *Watson*, and conclude that if there is a violation in this case of the statutory standards, then the plaintiffs in this case have a private right of action enforceable under section 1983.”); cf. *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1153 n.7 (9th Cir. 2007) (noting defendants did not dispute district court ruling that plaintiffs had enforceable right under availability provision).

In addition, the Tenth Circuit may have implicitly accepted the proposition that the availability provision remains enforceable when it “assume[d] without deciding” that the plaintiffs could enforce availability provision rights through § 1983. *Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1212 n.1 (10th Cir. 2007) (quoting *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1143 (10th Cir. 2006)). Thus, circuit courts have continued to follow their pre-DRA case law to find availability provision rights enforceable, but have not directly addressed the new post-DRA Medicaid scheme.

sion, although it did not address the DRA's changes to the Medicaid Act.²⁰⁴ The court found that a male-to-female transgendered person did not have an unambiguously conferred right to feminizing hormones and to two gender reassignment surgeries.²⁰⁵ In reaching its conclusion, the court examined a pre-DRA federal regulation that permitted a state plan to place “*appropriate limits* on a service based on such criteria as medical necessity or utilization control procedures.”²⁰⁶

The court looked to the regulations as it employed the *Gonzaga* analysis, and found that the plaintiff failed to assert an enforceable right. First, the court determined that the “appropriate limits” that a state may impose under the regulations meant that the rights conferred upon the plaintiff were not unambiguous.²⁰⁷ In addition, the court found that the availability provision failed the “vague and amorphous” prong of the *Blessing* test, since the regulation’s “utilization control procedures” created an undefined and loose standard.²⁰⁸ This case is significant not only because the court found that the availability provision was unenforceable, but because of the manner in which it went about it: looking to the implementing regulations.

The question then is whether *Casillas* is an aberration, based on the unusual facts of the case, or signals a shift in the § 1983 enforceability of the availability provision. On the one hand, the treatment at issue in *Casillas*, gender reassignment surgery, may have led the court to look to the underlying merits of the case when deciding the question of enforceability. The regulation allows a state agency to place “appropriate limits”

204. 580 F. Supp. 2d 235, 243 (S.D.N.Y. 2008). The Southern District of New York is in the Second Circuit, so the three decisions discussed supra Parts II.B.1.–B.3 were not binding on the *Casillas* court.

205. *Casillas*, 580 F. Supp. 2d at 242–43. The plaintiff challenged New York’s regulation that disallowed reimbursement for gender reassignment treatments and services. N.Y. Comp. Codes R & Regs. tit. 18, § 505.2(l) (2008) (mistakenly reported as § 505.2(i)).

206. 42 C.F.R. § 440.230(d) (2008) (emphasis added). There is a split among the circuits regarding whether regulations may establish enforceable rights. However, even some circuits that have found regulations cannot create enforceable rights have held that courts may turn to regulations to help interpret the content of statutory rights. See Bradford C. Mank, Can Administrative Regulations Interpret Rights Enforceable Under Section 1983?: Why *Chevron* Deference Survives *Sandoval* and *Gonzaga*, 32 Fla. St. U. L. Rev. 843, 844 (2005) (“[S]ome decisions in these circuits have recognized that valid regulations may help courts interpret, ‘define,’ or ‘flesh out’ the content of statutory rights.”). For an argument that where Congress delegates authority to an agency to issue regulations implementing a congressionally intended individual right, the agency’s interpretation of those rights in its regulations should be presumptively enforceable through § 1983, see *id.* at 895–96.

207. *Casillas*, 580 F. Supp. 2d at 242–43.

208. *Id.* at 243. But cf. *G. ex rel. K. v. Haw. Dep’t of Human Servs.*, Civ. Nos. 08-00551 ACK-BMK, 09-00044 ACK-BMK, 2009 WL 1322354, at *17 (D. Haw. May 11, 2009) (using regulation to find a Medicaid provision, 42 U.S.C. § 1396u-2(b)(5) (2006), was not too vague for judicial enforcement because it “furnish[ed] specific criteria for states to evaluate”).

on a service, and it is likely that the *Casillas* court viewed gender reassignment surgery, perhaps not unreasonably, as being among those services that a state might appropriately limit. On the other hand, the regulation cited in *Casillas* is broad enough to render many medical services properly excludable by a state agency, depending on how much leeway states are given to interpret the “appropriate limits” they can place on services.²⁰⁹ It is unclear whether *Casillas* is limited to its unique facts, or whether later courts will follow its reasoning to allow states to limit a number of Medicaid services.²¹⁰

C. *Possible Future Challenges to Enforcing the Availability Provision Through § 1983.*

Although at this point there has been little dispute that the availability provision can be enforced through § 1983, the combination of the DRA, the *Sabree* court’s hesitation when finding enforceable rights, and the *Casillas* decision may bode poorly for the availability provision’s continued enforceability. First, the DRA has changed the face of the Medicaid Act, and at least one commentator has argued that this alone is enough to render the availability provision unenforceable through § 1983.²¹¹ Second, in *Sabree*—post-*Gonzaga* but pre-DRA—the Third Circuit found a close question existed in deciding whether the state-focused structural elements of the Medicaid Act outweighed the availability provision’s rights-creating language.²¹² The structural changes initiated by the DRA could be enough to tip the balance against finding enforceable rights. Finally, *Casillas* presents an analysis of the availability provision that, when coupled with the DRA’s changes and the *Sabree* court’s hesita-

