
CASE NOTE

PRIVATE ENFORCEMENT OF SPENDING CONDITIONS AFTER *DOUGLAS*

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Congress cannot compel the states to implement its regulatory agenda, but it may purchase their compliance through the exercise of its spending power.¹ Today, the federal government achieves many of its signature policy goals, including the provision of Medicaid benefits to the poor, disabled, and elderly, in cooperation with the states.² These joint spending programs promote federalism values, but they also place important federal initiatives at the mercy of state budgetary pressures. When the economy falters and state revenues decline, entitlement programs like Medicaid become a perennial target for cuts. In *Douglas v. Independent Living Center of Southern California, Inc.*, a case from the 2011 term, the Supreme Court considered whether hospitals and other private parties have an implied right of action under the Supremacy Clause to challenge the sufficiency of state payments under a cooperative spending program.³

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¹ *South Dakota v. Dole*, 483 U.S. 203, 206 (1987) (“Congress may attach conditions on the receipt of federal funds, and has repeatedly employed the power ‘to further broad policy objectives by conditioning receipt of federal moneys upon compliance . . . with federal statutory and administrative directives.” (quoting *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980) (opinion of Burger, C.J.))).

² See Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and “Dual Sovereignty” Doesn’t*, 96 MICH. L. REV. 813, 815 (1998) (explaining the theory of cooperative federalism, by which state and local governments share policymaking responsibility with the federal government in areas ranging from unemployment insurance to historic preservation).

³ 132 S. Ct. 1204, 1207 (2012).

In this Case Note, I explore the background, history, and resolution of the *Douglas* litigation in the Supreme Court. I argue that the Court was right to suggest that private enforcement of the Medicaid statute sits uncomfortably within the system of agency oversight prescribed by Congress. But that is not to say that a Supremacy Clause action should never be available in the spending context. Though some scholars have likened joint spending programs to contracts between the state and federal governments, an analogy that might suggest a limited role for private parties in enforcing their terms,⁴ I reject that view and explore some cases in which a Supremacy Clause action would be appropriate.

I. MEDICAID'S EQUAL ACCESS PROVISION

Congress created Medicaid in 1965 to provide health insurance to certain vulnerable populations, including the blind, disabled, elderly, and children from needy families.⁵ Unlike Medicare, which is funded and administered entirely by the federal government, Medicaid is a miscellany of fifty-six health insurance programs run by the states and territories with substantial financial assistance from the federal government.⁶ Until the passage of the Patient Protection and Affordable Care Act (ACA), states had considerable discretion to limit the class of individuals they would insure;⁷ they retain discretion even now to design the package of benefits and set payment rates for doctors, hospitals, and other providers.⁸ The states submit “plans for medical assistance” that outline the substance of their program to the Centers for Medicare and Medicaid Services (CMS).⁹

⁴ See, e.g., David E. Engdahl, *The Contract Thesis of the Federal Spending Power*, 52 S.D. L. REV. 496 (2007).

⁵ See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.); MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 28 (2011).

⁶ KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: A PRIMER 5 (2010).

⁷ In the ACA, Congress required the states to extend Medicaid coverage to all eligible individuals under the age of sixty-five who earn less than 133% of the federal poverty level. See HINDA CHAIKIND ET AL., CONG. RESEARCH SERV., PPACA: A BRIEF OVERVIEW OF THE LAW, IMPLEMENTATION, & LEGAL CHALLENGES 2 (2011). The Supreme Court struck down that requirement as unduly coercive in *National Federation of Independent Business v. Sebelius*, holding that Congress could not induce the states to expand coverage by threatening to withdraw all Medicaid funding if they refused to do so. 132 S. Ct. 2566, 2606-07 (2012). The Medicaid expansion is not a dead letter, however. Congress may still offer substantial financial inducement for states to expand their Medicaid rolls; it simply may not force them to do so under pain of penalty. *Id.*

⁸ See KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 6, at 5.

⁹ *Financing and Reimbursement*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html> (last visited Nov. 7, 2012); see also 42 U.S.C. § 1396a(a) (2006) (describing the requirements for a state medical assistance plan).

If approved, the federal government reimburses states between fifty and eighty-three percent of the cost of providing care.¹⁰ In fiscal year 2010, the federal and state governments spent a combined \$406 billion to fund health insurance coverage for sixty-eight million people.¹¹

Congress attaches numerous conditions to the Medicaid funds it provides to the states. Although participation in Medicaid is voluntary, these conditions bind the states once they join the program,¹² as all of them had by 1982.¹³ The condition at issue in *Douglas*, the so-called equal access provision, requires that states

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers 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.¹⁴

The courts of appeals have divided in interpreting the demands this provision places on the states. The Ninth Circuit, for example, requires states to gather data and to reimburse providers at rates that “bear a reasonable relationship” to the cost of providing services,¹⁵ while the Seventh Circuit does not mandate that the states consider real-world costs.¹⁶ No matter what the operative legal standard, in practice Medicaid reimburses providers only a fraction of what they would receive from Medicare or private insurers.¹⁷ That Medicaid trails these other payers is largely a function of state budget pressures. Unlike the federal government, most

¹⁰ See 42 U.S.C. § 1396d(b)(1).

¹¹ MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 5, at 2, 38.

¹² See *Harris v. McRae*, 448 U.S. 297, 301 (1980); *Hope Med. Grp. for Women v. Edwards*, 63 F.3d 418, 421 (5th Cir. 1995).

¹³ In 1982, Arizona became the last state to participate in Medicaid. See Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 445 n.69 (2011).

¹⁴ 42 U.S.C. § 1396a(a)(30)(A).

¹⁵ See *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1498 (9th Cir. 1997).

¹⁶ See *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (reasoning that § 1396a(a)(30) “requires each state to produce a *result*, not to employ any particular methodology for getting there”); see also *Methods for Assuring Access to Covered Medicaid Services*, 76 Fed. Reg. 26,342, 26,343 (May 6, 2011) (to be codified at 42 C.F.R. pt. 447) (noting that the split in the circuits has subjected states “to considerable uncertainty as they move forward in designing service delivery systems and payment methodologies”).