209. 42 C.F.R. § 440.230(d). States’ “appropriate limits” on services may actually conflict with other Medicaid regulations, which provide that “[e]ach State must ensure that all services covered under the State plan are available and accessible to enrollees,” *id.* § 438.206(a), and that “[t]he State must ensure, through its contracts, that each [Managed Care Organization] . . . [m]aintains and monitors a network of appropriate providers . . . sufficient to provide access to all services covered under the contract,” considering, among other things, “the geographic location of providers and Medicaid enrollees,” *id.* § 438.206(b)(1).

210. For two post-*Casillas* examples of courts following pre-DRA precedent and upholding plaintiffs’ right to sue under § 1983 for a violation of the availability provision, see *D.W. v. Walker*, No. 2:09-cv-00060, 2009 WL 1393818, at *6 (S.D. W. Va. May 15, 2009) (order denying motion to dismiss) (citing *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004), which was not binding on the court, and holding availability provision intended to benefit the plaintiffs, not “vague and amorphous” and therefore “the statute[] confer[s] rights that are vindicable under § 1983”); *Crawley v. Ahmed*, No. 08-14040, 2009 WL 1384147, at *17–*19 (E.D. Mich. May 14, 2009) (issuing order denying motion to dismiss and following *Westside Mothers v. Olszewski* (*Westside Mothers II*), 454 F.3d 532 (6th Cir. 2006), to find availability provision enforceable under § 1983). But see *Ravenwood v. Daines*, No. 06-CV-6355-CJS, 2009 WL 2163105, at *2–*9 (W.D.N.Y. July 17, 2009) (quoting extensively from *Casillas* and following reasoning because both cases “involved *the same defendant, the same legal issues,*” and nearly identical facts).

211. See Donenberg, *supra* note 22, at 1523.

212. See *supra* text accompanying note 182.

tion in finding enforceable rights, creates the possibility that the availability provision will no longer be enforceable through § 1983.²¹³ These three developments are discussed *infra* Parts II.C.1, II.C.2, and II.C.3, respectively.

1. *How the DRA Altered the Structure of the Medicaid Act.* — The DRA altered the structure of the Medicaid Act²¹⁴ in two distinct ways, both of which provide states with increased flexibility in how they may structure their plans.²¹⁵ First, the benchmark coverage provision allows a state to enroll recipients in preexisting health insurance plans, as opposed to providing them with a defined set of benefits.²¹⁶ Second, under the DRA, states may impose new copayments and premiums upon certain types of beneficiaries.²¹⁷ As a result of these changes, the Act as a whole is less individual-focused and more state-focused.²¹⁸

The benchmark provisions are significant because they allow states increased flexibility in providing benefits.²¹⁹ This movement has eliminated the state's obligation to provide specific services to some groups of Medicaid eligible individuals: The former system entitled the beneficiary to coverage that included specified benefits,²²⁰ whereas new changes entitle the individual only to payment for a system of coverage, with few limits on the design of the actual health insurance plan.²²¹ In addition, a state can enroll *individuals* in benchmark coverage without enrolling an entire group of beneficiaries.²²² Thus, the increased flexibility the DRA provides to the states has altered the structure and orientation of the Medicaid Act.

Similarly, the DRA's cost sharing provisions are state-focused, and in fact may limit individuals' access to health services.²²³ The DRA provides that states may impose cost sharing provisions on various types of benefi-

213. *Casillas*, 580 F. Supp. 2d at 235.

214. For a view from commentators on how significant these changes were, see *supra* notes 122, 124, and accompanying text.

215. See *supra* note 122 and accompanying text.

216. See *supra* Part I.C.1.

217. See *supra* Part I.C.2.

218. See Donenberg, *supra* note 22, at 1527 (noting DRA language focused on state policy and practice, not on individual rights).

219. See *supra* note 122 and accompanying text. As of the end of fiscal year 2008, eight states had approved benchmark or benchmark equivalent plans for some groups of Medicaid beneficiaries. See Kaiser Comm'n on Medicaid and the Uninsured, *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn* 41–42 (2008), available at <http://www.kff.org/medicaid/upload/7815.pdf> (on file with the *Columbia Law Review*) (discussing plans of Idaho, Kansas, Kentucky, South Carolina, Virginia, Washington, West Virginia, and Wisconsin).

220. See *supra* note 19 and accompanying text.

221. Rosenbaum, *supra* note 3, at 41.

222. 42 U.S.C. § 1396u-7(a)(2)(A) (2006) (“[A] State may require that a full-benefit eligible individual . . . within a group obtain [benchmark benefits].”).