¹⁷ See 146 CONG. REC. E2083 (2000) (extension of remarks of Rep. John D. Dingell) (lamenting that “Medicaid payment rates are a fraction of what Medicare pays,” and giving examples); Denise Grady, *Children on Medicaid Shown to Wait Longer for Care*, N.Y. TIMES, June 16, 2011, at A24 (citing a study indicating that primary care doctors in Illinois receive \$160 from private insurers for a basic office visit, compared to \$99.86 from Medicaid).

states must balance their budgets.¹⁸ Medicaid consumes the “largest or second-largest share of state budgets,”¹⁹ and thus becomes a perennial target for savings when the economy slows and state revenues falter²⁰—especially because, unlike many state employees, private health care providers are not protected by union contracts.²¹ In some states, payments have dwindled to the point that doctors simply refuse to treat Medicaid patients. One woman told the *Los Angeles Times* that she spent more than six months searching for a doctor who would fit medical braces on her son, a Medicaid recipient who suffers from spina bifida;²² the same article quoted a primary care doctor who could not locate a single neurologist in the region to treat his Medicaid patients.²³

States have whittled Medicaid payments with impunity because CMS has only one tool to cudgel compliance with the equal access provision, and it is both exceedingly harsh and rarely, if ever, used.²⁴ If the agency determines that a state’s management of its Medicaid program has failed “to comply substantially” with federal conditions, it may cease making all or part of the payments that would otherwise be due to the state to support health insurance for the poor.²⁵ As many commentators have noted, CMS will almost never invoke this remedy against recalcitrant states because withholding funds would inevitably harm the vulnerable populations, including children, pregnant women, and the disabled, for whom Medicaid provides a critical safety net.²⁶ Rather than strong-arm the states, the agency seeks their cooperation through soft political persuasion and directs its limited enforcement resources to preventing fraud by doctors, hospitals, and other private-sector providers.²⁷ In an amicus brief filed in the *Douglas*

¹⁸ MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 5, at 20. For an overview of state balanced budget provisions, see NAT’L CONF. OF STATE LEGISLATURES, NCSL FISCAL BRIEF: STATE BALANCED BUDGET PROVISIONS (2012), available at <http://www.ncsl.org/documents/fiscal/StateBalancedBudgetProvisions2010.pdf>.

¹⁹ MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 5, at 38.

²⁰ *Id.* at 20.

²¹ See George Skelton, *Tax Loophole Saved At Expense of Poor*, L.A. TIMES, Feb. 18, 2008, at B1 (quoting a state senator who said it was easier to cut reimbursements to doctors than to reduce the salaries of “teachers or prison guards or highway patrolmen” because the former do not have union contracts).

²² See Evan Halper, *Further Fee Cuts Force a Medi-Cal Exodus*, L.A. TIMES, Mar. 24, 2008, at A1.

²³ *Id.*

²⁴ See Nicole Huberfeld, *Post-Reform Medicaid Before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS HEALTH L. 513, 522 (2012) (“[T]otal funding withdrawal has never happened, seemingly because CMS recognizes the draconian and counterproductive nature of penalizing states in this way.”).

²⁵ See 42 U.S.C. § 1396c (2006) (authorizing CMS to withhold payments to states); 42 C.F.R. § 430.35(a) (2011) (enumerating bases for withholding payments).

²⁶ E.g., Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 462-63 (2008).

²⁷ Abigail R. Moncrieff, *The Supreme Court’s Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2340-41 (2010).

case, former Health and Human Services officials likened the federal agency not to “a referee calling fouls,” but to “a coach giving support in the form of cash and expertise.”²⁸ Even if the agency were inclined to pursue more vigorous enforcement, these officials noted, it would not have the manpower: a staff of fewer than five hundred bears responsibility for overseeing Medicaid programs in fifty states and six territories.²⁹

Even as administrative enforcement has proven anemic, the Supreme Court has narrowed the field of statutes that private litigants may enforce under 42 U.S.C. § 1983—the statute that supplies a remedy for violations of federal rights.³⁰ For a time, the Court was willing to locate enforceable rights in Spending Clause statutes such as the Medicaid Act. In *Wilder v. Virginia Hospital Association*, the Court allowed hospitals to maintain a § 1983 suit to challenge Virginia’s tightfisted reimbursement rates as inconsistent with the Boren Amendment, a section of the Medicaid Act that required states to set payments at a level the “State finds . . . reasonable and adequate to meet the costs” of providing care.³¹ The majority found that this language gave hospitals a substantive right to reasonable payment,³² even though it arguably imposed only a procedural requirement on states to make findings about the sufficiency of their Medicaid rates.³³ After Congress repealed the Boren Amendment in 1997, the courts of appeals continued to recognize rights-creating language in other Medicaid funding conditions, including the equal access provision.³⁴ Indeed, when he was still a judge on the Third Circuit, Justice Alito suggested in dictum that Medicaid patients, if not providers, could proceed under § 1983 to enforce the equal access provision because they “plainly satisfy the intend-to-benefit requirement.”³⁵ Then-Judge Alito excavated legislative history from 1981, when Congress added the equal access provision to the statute, to support his conclusion that Congress intended the courts “to take appropriate

²⁸ Brief of Former HHS Officials as Amici Curiae in Support of Respondents at 22, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (No. 09-958), 2011 WL 3706105 (quoting Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement*, 58 VA. L. REV. 600, 620 (1972)).

²⁹ *Id.* at 19.

³⁰ In *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980), the Supreme Court held that § 1983 may be used to enforce rights created by federal statute, as well as by the Constitution.

³¹ 496 U.S. 498, 501-02 (1990) (quoting 42 U.S.C. § 1396a(a)(13)(A) (Supp. V 1982)).

³² *Id.* at 510.

³³ *Id.* at 527-28 (Rehnquist, C.J., dissenting) (arguing that the law granted, at most, a right to the “establishment of rates in accordance with that process,” rather than a right to any substantive result).

³⁴ See e.g., *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 927-28 (5th Cir. 2000) (concluding that § 30(A) is phrased in terms of patient benefit and thus supports a private right of action), *abrogated by Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007).

³⁵ *Pa. Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 543-44 (3d Cir. 2002) (en banc).

remedial action” where either the states or CMS failed to abide by the Medicaid Act’s requirements.³⁶

The landscape changed with *Gonzaga University v. Doe*, an important 2002 decision in which the Supreme Court offered a narrow interpretation of when federal funding conditions can support a private right of action under § 1983.³⁷ The plaintiff, a former student at Gonzaga, sued the university for releasing his records to a prospective employer, allegedly in violation of the Family Educational Rights and Privacy Act of 1974.³⁸ Congress passed this statute under its spending authority, granting federal funds to universities on the condition that they not maintain “a policy or practice” of releasing student records without written consent.³⁹ The Court rebuffed the plaintiff’s suit, holding that he could not enforce the statute using § 1983 because the funding condition imposed only a general duty on the grant recipients and did not confer an individual right against disclosure.⁴⁰ Having noted in previous cases that the plain language speaks of “rights, privileges, and immunities,”⁴¹ the Court emphasized that § 1983 provides a remedy only where a statute includes “rights-creating language” and is clearly intended to benefit a particular class of plaintiffs.⁴² In so doing, the Court demanded a clear statement from Congress before it would read funding conditions to create rights that may be vindicated via § 1983: “We made clear that unless Congress speaks with a clear voice, and manifests an unambiguous intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983.”⁴³ Accordingly, “it is *rights*, not the broader or vaguer ‘benefits’ or ‘interests,’ that may be enforced under the authority of that section.”⁴⁴

Importantly, the Court held that a plaintiff suing under § 1983 must meet the same threshold requirement as a plaintiff asserting an implied right of action: he must demonstrate that “Congress intended to create a federal right.”⁴⁵ In both settings, the Court will find statutes to confer

³⁶ *Id.* at 541 (quoting H.R. REP. NO. 97-158, at 301 (1981)).