223. See *supra* Part I.C.2.

ciaries.²²⁴ Thus, the new provisions allow states to increase copayments and premiums on some individuals and services—and to allow providers to condition care on such payment—despite the effect these increased health care costs will have on low-income individuals.²²⁵ One commentator has gone so far as to argue that because these effects were so well documented, Congress must have intended to render Medicaid rights unenforceable.²²⁶ Like the benchmark provisions, the DRA's cost sharing provisions seem to focus on the regulated state at the expense of the individual beneficiary. Taken together, these two provisions shift the structure of the Medicaid Act toward the state and away from the beneficiary. Whether this will affect the availability provision's § 1983 enforceability may rest on judicial determination of how much of a shift these provisions actually represent.

2. *The Sabree Court's Hesitation to Find Enforceable Rights.* — Though the *Sabree* court ultimately held that the structure of the Medicaid Act as a whole did not outweigh the rights-creating language of the availability provision, the court found the question a close one.²²⁷ The court's language shows ambivalence toward its decision:

Admittedly, plumbing for congressional intent by balancing the specific language of a few discrete provisions of [the Medicaid Act] against the larger structural elements of the statute is a difficult task. Nonetheless, it is evident, at least to us, that the statutory language, despite countervailing structural elements of the statute, unambiguously confers rights which plaintiffs can enforce.²²⁸

This ambivalence seems to invite other courts, and perhaps the Supreme Court, to disagree and find that the federal-state structure of Medicaid outweighs the individual-focused, rights-creating language of the availability provision.²²⁹ Although the Fifth and Ninth Circuits fol-

224. § 1396o-1(a)(1).

225. See Donenberg, *supra* note 22, at 1511 (noting these provisions “allow states for the first time to put concerns about recouping state revenues above the interests of individual beneficiaries in receiving medical services”).

226. See *id.* at 1525–26 (“[T]he well-documented empirical effects of premium and cost-sharing mechanisms also suggest strongly that Congress did not intend to confer a right to Medicaid benefits enforceable by § 1983.”). This argument, however, is far-fetched. The logic goes as follows: Since cost sharing makes it likely that some individuals will not use particular services, and Congress knew of this fact, the provisions cannot provide an enforceable right under § 1983. If this logic were correct, it would suggest that no entitlement or service with a fee attached should be enforced through § 1983. This argument would turn congressional knowledge that some individuals would forego this service into congressional intent to foreclose a § 1983 cause of action in any statutory scheme where fees are applied. Although fees may affect the content of a Medicaid right, they do not affect its analysis under § 1983.

227. See *supra* text accompanying note 182.

228. *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004).

229. As noted above, members of the Supreme Court have indicated that they disagree with current precedent that holds beneficiaries have individual rights to sue under Spending Clause acts in general, and the Medicaid Act in particular. See *supra* note

lowed suit in finding the availability provision enforceable post-*Gonzaga*, a court examining the post-DRA Medicaid Act could find that the DRA shifted the structure of the Act enough to prevail over the availability provision's rights-creating text.

3. *Will Casillas Be Read Narrowly or Broadly?* — The importance of *Casillas*, if it is followed, will depend on how subsequent courts frame its holding. On the one hand, the holding appears narrow and fact specific: The availability provision does not confer the specific—and somewhat unusual—right that this plaintiff asserts.²³⁰ On the other hand, the holding may be viewed as broad and far reaching: As a result of the implementing regulations, “[t]he ‘right’ conferred in [the availability provision] is not unambiguously conferred upon any individual or class of individuals.”²³¹ The court reached this conclusion without considering the DRA and its potential to weaken preexisting rights. This case may foreshadow a post-DRA, post-*Gonzaga* era in availability provision enforcement in which courts find that Medicaid recipients are not entitled to any specific treatment or care.²³² Whether this case proves an aberration of nonenforceability or signals a sea change in the case law may depend on how this precedent is interpreted in conjunction with the DRA and the circuit courts’ application of *Gonzaga*.²³³

III. DESPITE THE DRA’S CHANGES TO THE MEDICAID ACT, THE AVAILABILITY PROVISION REMAINS ENFORCEABLE THROUGH § 1983

This Part applies the *Gonzaga* test to the post-DRA Medicaid Act using the post-*Gonzaga* circuit court opinions as guides. It concludes that, had the circuit courts addressed the DRA changes directly, they would not have altered their finding of enforceable rights. This discussion is needed because without a thorough analysis of precisely how much the DRA has changed the Medicaid Act—and how much it has left intact—courts may note the DRA’s changes to the structure of Medicaid²³⁴ and

82 (citing opinions by Justices Scalia and Thomas arguing against right of beneficiaries to bring suit).

230. See *Casillas v. Daines*, 580 F. Supp. 2d 235, 243 (S.D.N.Y. 2008) (concluding availability provision “does not unambiguously confer the right that this plaintiff asserts”).

231. *Id.* at 242–43 & n.3 (citing *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 111–12 (1989) (holding, based on regulations promulgated under statute, statute was not vague and amorphous)).

232. *Id.* (noting that availability provision “do[es] not mandate that a particular level or type of care must be provided”). But see *supra* note 210 for recent court decisions finding the availability provision enforceable through § 1983.

233. Cf. *Rosenbaum*, *supra* note 3, at 47 (suggesting that Medicaid legislation in the future may lead to “one of those magical ‘tipping points’ when the law ceases to be one thing and becomes another in the eyes of courts”).

234. Some commentators have argued that the DRA drastically changes the basic structure of Medicaid. See, e.g., *supra* notes 122, 124, and accompanying text (discussing DRA’s extensive changes to Medicaid).

too hastily conclude that plaintiffs no longer have enforceable rights under the availability provision.²³⁵ A thorough examination of how much the DRA has changed the structure of the Medicaid Act and how

235. Although this Note argues that under certain circumstances Medicaid's availability provision remains enforceable through § 1983 litigation, there are also a number of possible alternative causes of action that a beneficiary can pursue. First, if a plaintiff's claim is a result of a lack of rules—for example, if a state does not have rules to ensure that Medicaid providers or plans are actually offering care and services to beneficiaries—a plaintiff may be able to file a rulemaking petition with the state agency to request that the agency adopt, amend, or repeal the applicable rule. See, e.g., Me. Rev. Stat. Ann. Tit. 5, § 8055 (2002) (allowing petitions for rule adoption or modification, which may be denied with reasons unless petition “is submitted by 150 or more registered voters of the State,” in which case agency must “initiate appropriate rulemaking proceedings within 60 days”); Mont. Admin. R. 1.3.205 (2008) (authorizing interested persons or members of the legislature to petition agency to adopt, amend, or repeal a rule, which agency can grant or deny with written reasons); N.H. Rev. Stat. Ann. § 541-A:4 (2007) (allowing petitions by interested persons, which agency may grant or deny with written reasons “within 30 days of receiving the petition”); Tex. Gov't Code § 2001.021 (2008) (allowing petitions by interested persons, which agency may grant or deny with written reasons “not later than the 60th day after the date of submission”). See generally Jane Perkins, Sarah Somers & Steve Hitov, Nat'l Health Law Program, *Preparing and Managing a Medicaid Case: An Introductory Guide* 14–18 (2006), available at <http://www.healthlaw.org/search/item.129064> (on file with the *Columbia Law Review*) (discussing “the different fora in which advocates might bring claims and some of the advantages and drawbacks of each”).

Second, one commentator has argued that a fair hearing before a state administrative agency provides another alternative route to relief. See Donenburg, *supra* note 22, at 1527–45 (discussing fair hearing alternative, but noting, on balance, “[f]air hearing actions will be somewhat less effective at restraining state action than federal legal mechanisms like § 1983, since there is variability in the scope of the fair hearing right across the states”).

Third, it is possible that a Medicaid beneficiary will be able to sue under a contract theory. See *Smallwood v. Cent. Peninsula Gen. Hosp.*, 151 P.3d 319, 324 (Alaska 2006) (holding plaintiff had contract-based right of action as third-party beneficiary of provider agreement between hospital and state); cf. *Mall v. Pub. Health Trust*, 88 F. Supp. 2d 1376, 1385 (S.D. Fla. 2000) (finding Medicaid's prohibition on “balance billing” creates “a third-party beneficiary contractual obligation on the part of the health care provider to collect from the Medicaid patient no more than the amount of the Medicaid payment”).

A final alternative avenue for a plaintiff in federal court may be a suit claiming that the federal Medicaid Act preempts a state plan or action under the Supremacy Clause of the Constitution, U.S. Const. art. VI, cl. 2. The Supremacy Clause provides that federal law is “the supreme Law of the Land,” which overrides “any Thing in the Constitution or Laws of any State.” *Id.* In the past, the Supreme Court has found preemption of state action based not only on federal statutes, but also on administrative regulations, executive orders, and common law. See Chang Derek Liu, Note, *The Blank Page Before You: Should the Preemption Doctrine Apply to Unwritten Practices?*, 109 *Colum. L. Rev.* 350, 363–64, 384–94 (2009) (arguing preemption doctrine should reach systemic unwritten policies of state agencies). Preemption is a parallel and alternative route for a plaintiff to sue in federal court. *Lankford v. Sherman*, 451 F.3d 496, 509, 513 (8th Cir. 2006) (finding no enforceable rights under § 1983 but holding “plaintiffs have established a likelihood of success on the merits of their preemption claim as it relates to Medicaid's reasonable-standards requirement”); see also *supra* note 24 (collecting commentary discussing preemption suits). A more thorough review of these alternatives is outside the scope of this Note.

this post-DRA Act will fare under a *Gonzaga* analysis is therefore necessary.