³⁷ 536 U.S. 273 (2002).

³⁸ *Id.* at 277.

³⁹ *Id.* at 278-79.

⁴⁰ *Id.* at 287.

⁴¹ *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 509 (1990) (quoting *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989)).

⁴² *Gonzaga*, 536 U.S. at 290.

⁴³ *Id.* at 280 (brackets and internal quotation omitted).

⁴⁴ *Id.* at 283; *see also* *Astra USA, Inc. v. Santa Clara Cnty.*, 131 S. Ct. 1342, 1347 (2011) (“Recognition of any private right of action for violating a federal statute, currently governing decisions instruct, must ultimately rest on congressional intent to provide a private remedy.” (brackets and internal quotation omitted)).

⁴⁵ *Gonzaga*, 536 U.S. at 283 (emphasis omitted).

individual rights only when they are “phrased in terms of the persons benefited”⁴⁶ or evince concern for “whether the needs of any particular person have been satisfied;”⁴⁷ an “aggregate focus” does not beget enforceable rights.⁴⁸ The implied right of action and § 1983 inquiries differ only in that plaintiffs proceeding under the former must show that Congress intended to furnish both a right and a private remedy; this showing is unnecessary with the latter because § 1983 itself affords the remedy.⁴⁹

Since *Gonzaga*, the courts of appeals have almost uniformly held that Medicaid’s equal access provision does not contain the sort of rights-creating language that would permit private enforcement under § 1983.⁵⁰ The Ninth Circuit, for instance, found that the provision embraces “flexible, administrative standards” that do not “unmistakably” telegraph Congress’s intent to create a right for either providers or beneficiaries.⁵¹ To the contrary, the court found that the statute encompassed competing objectives, directing the states to provide payments that were efficient and economical, and thus taxpayer-protective, while simultaneously ensuring broad-based access to care.⁵² It concluded that this internal tension “supports the conclusion that § 30(A) is concerned with overall methodology rather than conferring individually enforceable rights on individual Medicaid recipients.”⁵³ With the § 1983 right of action all but foreclosed, Medicaid patients and providers had to seek another avenue into federal court when California reduced its already meager reimbursements in 2008.

II. DOUGLAS: FACTS AND DECISIONS BELOW

In January 2008, California was in a fiscal tailspin. With the state facing a \$14.5 billion deficit, the governor declared an emergency and urged lawmakers to consider a package of austere cuts: releasing inmates from

⁴⁶ *Id.* at 284 (quoting *Cannon v. Univ. of Chi.*, 441 U.S. 677, 690 n.13 (1979)).

⁴⁷ *Id.* at 288 (quoting *Blessing v. Freestone*, 520 U.S. 329, 343 (1997)).

⁴⁸ *Id.*

⁴⁹ *Id.* at 284.

⁵⁰ See *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007); *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542-43 (6th Cir. 2006); *N.Y. Ass’n of Homes & Servs. for the Aging v. DeBuono*, 444 F.3d 147, 148 (2d Cir. 2006) (per curiam); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004). *But see* *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005, 1015-16 (8th Cir. 2006) (holding that since the Supreme Court did not overrule *Wildler v. Virginia Hospital Association*, 496 U.S. 498 (1990), the equal access provision could still create a federal right).

⁵¹ *Sanchez v. Johnson*, 416 F.3d 1051, 1059 (9th Cir. 2005).

⁵² *Id.*

⁵³ *Id.* at 1059-60.

overcrowded prisons, slashing funding for local school districts, and reducing remuneration for the physicians, hospitals, and pharmacies that serve the state's Medicaid population.⁵⁴ The state's payments to health care providers were already the lowest in the nation, and legislators recognized that further begging of the reimbursement rates would discourage providers from accepting Medicaid patients and deprive the poor of critical access to care.⁵⁵ One Republican lawmaker warned during the budget debates that retrenchment would "lead to the demise of the Medi-Cal program as we know it."⁵⁶ Despite deep misgivings from both parties, the legislature cinched payments to health care providers by as much as ten percent.⁵⁷ To lawmakers, the decision was a Hobson's choice necessitated by fiscal crisis; to the patients and providers who brought suit to challenge the new rates, it was a bald-faced violation of the Medicaid statute's equal access provision. In a flurry of lawsuits eventually consolidated before the Supreme Court, these patients and providers sought injunctions to prevent the state health director from implementing the new payment schedules.

The plaintiffs proposed a novel theory in *Douglas v. Independent Living Center*.⁵⁸ Unable to proceed under § 1983, they claimed to have an implied right of action under the Supremacy Clause to challenge the sufficiency of state payments in federal court.⁵⁹ They reasoned that Medicaid's equal access provision, also referred to as § 30(A), creates a binding obligation that preempts incompatible state laws setting payment rates too low to ensure sufficient access to care.⁶⁰ Importantly, they argued that a federal right under § 30(A) is not required when a party sues on a preemption theory.⁶¹ Instead, they argued that the Supremacy Clause is a ballast that helps maintain the proper balance of power between the federal government and the states, and that private litigants may enforce those "structural" protections as long as they satisfy the standing requirement of Article III.⁶²

⁵⁴ Evan Halper, *Governor's Budget Derails His Lofty Goals*, L.A. TIMES, Jan. 11, 2008, at A1; see also *Brown v. Plata*, 131 S. Ct. 1910, 1936 (2011) (attributing unsafe and unsanitary conditions in California state prisons to "chronic and worsening budget shortfalls").

⁵⁵ Skelton, *supra* note 21.

⁵⁶ *Id.*

⁵⁷ See CAL. WELF. & INST. CODE § 14105.19(b)(1) (West 2012).

⁵⁸ One of the attorneys involved in the case, Rochelle Bobroff, helped develop this theory in the academic literature. See generally Rochelle Bobroff, *Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes*, 10 LOY. J. PUB. INT. L. 27 (2008).