It is important to note that although specific types of availability provision claims will be foreclosed by the DRA, many will not. As the *Casillas* court noted when discussing Medicaid, “[w]hether a statute unambiguously confers a right is not a binary question. The statute may confer a right of some type upon some class of persons without conferring the particular right asserted by the plaintiff in suit.”²³⁶ It is imperative for courts to be mindful of *who* the plaintiff is and *what claims* she is asserting. There are several groups of beneficiaries and services that the DRA explicitly exempts from its provisions. Throughout this Part, “nonprotected beneficiaries” will refer to those groups that can be enrolled in benchmark or benchmark equivalent coverage, or are allowed to have premiums imposed upon them by the DRA because they are not members of any protected groups.²³⁷ “Nonprotected services” will refer to services upon which states may impose a form of copayment.²³⁸ For the *Gonzaga* analysis, whether the state in which an individual receives services has decided to impose premiums or copayments or to provide benchmark coverage should not matter. Since the text of the provision and the structure of the Act as a whole are the only relevant inquiries under *Gonzaga*, whether the particular state at issue has taken advantage of the flexibility allowed by the DRA should be irrelevant.

236. *Casillas*, 580 F. Supp. 2d at 241.

237. The following groups are not eligible for enrollment in benchmark or benchmark equivalent plans: pregnant women with incomes at or below 133% of the poverty line, blind or disabled individuals, dually eligible Medicare/Medicaid beneficiaries, terminally ill hospice patients, institutionalized individuals, individuals with special medical needs, beneficiaries qualifying for long term care, children in foster care, TANF parents, women receiving treatment for breast or cervical cancer, beneficiaries with tuberculosis, aliens receiving care for an emergency medical condition, and the medically needy. 42 U.S.C. § 1396u-7(a)(2)(B) (2006); NHeLP Health Advocate, *supra* note 125, at 26.

In addition, states cannot impose premiums (fees) on the following groups: individuals whose family income does not exceed the poverty line, children in mandatory coverage categories under the age of eighteen (such as children in foster care), persons in institutions, women in treatment for breast or cervical cancer, pregnant women, and terminally ill individuals receiving hospice care. § 1396o-1(a)(2)(A), (b)(3)(A); NHeLP, Health Advocate, *supra* note 125, at 23 chart 2.

238. States cannot impose copayments on services for individuals under the age of eighteen in mandatory coverage categories, pregnant women, terminally ill individuals receiving hospice care, persons in institutions, women in treatment for breast or cervical cancer, and disabled children. § 1396o-1(b)(3)(B). Nor can states impose copayments on the following services: preventive services (such as well-baby and well-child care and immunizations) for children under the age of eighteen regardless of income, emergency services, and family planning services. *Id.*; NHeLP, Health Advocate, *supra* note 125, at 23.

A. *Enforcing the Availability Provision Through § 1983 After the DRA and Gonzaga*

The DRA's changes suggest that a number of plaintiffs' claims will not pass the initial *Gonzaga* inquiry because the text of the statute does not unambiguously confer rights upon them. These claims are discussed *infra* Part III.A.1. However, a number of claims will survive *Gonzaga*'s textual inquiry, since the availability provision still requires the states to make certain medical services available. These claims are discussed *infra* Part III.A.2. Next, Part III.A.3 analyzes the enforceability of any viable claims using the post-*Gonzaga* circuit court decisions,²³⁹ and Part III.A.4 bolsters this analysis using legislative history. Ultimately, this Note concludes that these claims remain viable because the DRA has not so drastically changed the structure of the Medicaid Act so as to overcome the availability provision's strong rights-creating language.

1. *Some Availability Provision Claims Will Not Survive Gonzaga's Initial Textual Inquiry.* — Post-DRA, certain plaintiffs will not be able to assert particular claims because they will not survive *Gonzaga*'s initial textual analysis. For example, as a result of the DRA's changes, individuals who are not protected from benchmark coverage likely do not have a viable claim that a state has violated their right to a particular service referenced in the availability provision.²⁴⁰ To illustrate, assume that a non-disabled senior who formerly received nursing home care is a nonprotected beneficiary. If this were the case, the individual would be unable to claim that she is entitled to nursing home care, because particular treatment is no longer mandatory for nonprotected individuals who may be enrolled in benchmark coverage with no defined benefits.²⁴¹ Similarly, a plaintiff asserting a right to nonprotected services without copayment will lose, since the DRA provisions explicitly give states leeway to require copayment for particular services.²⁴²

2. *Many Availability Provision Actions Will Still Survive Gonzaga's Textual Prong.* — Though *Gonzaga* and the DRA may dispose of some suits, many beneficiaries' post-DRA claims will survive *Gonzaga*'s textual inquiry. As the Court has noted, the test for enforceability is claim- and plaintiff-specific, and each plaintiff's claim must be individually considered. The relevant question is "whether each separate claim satisfies the

239. See *supra* Part II.B.

240. The DRA provides that the benchmark provisions apply "notwithstanding" any other section of the Act. § 1396u-7(a)(1)(A). Individuals enrolled in a benchmark equivalent plan, on the other hand, will be able to bring claims if a state plan fails to provide them with any of the statutorily enumerated minimum services—which are enumerated only for benchmark equivalent plans—such as inpatient and outpatient services, as well as well-baby and well-child care. See *supra* text accompanying note 135.

241. See *supra* notes 199–203 and accompanying text for discussion of the Ninth Circuit case of *Watson v. Weeks*, on which this hypothetical is based. The *Watson* court did address the DRA's changes to the Medicaid Act. See text accompanying *supra* note 162.

242. § 1396o-1(a)(1).

criteria [the Court] ha[s] set forth for determining whether a federal statute creates rights.”²⁴³ In addition to examining a claim with particularity, a court must answer whether a statutory provision is enforceable with regard to a particular plaintiff since a statute “may confer a right of some type upon some class of persons without conferring the particular right asserted by the plaintiff in a suit.”²⁴⁴

Individuals—both protected and nonprotected—will continue to have a number of claims. If protected from benchmark coverage, they will be entitled to the services referenced in the availability provision,²⁴⁵ and the DRA will be irrelevant at this stage of the inquiry. If protected from premiums and copayments, they may bring a claim against the state if it imposes those obligations on them.²⁴⁶ For individuals in nonprotected groups with regard to benchmark coverage, they may sue if the state fails to enroll them in a coverage plan. To use our previous example, although she may not have an enforceable right to nursing home care, the elderly woman may still bring suit against the state for failing to pay for her enrollment in a benchmark or benchmark equivalent plan, because it has not met the availability provision’s requirement that it make “medical assistance available” to her.²⁴⁷ For individuals in nonprotected groups with regard to premiums and copayment, they may bring suit if they paid their premium or copayment and are not provided services. An individual who is enrolled in a benchmark equivalent plan that does not offer the minimum required services may also maintain a claim under the post-DRA availability provision. This list is not exhaustive, it merely illustrates the types of post-DRA availability provision suits that beneficiaries will continue to be able to bring.

Because the DRA has not changed the text of the availability provision, the textual analyses of the post-*Gonzaga* circuit courts discussed above are still sound. First, like Titles VI and IX, which provide that “[n]o person . . . shall . . . be subjected to discrimination,”²⁴⁸ the availability provision’s requirement that a state plan must provide for making medical assistance available is “mandatory, rather than precatory.”²⁴⁹ Second, the availability provision focuses on the individual protected, as opposed to the state.²⁵⁰ Third, the availability provision does not have an aggregate or systemwide focus.²⁵¹ Thus, the primary mode of analysis under the *Gonzaga* test—the textual inquiry—is unchanged by the DRA.

243. *Blessing v. Freestone*, 520 U.S. 329, 342 (1997).

244. *Casillas v. Daines*, 580 F. Supp. 2d 235, 241 (S.D.N.Y. 2008).

245. See *supra* note 19 for a list of enumerated services.

246. See *supra* notes 237–238 for a list of groups protected from copayments and premiums.

247. § 1396a(a)(10)(A).

248. *Id.* § 2000d; 20 U.S.C. § 1681(a) (2006).

249. *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir. 2004) (citing *Blessing v. Freestone*, 520 U.S. 329, 341 (1997)).

250. *Id.*

251. *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 604 (5th Cir. 2004).

3. *Gonzaga's Structural Inquiry*. — An inquiry into the structure of the Medicaid Act as a whole is integral to the *Gonzaga* analysis, because it may override the clear textual language of the provision at issue. In its discussion of whether FERPA creates enforceable rights, the *Gonzaga* Court “buttressed” its conclusion that the text failed to unambiguously confer rights by turning to the structure of the statute.²⁵² Following *Gonzaga*, the Third Circuit in *Sabree*—the most comprehensive of the circuit court opinions examining the availability provision in light of *Gonzaga*—found both textual and structural inquiry relevant to determining whether the availability provision confers enforceable rights.²⁵³ Similarly, although the Fifth Circuit in *Dickson* noted that a statute that focused on a state’s obligations was not per se unenforceable,²⁵⁴ if the DRA has changed the focus of the Medicaid Act significantly enough, a court could find, relying on *Gonzaga*, that the availability provision does not create enforceable rights.²⁵⁵ This inquiry into an act’s structure should be “a holistic endeavor.”²⁵⁶ Thus, a court must inquire—as did the courts in *Gonzaga*, *Sabree*, and *Dickson*—whether, despite the clear rights-creating language of the availability provision, the structure of the Medicaid Act as a whole indicates lack of congressional intent to confer an enforceable right upon the plaintiff.²⁵⁷

The benchmark and copayment provisions affect the structure of the Medicaid Act because the provisions *themselves* likely do not pass *Gonzaga*’s textual inquiry.²⁵⁸ The text of the DRA provisions says nothing of individual entitlements or rights.²⁵⁹ In addition, these provisions are precatory, rather than mandatory,²⁶⁰ since they give a state discretion to provide benchmark coverage or impose premiums or copayment on non-protected groups if it wishes. Finally, the provisions focus on “‘the aggregate services provided by the State,’ rather than ‘the needs of any particu-

252. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 289 (2002) (discussing FERPA’s enforcement mechanism).

253. *Sabree*, 367 F.3d at 191.

254. See *supra* Part II.B.2.

255. The *Gonzaga* Court noted that “FERPA’s nondisclosure provisions further speak only in terms of institutional policy and practice . . . [t]herefore . . . they have an aggregate focus, they are not concerned with whether the needs of any particular person have been satisfied, and they cannot give rise to individual rights.” *Gonzaga*, 536 U.S. at 288 (citations and internal quotation marks omitted).