⁵⁹ See Brief of Respondents Santa Rosa Memorial Hospital at 12-13, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (No. 10-283), 2011 WL 3288334.

⁶⁰ *Id.* at 9.

⁶¹ *Id.* at 22.

⁶² *Id.* at 24-26.

The plaintiffs found a receptive audience in the Ninth Circuit, which concluded that the Supremacy Clause does indeed provide a private right of action for plaintiffs seeking to challenge state compliance with federal funding conditions.⁶³ Although it was not one of the rulings challenged before the Supreme Court,⁶⁴ the Ninth Circuit gave its fullest articulation of this principle in 2008, in an earlier stage of the *Douglas* litigation.⁶⁵ Judge Marsha S. Berzon's opinion for the court of appeals held that plaintiffs do not need an antecedent federal right in order to bring a preemption claim.⁶⁶ The panel reasoned that such a requirement would conflate a Supremacy Clause right of action with a § 1983 action, when they in fact afford plaintiffs alternative avenues of relief.⁶⁷ The panel observed that the Supreme Court has "consistently assumed" that the Supremacy Clause supplies a right of action for plaintiffs challenging the incongruity of state and federal law, but "without comment" on the source or scope of that action.⁶⁸ Other commentators have also noted that the Court has reached the merits of many preemption claims without clearly identifying the underlying right of action.⁶⁹ It may do this because the federal courts have subject matter jurisdiction over preemption claims, which present a federal question,⁷⁰ even if plaintiffs have only an "arguable," as opposed to a "valid," right of action.⁷¹

⁶³ *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1058 (9th Cir. 2008).

⁶⁴ The seven decisions that were joined in *Douglas* are as follows: *Santa Rosa Mem'l Hosp. v. Maxwell-Jolly*, 380 F. App'x 656 (9th Cir. 2010); *Dominguez v. Schwarzenegger*, 596 F.3d 1087 (9th Cir. 2010); *Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010); *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 374 F. App'x 690 (9th Cir. 2010); *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 342 F. App'x 306 (9th Cir. 2009); *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009); and *Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009).

⁶⁵ *Shewry*, 543 F.3d at 1062.

⁶⁶ *Id.* at 1058.

⁶⁷ *Id.* at 1062 (citing *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006)); see also *AlohaCare v. Hawaii Dep't of Human Servs.*, 572 F.3d 740, 745 (9th Cir. 2009); David Sloss, *Constitutional Remedies for Statutory Violations*, 89 IOWA L. REV. 355, 362-63 (2004).

⁶⁸ *Shewry*, 543 F.3d at 1055-56; see also Brief for the United States as Amicus Curiae Supporting Petitioner at 9, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (No. 09-958), 2011 WL 2132705 ("Although the Court has not explored the nature or source of the cause of action, its cases reflect a longstanding practice of permitting private parties to bring suit in federal court to enjoin state regulatory action from which the plaintiffs claim immunity under federal law.").

⁶⁹ E.g., Bradley J. Sayles, *Preemption or Bust: A Review of the Recent Trends in Medicaid Preemption Actions*, 27 J. CONTEMP. HEALTH L. & POL'Y 120, 133 (2010).

⁷⁰ See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983) ("A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.").

⁷¹ See *Verizon Md. Inc. v. Public Serv. Comm'n of Md.*, 535 U.S. 635, 642-43 (2002) ("It is firmly established in our cases that the absence of a valid (as opposed to arguable) cause of action

For more than a century, the Court has allowed private parties to seek injunctions to prevent the implementation of state laws that conflict with federal laws. In *Ex parte Young*, a group of railroads sued the Minnesota attorney general to block a state order reducing the maximum rates that railroads could charge for freight and passengers.⁷² The railroads claimed that the new rates were “unjust, unreasonable, and confiscatory” and deprived them of property without due process of law.⁷³ The Supreme Court held that the federal courts possess inherent power to issue an injunction to prevent state officers from executing laws that violate the Constitution.⁷⁴ Without *Young*, a party wishing to challenge a state law might have to wait for the state to enforce the law against him and then assert its unconstitutionality as a defense. *Young* allowed litigants to use the Constitution as a sword to preempt the enforcement of state statutes that conflict with federal law.⁷⁵ Although such actions are for all intents and purposes directed at the state, the Court invented a legal fiction to avoid the Eleventh Amendment bar on suits against the states: state officers act ultra vires when they implement unconstitutional laws and thus may be sued in their individual capacity.⁷⁶

Plaintiffs seeking to block a state law or policy under *Young* may sue for injunctive relief, not for damages,⁷⁷ but this limitation does not bar injunctions that may impact the state fisc.⁷⁸ As scholars have recognized, *Ex parte Young* provides a critical means for the courts to rein in the states when

does not implicate subject-matter jurisdiction, *i.e.*, the courts’ statutory or constitutional *power* to adjudicate the case.” (internal quotation omitted)); *Bell v. Hood*, 327 U.S. 678, 682 (1946) (“Jurisdiction . . . is not defeated . . . by the possibility that the averments might fail to state a cause of action on which petitioners could actually recover.”).

⁷² *Ex parte Young*, 209 U.S. 123, 130 (1908).

⁷³ *Id.*

⁷⁴ *See id.* at 155-56 (“[O]fficers of the state . . . violating the Federal Constitution, may be enjoined by a Federal court of equity from such action.”).

⁷⁵ *See* John Harrison, *Ex Parte Young*, 60 STAN. L. REV. 989, 990 (2008) (“*Ex parte Young* approved the use against a state officer of a standard tool of equity, an injunction to restrain proceedings at law. Through an anti-suit injunction a party who would be the defendant in a corresponding lawsuit can enforce in equity a legal position that would be a defense at law.”).

⁷⁶ *See Ex parte Young*, 209 U.S. at 159-60:

If the act which the state attorney general seeks to enforce be a violation of the Federal Constitution, the officer, in proceeding under such enactment, comes into conflict with the superior authority of that Constitution, and he is in that case stripped of his official or representative character and is subjected in his person to the consequences of his individual conduct. The state has no power to impart to him any immunity from responsibility to the supreme authority of the United States.

⁷⁷ LINDA MULLEN ET AL., UNDERSTANDING FEDERAL COURTS AND JURISDICTION 491 (1998).

⁷⁸ *See Milliken v. Bradley*, 433 U.S. 267, 289 (1977) (holding that federal courts may grant injunctive relief against state officials “notwithstanding a direct and substantial impact on the state treasury”).

their laws threaten to frustrate federal law or policy, thus maintaining the balance of power between the federal government and the states.⁷⁹ While the case law clearly allows for injunctive relief in cases of direct federal-state conflict, it is less clear that plaintiffs may invoke *Young* if the state is failing to discharge its obligations under a cooperative spending program monitored by a federal administrative agency.