256. *Sabree*, 367 F.3d at 190 (quoting *U.S. Nat’l Bank v. Indep. Ins. Agents*, 508 U.S. 439, 455 (1993)).

257. See *supra* notes 181–182 and accompanying text.

258. See *supra* Part II.C.1.

259. See 42 U.S.C. § 1396o-1(a) (2006) (“[A] State . . . at its option . . . may impose premiums and cost sharing [copayments]”); *id.* § 1396u-7(a)(1)(A) (providing that “a State, at its option . . . may provide for medical assistance” through benchmark coverage).

260. Cf. *supra* text accompanying notes 52–53 (noting *Pennhurst* Court found statute at issue did not impose binding obligation on the states because language was precatory rather than mandatory).

lar person.’”²⁶¹ Thus, because the DRA provisions do not create an individual right to benchmark coverage, they are likely not enforceable through § 1983. Under *Sabree*, the unenforceability of the DRA provisions is relevant to the structure of the Medicaid Act, and these provisions may weigh against finding enforceable rights in the availability provision.²⁶²

On balance, however, the DRA’s structural changes are insufficient to alter the enforceability of the availability provision: Although the DRA may have affected the content of Medicaid rights, it does not render those rights unenforceable under § 1983. First, because protected groups are exempted from the DRA, its impact on the structure or scheme of the Medicaid Act as a whole is decreased. As opposed to the Medicaid Act provisions that the *Sabree* court noted weighed against the rights-creating language of the availability provision,²⁶³ the DRA does not apply across the board. According to the *Sabree* court: “The language used by Congress in 42 U.S.C. § [] 1396a(a)(10) . . . explicitly creates rights.”²⁶⁴ This broad provision—requiring states to “mak[e] medical assistance available”²⁶⁵—should carry more structural weight than the DRA, which applies only in certain instances and is codified in various sections of the Act. Second, the DRA does not just have to contend with the rights-bearing language of the availability provision; courts have found that *other* Medicaid provisions create enforceable rights.²⁶⁶ The flexibility given to the states *in certain circumstances* by the DRA is not sufficient to outweigh the rights created in the availability provision and other provisions within the Medicaid Act.²⁶⁷ Thus, the overall individual-focused nature of the Medicaid Act as a whole has not been dramatically changed by the DRA.²⁶⁸

Further, the DRA provisions require the state to examine each beneficiary individually.²⁶⁹ This fact decreases the DRA provisions’ effect on

261. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282 (2002) (quoting *Blessing v. Freestone*, 520 U.S. 329, 343 (1997)).

262. See *supra* Part II.B.1.

263. See *id.*

264. *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004).

265. 42 U.S.C. § 1396a(a)(10) (2006).

266. The Third Circuit in *Sabree*, for instance, found that § 1396a(a)(8), which provides that “assistance shall be furnished with reasonable promptness to all eligible individuals,” was enforceable through § 1983. *Sabree*, 367 F.3d at 190; see also *Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002) (finding enforceable right under § 1396a(a)(8) post-*Gonzaga*).

267. See *Tobin & Bobroff*, *supra* note 24, at 147 (arguing DRA’s “discrete amendments do not fundamentally alter Medicaid”). But see *Donenberg*, *supra* note 22, at 1524 (arguing DRA “represent[s] serious structural modifications of Medicaid”).

268. See *Tobin & Bobroff*, *supra* note 24, at 148 (“[The DRA’s] changes were ones of degree rather than kind.”).

269. See, e.g., *supra* note 237 for lists of groups that the states cannot enroll in benchmark coverage, and groups that cannot be required to share in their health care costs.

the Act as a whole. While the DRA concerns “groups of individuals,” each person is provided benefits based upon their unique position, since the benchmark provisions do not require the state to treat all individuals in a particular group the same for the purposes of benchmark enrollment.²⁷⁰ An illustration: If a state wanted to enroll all blonde-haired people in benchmark coverage (assuming that blondness is not a protected group), it could do so for all blonde-haired people *unless* a blonde is also a member of a protected group, for instance, blind or disabled individuals.²⁷¹ So although people are initially considered as members of a group, they must also be disaggregated, since the state must consider whether each individual is or is not a member of particular groups in order to determine which kind of coverage it can legally provide under the DRA. As noted by the Ninth Circuit in *Watson v. Weeks*, a statute may still be individually focused even if it treats people as groups or types of individuals.²⁷² Thus, despite the changes that the DRA made to the Medicaid Act, the Act as a whole still “requires states to provide particularly specified benefits to particularly specified types of individuals” and should pass the *Gonzaga* test for § 1983 enforceability, at least with respect to some types of claims presented by some individuals.²⁷³

4. *Legislative History.* — Under *Gonzaga*, a court should also look to legislative history to determine whether the availability provision creates enforceable rights. Although it is not *required* where the plain meaning of a statute is clear,²⁷⁴ it may be useful to show congressional intent regarding enforceable rights. In *Gonzaga*, after discussing the text of the provision and the structure of FERPA as a whole, the Court briefly noted the statute’s legislative history.²⁷⁵ One commentator has argued that, just as *Gonzaga* considered FERPA’s legislative history, “lower courts should routinely consider a statute’s legislative history as one factor in ascertaining congressional intent about whether it creates individual rights.”²⁷⁶

Congressional silence in the face of judicial decisions finding the availability provision enforceable through § 1983 may indicate congressional intent to confer enforceable rights. All of the pre-DRA circuit

270. See *supra* note 222 and accompanying text; see also *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 603 (5th Cir. 2004) (noting requirement of state action— “[a] state must provide”—does not mean statute fails to confer enforceable rights (internal quotation marks omitted) (quoting § 1396a(a)(10)(A)(i))).

271. See § 1396u-7(a)(2)(B)(ii) (listing blind or disabled individuals as among those who states cannot enroll in benchmark coverage).

272. *Watson v. Weeks*, 436 F.3d 1152, 1161 (9th Cir. 2006); see *supra* Part II.B.3 for a discussion of this case.

273. *Watson*, 436 F.3d at 1161.

274. See *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir. 2004) (“Where, as here, the plain meaning of the text is evident, we need not look further to determine congressional intent.”); see also *Darby v. Cisneros*, 509 U.S. 137, 147 (1993) (“Recourse to the legislative history . . . is unnecessary in light of the plain meaning of the statutory text.”).

275. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 290 (2002).

276. Mank, *Suing Under § 1983*, *supra* note 83, at 1479–80.

courts that addressed the issue found that the availability provision conferred enforceable individual rights.²⁷⁷ There does not appear to be any legislative history relating to the DRA that indicates that Congress intended to foreclose this judicially recognized enforceability. The Supreme Court has noted: “Congressional silence as to private remedies should be interpreted . . . as acquiescing in the accepted view.”²⁷⁸ Moreover, when Congress passed the DRA—a major act affecting Medicaid—after three circuit courts found the availability provision enforceable under § 1983 post-*Gonzaga*, it did not contradict these decisions. This congressional refusal to address the issue may indicate agreement with the circuit courts that continued to find the availability provision enforceable through § 1983.²⁷⁹

Further, there is some indication that Congress passed the DRA knowing that Medicaid included beneficiaries’ basic rights to services. Senator Judd Gregg, the DRA’s sponsor and Chair of the Senate Budget Committee, which voted on the bill, noted: “If you are at a certain income level in this country, you have a right to certain benefits. . . . [A]nd those payments have to be made. . . . [I]f a person meets a certain set of criteria, then *that person has a right to the support of that program.*”²⁸⁰

It would seem, then, that the DRA does not reflect a change in congressional understanding of the relationships between the federal government and the states—and between the states and the beneficiaries—in the context of Medicaid: Individuals are entitled to benefits from the state, and the state is entitled to payment from the federal government for providing these benefits. Because Congress believes individuals have mandatory rights to certain benefits if they meet eligibility criteria, the § 1983 inquiry is over. Congress need only intend to create a right; § 1983 provides the remedy.²⁸¹

277. See *supra* Part II.B.

278. *California v. Sierra Club*, 451 U.S. 287, 296 n.7 (1981). But see Donenberg, *supra* note 22, at 1525 n.154 (“[A] lack of legislative history explicitly indicating Congress’s intent to abrogate the § 1983 right to enforce Medicaid benefits is unlikely to be relevant.”).

279. See *Johnson v. Transp. Agency*, 480 U.S. 616, 629 n.7 (1987) (“Congress has not amended the statute to reject our construction, nor have any such amendments even been proposed, and we therefore may assume that our interpretation was correct.”). But see *id.* at 672 (Scalia, J., concurring) (“I think we should admit that vindication by congressional inaction is a canard.”).

280. 151 Cong. Rec. S12,065-66 (2005) (emphasis added).

281. See *supra* note 87 (noting § 1983 provides remedy for violation of federal rights); see also *Gonzaga Univ. v. Doe*, 536 U.S. 273, 284 (2002) (“Plaintiffs suing under § 1983 do not have the burden of showing an intent to create a private remedy because § 1983 generally supplies a remedy for the vindication of rights secured by federal statutes.”).

CONCLUSION

The Medicaid Act involves both a federal-state funding partnership, and a relationship between a state and those of its citizens in need of health care. The availability provision contains the Act's most basic statement: It mandates that a state make medical assistance available to those who qualify for it. When a state fails to provide medical assistance to qualifying beneficiaries, the individuals' recourse has traditionally been to sue the state in federal court through § 1983. Recently, however, the Supreme Court's *Gonzaga* opinion heightened the test for enforceable rights under § 1983. As a result, Medicaid beneficiaries have lost a remedy to enforce many of their rights, as circuit courts have found certain Medicaid provisions unenforceable through the traditional § 1983 path. Despite this change, a number of circuit courts have continued to find the availability provision enforceable. Although the DRA has altered the *types* of claims that will survive *Gonzaga*'s initial textual inquiry, it has not sufficiently altered the structure of the Medicaid Act so as to entirely foreclose availability provision suits under § 1983.