The United States, supporting California as amicus curiae in *Douglas*, argued that the federal-state relationship takes on a different hue in the context of such joint programs.⁸⁰ First, the solicitor general questioned whether preemption is even at issue when states merely underperform in providing benefits mandated by a federal spending program.⁸¹ Preemption, the United States said, comes into play only when federal law collides with a “wholly independent state program dealing with the same or a similar problem.”⁸² In this case, California was not attempting to regulate in a field where federal law already prescribed the rules of conduct. Instead, it was providing benefits at the direction of the federal government and with subsidies from the federal purse. While the state’s meager payments under the Medi-Cal program might have been insufficient to fully realize the federal government’s goal of providing health care to the poor, they did not actively undermine the federal prerogative as a contrary regulation would.

Second, the United States argued that a private right of action under the Supremacy Clause would sit uncomfortably not only with the Court’s implied right of action and § 1983 jurisprudence, but also with the contractual nature of the federal-state spending program.⁸³ The government’s brief intimated that private enforcement would disrupt the harmonious state of affairs between the federal government and the states: “Recognition of a nonstatutory cause of action for Medicaid providers and beneficiaries in this setting would be in tension with the nature of the federal-state relationship and the enforcement scheme contemplated by the statute.”⁸⁴ The Medicaid statute envisions that the federal and state governments will work together as allies and collaborators; preemption means that the federal government is bigfooting the states.⁸⁵

⁷⁹ See ERWIN CHEMERINSKY, FEDERAL JURISDICTION 435 (5th ed. 2007) (“Without *Young*, federal courts often would be powerless to prevent state violations of the Constitution and federal laws.”).

⁸⁰ Brief for the United States as Amicus Curiae Supporting Petitioner, *supra* note 68, at 16-17.

⁸¹ *Id.* at 21-22.

⁸² *Id.* (quoting *N.Y. State Dep’t of Soc. Servs. v. Dublino*, 413 U.S. 405, 411 n.9 (1973)).

⁸³ *Id.* at 25.

⁸⁴ *Id.*

⁸⁵ *Cf. Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2632-33 (2012) (Ginsburg, J., concurring in part, concurring in the judgment, and dissenting in part) (noting that Medicaid “is

III. THE SUPREME COURT'S DECISION IN *DOUGLAS*

In *Douglas*, the Supreme Court left unanswered whether the Supremacy Clause provides a private right of action to enforce federal spending conditions.⁸⁶ The case's factual underpinnings had changed since certiorari was granted the year before, and the five-member majority concluded that the case could benefit from further briefing and argument in the court of appeals.⁸⁷ At the time the Court agreed to review the Ninth Circuit's decisions, CMS had rejected California's Medicaid reductions because the state had not shown that the new rates were "sufficient to enlist enough providers," as required by the equal access provision.⁸⁸ Less than a month after oral argument, however, the agency completed the formal administrative review sought by the state and retroactively approved some of the state's cuts.⁸⁹ "In light of the changed circumstances," the Court wrote, "we believe that the question before us now is whether, once the agency has approved the state statutes, groups of Medicaid providers and beneficiaries may still maintain a Supremacy Clause action asserting that those statutes are inconsistent with the federal Medicaid law."⁹⁰ The Court remanded the case for the court of appeals to decide the question in the first instance.⁹¹

At the same time, Justice Breyer's opinion for the five-member majority left the distinct impression that, once the federal agency had approved the new rates, the plaintiffs should proceed under the Administrative Procedure Act (APA), not the Supremacy Clause.⁹² Federal courts apply a deferential standard of review to agency actions, setting aside agency decisions under the APA only if they are arbitrary, capricious, or an abuse of discretion.⁹³ If courts were to accord less deference in actions brought under the Supremacy Clause, they might "make superfluous or . . . undermine traditional APA review."⁹⁴ What is more, conflicting decisions issued by the agency

designed to advance cooperative federalism," affords states "considerable autonomy," and gives them more influence than they would have had if Congress had "established Medicaid as an exclusively federal program" (internal quotation omitted).

⁸⁶ *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1211 (2012) ("In the present posture of these cases, we do not address whether the Ninth Circuit properly recognized a Supremacy Clause action to enforce this federal statute before the agency took final action.").

⁸⁷ *Id.* at 1207-08.

⁸⁸ Brief for the United States as Amicus Curiae Supporting Petitioner, *supra* note 68, at 8.

⁸⁹ See *Douglas*, 132 S. Ct. at 1209; see also Letter from Donald B. Verrilli Jr., U.S. Solicitor General, to William K. Suter, Clerk of the U.S. Supreme Court (Oct. 28, 2011) (on file with the *University of Pennsylvania Law Review*).

⁹⁰ *Douglas*, 132 S. Ct. at 1207.

⁹¹ *Id.* at 1208.

⁹² *Id.* at 1211.

⁹³ See 5 U.S.C. § 706(2)(A) (2006).

⁹⁴ *Douglas*, 132 S. Ct. at 1211.

and the courts of appeals could sow confusion and imperil “the uniformity that Congress intended by centralizing administration of the federal program in the agency.”⁹⁵ The decision echoed *Astra USA, Inc. v. Santa Clara County* in its concern that private enforcement could disrupt the consistency that comes with vesting oversight in a single agency.⁹⁶ In *Astra*, the Court barred public hospitals and clinics from suing drug manufacturers for breach of a price-ceiling contract that the manufacturers signed with the federal government as a condition of participating in the Medicaid program.⁹⁷ The Court reasoned that private rights of action might produce conflicting decisions in the courts of appeals and “undermine the agency’s efforts to administer both Medicaid and § 340B harmoniously and on a uniform, nationwide basis.”⁹⁸

The *Douglas* majority offered no comment on whether plaintiffs had a cause of action to enjoin the rate reductions *before* the agency decided whether the cuts complied with the Medicaid Act. States must seek agency approval to amend their Medicaid plans, including the payments they make to health care providers, and the process often drags on for months or even years.⁹⁹ As Justice Kagan noted during oral argument, California implemented its 2008 rate reductions before the agency had completed its review of the changes to the state plan.¹⁰⁰ If plaintiffs could bring suit under the Supremacy Clause, a federal court could issue an injunction to preserve the status quo and ensure that the state did not unilaterally slash its Medicaid program while it waited for the agency to issue a decision.¹⁰¹ In this way, the private right of action would be a helpmate, not a hindrance, to agency enforcement.¹⁰² Because the Eleventh Amendment bars suits for retroactive recovery of benefits,¹⁰³ states may attempt to save money by exploiting the lag time during which the agency is reviewing the rate changes. This is

⁹⁵ *Id.* at 1211; *see also* *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44, 74 (1996) (holding that an *Ex parte Young* action would not lie where Congress had created a complex and detailed administrative scheme for enforcing a federal right).

⁹⁶ *See Astra USA, Inc. v. Santa Clara Cnty.*, 131 S. Ct. 1342, 1349 (2011).

⁹⁷ *Id.* at 1345.

⁹⁸ *Id.* at 1349.

⁹⁹ Catherine M. Sharkey, *Preemption as a Judicial End-Run Around the Administrative Process?*, 122 YALE L.J. ONLINE 1, 2 (2012), <http://yalelawjournal.org/2012/04/30/sharkey.html>.

¹⁰⁰ *See* Transcript of Oral Argument at 6, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (No. 09-958) (Kagan, J.).

¹⁰¹ At oral argument, Justice Breyer suggested that the Court could issue an injunction and then refer the merits of the claim to the agency under the primary jurisdiction doctrine. *See id.* at 38 (Breyer, J.).

¹⁰² *See Sharkey, supra* note 99, at 4 (“On that view, APA review remains the preferred route, but private parties need an additional, limited court option to hold the states at bay until the agency makes a final determination.”).

¹⁰³ *See Edelman v. Jordan*, 415 U.S. 651, 678 (1974).

especially true because the population that would benefit from more robust Medicaid payments, including the poor and disabled, may not have the political clout of other groups to lobby for a share of limited state funds.¹⁰⁴

Chief Justice Roberts, writing for the four dissenters, would have held that the Supremacy Clause does not supply a right of action where, as here, the statute does not explicitly provide one.¹⁰⁵ He viewed the clause as a rule of decision that ensures federal law will trump state law whenever the two conflict.¹⁰⁶ It secures federal power by giving effect to Congress's intent, but it does not of its own force provide "a source of any federal rights."¹⁰⁷ In the dissenters' view, recognizing an implied right of action under the Supremacy Clause would impermissibly amplify the substantive right or benefit that Congress intended to provide: "Saying that there is a private right of action under the Supremacy Clause would substantively change the federal rule established by Congress in the Medicaid Act. That is not a proper role for the Supremacy Clause, which simply ensures that the rule established by Congress controls."¹⁰⁸ In the Chief Justice's view, a Supremacy Clause right of action would also allow litigants to make "a complete end-run" around the limits the Court has placed on implied statutory and § 1983 rights of action in cases such as *Gonzaga*.¹⁰⁹ As he said at oral argument, "We've wasted a lot of time trying to figure out whether there's an implied right of action under a particular statute if there has always been one under the Supremacy Clause."¹¹⁰

Chief Justice Roberts left open the possibility that a Supremacy Clause action might lie in cases where the exercise of the Court's equitable power would "give[] effect to the federal rule, rather than contraven[e]

¹⁰⁴ At the same time, physicians, hospitals, and other health care providers—groups that do have substantial political influence—also have an interest in lobbying for higher Medicaid rates. The organizational heft of the American Medical Association is particularly well-documented. See, e.g., Lawrence Gostin, *The Formulation of Health Policy by the Three Branches of Government*, in SOCIETY'S CHOICES: SOCIAL AND ETHICAL DECISION MAKING IN BIOMEDICINE 335, 348 (Ruth Ellen Bulger et al. eds., 1995).

¹⁰⁵ See *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1212 (2012) (Roberts, C.J., dissenting).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* (quoting *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 613 (1979)); see also *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989) (same).

¹⁰⁸ *Douglas*, 132 S. Ct. at 1212-13 (Roberts, C.J., dissenting).

¹⁰⁹ *Id.* at 1213. For a critique of this argument, see generally Stephen I. Vladeck, Douglas and the Fate of Ex Parte Young, 122 YALE L.J. ONLINE 13 (2012), <http://yalelawjournal.org/2012/04/30/vladeck.html>. Professor Vladeck argues that the Chief Justice's reliance on *Gonzaga* is misplaced because that case implicated only Congress's ability to define when private rights of action are available under a federal statute. *Id.* at 17-18. "In contrast, . . . a plaintiff who seeks injunctive relief in a case like *Douglas* is seeking as much to enforce the Constitution against the state officer as he or she is seeking to enforce the relevant federal statute." *Id.* at 17.

¹¹⁰ Transcript of Oral Argument, *supra* note 100, at 30 (Roberts, C.J.).

it.”¹¹¹ He would allow offensive use of the Supremacy Clause where, as in *Ex parte Young*, litigants faced the imminent threat of an “enforcement proceeding” carrying criminal or civil penalties under an unconstitutional state law.¹¹² But where a litigant faced the mere loss of benefits, Chief Justice Roberts would hold that *Young* does not apply.¹¹³ As the next section will explain, the Court had not previously taken such a cramped view of *Young* or of preemption claims generally.

Notably absent from the dissent was any discussion of the so-called contract theory of the spending power. It is undisputed that the Spending Clause is not simply an instrument for meting out benefits. Rather, Congress may also leverage the power of the purse to persuade states to comply with federal policy preferences.¹¹⁴ The Supreme Court has explicitly held that Congress may exercise the spending power to achieve indirectly what it may not accomplish directly through its enumerated powers in Article I.¹¹⁵ When states agree to abide by certain conditions in exchange for federal largesse, the result is “much in the nature of a contract.”¹¹⁶ Under the common law, third-party beneficiaries generally cannot enforce contract terms unless the contracting parties so intended.¹¹⁷ If we consider citizens to be like third-party beneficiaries, then the contract theory holds that only the federal government may enforce spending conditions against the state unless the governing statute confers the right to sue on others.¹¹⁸ As the Court observed in *Gonzaga*, “In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance . . . is not a private cause of action . . . but rather action by the Federal Government to terminate funds to the State.”¹¹⁹

Douglas presented the Court with the opportunity to hold that spending conditions do not admit of private enforcement because of their contract-like

¹¹¹ *Douglas*, 132 S. Ct. at 1213 (Roberts, C.J., dissenting).

¹¹² *See id.*

¹¹³ *See id.*

¹¹⁴ *See generally* *Hills*, *supra* note 2, at 858-91.

¹¹⁵ *See* *South Dakota v. Dole*, 483 U.S. 203, 206 (1987) (holding that Congress could act “indirectly under its spending power” to encourage states to set the drinking age at twenty-one, whether or not it could “regulate drinking ages directly”); *United States v. Butler*, 297 U.S. 1, 66 (1936) (“[T]he power of Congress to authorize expenditure of public moneys for public purposes is not limited by the direct grants of legislative power found in the Constitution.”).

¹¹⁶ *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); *see also* *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (same).

¹¹⁷ *See* *Astra USA, Inc. v. Santa Clara Cnty.*, 131 S. Ct. 1342, 1347 (2011) (reciting this rule in a spending case).

¹¹⁸ *Id.*

¹¹⁹ *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (quoting *Pennhurst*, 451 at 28).

quality, a position urged by Justice Thomas in a recent case.¹²⁰ The Chief Justice's dissent never alluded to the theory, but it may have inspired his reasoning.¹²¹ In *Pennhurst* and other spending cases, the Court has held that Congress must speak clearly when imposing funding conditions.¹²² This "notice principle" implies that the federal government must explicitly alert the states if private litigants may sue to enforce spending conditions.¹²³ To the dissenters, it might have appeared especially improper to subject the states to a private right of action unless they manifestly agreed to this mode of enforcement when they joined the cooperative spending program. Yet the dissent did not adopt this theory, and only future cases will tell whether it may have inflected its reasoning.

IV. LIMITS ON SUPREMACY CLAUSE INJUNCTIONS

Both the majority and dissent in *Douglas* expressed doubt that litigants may challenge the adequacy of state Medicaid payments under the Supremacy Clause.¹²⁴ Yet it is clear that plaintiffs may assert preemption claims in at least some cases where states play fast and loose with federal spending conditions. Courts have been willing to entertain preemption claims when states engraft limitations on the use of federal funds that were not envisioned by Congress when it created the cooperative spending program in question.¹²⁵ Although the contract thesis might suggest otherwise, the federal and state governments are not equal partners to the bargain. Congress designs such programs, and the states take or leave the funding on the terms offered.¹²⁶ If

¹²⁰ See *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 683 (2003) (Thomas, J., concurring) (raising "serious questions as to whether third parties may sue to enforce Spending Clause legislation").

¹²¹ See Vladeck, *supra* note 109, at 18 n.26 (venturing the "possibility" that the *Douglas* dissenters were particularly skeptical of private enforcement of spending conditions, but noting their language "is hardly limited to prospective enforcement of Spending Clause statutes").

¹²² See, e.g., *Pennhurst*, 451 U.S. at 24-25.

¹²³ Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L.J. 345, 403, 408 (2008).

¹²⁴ Compare *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1210 (2012) (suggesting that CMS's approval of California's rate changes "may require" plaintiffs "to proceed by seeking review of the agency determination under the [APA] rather than in an action against California under the Supremacy Clause"), with *id.* at 1215 (Roberts, C.J., dissenting) ("When Congress did not intend to provide a private right of action to enforce a statute enacted under the Spending Clause, the Supremacy Clause does not supply one of its own force.").

¹²⁵ See, e.g., *Carleson v. Remillard*, 406 U.S. 598, 600, 604 (1972) (holding restrictive state eligibility criteria for certain federal welfare benefits invalid under the Supremacy Clause); *Townsend v. Swank*, 404 U.S. 282, 285 (1971) (holding, in a § 1983 suit, that an Illinois law restricting eligibility for certain federal educational benefits was "invalid under the Supremacy Clause").

¹²⁶ See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2630 (2012) (Ginsburg, J., concurring in part, concurring in the judgment, and dissenting in part) ("States have no entitlement to receive any Medicaid funds; they enjoy only the opportunity to accept funds on Congress' terms.").

a state imposes additional regulatory burdens, it may “interfere with the careful balance struck by Congress” between competing policy goals.¹²⁷

Should *Douglas* return to the Supreme Court, the Justices would almost certainly seek to place limits on its implied right of action theory. There is a way to do so without altogether foreclosing the possibility of a Supremacy Clause action in the spending context. The Justices should distinguish between two types of preemption challenges that may arise out of cooperative spending programs: (1) those alleging direct conflict between federal and state regulations and (2) those, such as *Douglas*, alleging insufficient state performance. The Court should continue recognizing Supremacy Clause actions in the first type of case. But in the second, where states are merely truant in their obligations under a cooperative spending program, it is less obvious that litigants should be able to ask the courts to intervene, at least under the Supremacy Clause.

A. *Viable Supremacy Clause Actions*

Planned Parenthood of Houston & Southeast Texas v. Sanchez,¹²⁸ from the Fifth Circuit, provides a good example of a case in which a Supremacy Clause action should be sustained. There the federal government provided funds to the states through the Public Health Service Act to help expand access to family planning, on the condition that the money not be used for abortions.¹²⁹ Unsatisfied that this condition protected incipient life, Texas passed a law restricting distribution of the federal funds to groups that performed elective abortions, even if the abortion procedures were paid for with private donations.¹³⁰ Six Planned Parenthood clinics, which had previously segregated abortion from other family planning services to remain eligible for the federal funds, brought suit directly under the Supremacy Clause.¹³¹

The Fifth Circuit recognized that the plaintiffs had “an implied right of action to seek injunctive relief from a state statute purportedly preempted by federal Spending Clause legislation.”¹³² It concluded, however, that the Texas law might be saved through a narrowing construction that permitted groups like Planned Parenthood to continue receiving funds if they created

¹²⁷ *Arizona v. United States*, 132 S. Ct. 2492, 2505 (2012).

¹²⁸ 403 F.3d 324 (5th Cir. 2005).

¹²⁹ *Id.* at 327.

¹³⁰ *Id.* at 328.

¹³¹ *Id.* at 327-29.

¹³² *Id.* at 335.

“affiliates,” or separate legal entities, to provide abortion services.¹³³ Absent such a construction, the Fifth Circuit concluded that the state law would almost certainly be “doomed to preemption”¹³⁴ because it excluded certain groups that Congress intended to include in the federal program.¹³⁵ While a state may impose “modest impediments” on the groups receiving federal funds, “a state eligibility standard that altogether excludes entities that might otherwise be eligible for federal funds is invalid under the Supremacy Clause.”¹³⁶

Sanchez is a classic case for preemption, and it illustrates precisely why the *Ex parte Young* remedy is needed in the spending context. State legislators face internal political pressures, and they may be tempted to use the federal bounty to please local constituents at the expense of federal policy. Although Texas and the federal government arguably shared the objective of minimizing taxpayer-funded abortions, Texas’s more restrictive policy risked upsetting the compromise Congress had struck between restricting abortions and improving access to health care. The Supreme Court has consistently found such “additional or auxiliary regulations” preempted when they interfere with Congress’s careful weighing of legislative alternatives.¹³⁷ In this case, the Fifth Circuit identified a narrowing construction that avoided a head-on collision between federal and state law. Yet it also recognized that, had no such construction been available, the Supremacy Clause suit would have been an important tool for vindicating the federal interest and restoring the balance upset by the competing state law.

PhRMA v. Walsh likewise concerned state action that risked undermining goals the federal government sought to achieve through a cooperative spending program.¹³⁸ In an effort to make prescription drugs more affordable, Maine required drug manufacturers that participated in Medicaid to offer rebates to uninsured residents.¹³⁹ If the manufacturers refused, Medicaid patients had to obtain approval from the state before purchasing the company’s drugs.¹⁴⁰ The drug companies believed this administrative hurdle would reduce sales, and they brought suit for injunctive relief on the ground that Maine’s statute was preempted by the Medicaid Act.¹⁴¹

¹³³ *Id.* at 341.

¹³⁴ *Id.*

¹³⁵ *Id.* at 338.

¹³⁶ *Id.* at 336-37.

¹³⁷ *Cf. Arizona v. United States*, 132 S. Ct. 2492, 2502 (2012) (“Permitting the State to impose its own penalties for the federal offense here would conflict with the careful framework Congress adopted.”).

¹³⁸ *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 653-54 (2003).

¹³⁹ *Id.* at 653-55.

¹⁴⁰ *Id.* at 654.

¹⁴¹ *Id.* at 650, 656.

The Supreme Court sided with the state on the merits, holding that the state did not run afoul of the federal program by imposing “minimal or quite modest” burdens on Medicaid recipients in order to make prescriptions more widely available to its residents.¹⁴² At the same time, a majority of the Court implicitly recognized that third parties had a cause of action to challenge state laws that might chafe against the Medicaid Act’s objectives.¹⁴³ Only Justices Scalia and Thomas, who filed concurring opinions, questioned the premise of the suit. Justice Scalia argued that the Medicaid Act provides only one remedy, termination of federal funding to the states, and the drug companies could seek relief from the courts only where CMS’s refusal to terminate was arbitrary, capricious, or an abuse of discretion under the APA.¹⁴⁴ Justice Thomas relied on the contract theory and expressed doubts “as to whether third parties may sue to enforce Spending Clause legislation—through pre-emption or otherwise.”¹⁴⁵

Sanchez and *PhRMA* recognized the important ends served by implied rights of action under the Supremacy Clause. In our system of dual sovereignty, the clause helps maintain the proper distribution of federal and state power.¹⁴⁶ In concert with the Tenth Amendment, it supplies the principle that federal law bests contrary state law as long as the federal government is operating within its sphere of limited and enumerated powers.¹⁴⁷ *Sanchez* and *PhRMA* demonstrate that states may impose modest burdens that were not contemplated by Congress on potential federal aid recipients. But these restrictions must not frustrate the accomplishment of federal goals or distort the nature of federal programs. In such cases, the Supremacy Clause right of action would restore the proper balance of authority and keep states within

¹⁴² *Id.* at 671 (Breyer, J., concurring) (internal quotation omitted).

¹⁴³ See *Planned Parenthood of Hous. & Se. Tex. v. Sanchez*, 403 F.3d 324, 332 (5th Cir. 2005) (observing that, in *PhRMA*, “seven Justices assumed both that the federal courts have jurisdiction and that a claim was stated for Spending Clause preemption”).

¹⁴⁴ *PhRMA*, 538 U.S. at 675 (Scalia, J., concurring).

¹⁴⁵ *Id.* at 683 (Thomas, J., concurring).

¹⁴⁶ See *New York v. United States*, 505 U.S. 144, 159 (1992) (“We have observed that the Supremacy Clause gives the Federal Government a decided advantage in the delicate balance the Constitution strikes between state and federal power.” (brackets and internal quotation omitted)); Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 265 (2000) (“The Supreme Court routinely says that valid federal statutes preempt whatever state law ‘stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.’” (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941))).

¹⁴⁷ See *New York*, 505 U.S. at 156 (“If a power is delegated to Congress in the Constitution, the Tenth Amendment expressly disclaims any reservation of that power to the States; if a power is an attribute of state sovereignty reserved by the Tenth Amendment, it is necessarily a power the Constitution has not conferred on Congress.”).

the bounds of the law.¹⁴⁸ Chief Justice Roberts, writing in dissent in *Douglas*, appeared to cabin *Ex parte Young* to cases where parties faced an imminent state enforcement proceeding, with possible criminal or civil sanctions, rather than a loss of benefits.¹⁴⁹ This reading would seem to foreclose application of the *Young* remedy in cases like *Sanchez* and *PhRMA*, even though they fit the mold of a traditional preemption claim. Such a view would risk gelding Congress's authority to dictate how federal funds will be spent.

B. Douglas-Style Supremacy Clause Actions

Douglas bears a superficial resemblance to *Sanchez* and *PhRMA*, but it differs from them in at least one important way. *Douglas* involved state spending rather than state regulation of conduct, and it therefore touched on an important state sovereignty interest not implicated by *Sanchez* or *PhRMA*. Congress created Medicaid to make health care available to the poor and elderly, but it did not necessarily intend for states to sacrifice their freedom to shape their *own* spending priorities. If the Supreme Court were to recognize an implied right of action under the Supremacy Clause, it would shift delicate budgeting decisions from state legislatures to the federal courts and potentially award Medicaid recipients a greater share of state spending than they would receive through the political process.¹⁵⁰ Health care already consumes a substantial percentage of state budgets,¹⁵¹ and private litigation that forces states to devote more resources to Medicaid could result in the crowding out of other worthy programs. Congress avoided such distortion effects by limiting the remedies available to

¹⁴⁸ See *Green v. Mansour*, 474 U.S. 64, 68 (1985) (“Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law.”); Richard H. Fallon, Jr. & Daniel J. Meltzer, *New Law, Non-Retroactivity, and Constitutional Remedies*, 104 HARV. L. REV. 1731, 1778-79 (1991) (“Another principle, whose focus is more structural, demands a system of constitutional remedies adequate to keep government generally within the bounds of law.”); cf. *Bond v. United States*, 131 S. Ct. 2355, 2360 (2011) (holding that the defendant had standing to challenge the statute under which she was convicted on the ground that “Congress exceeded its powers by enacting it in contravention of basic federalism principles” secured by the Tenth Amendment).

¹⁴⁹ See *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1213 (2012) (Roberts, C.J., dissenting).

¹⁵⁰ See *supra* note 54 and accompanying text; see also Huberfeld, *supra* note 24, at 539 (“Medicaid has long been regarded as a program that requires cost containment.”); Abby Goodnough, *Spending on Medicaid Has Slowed, Survey Finds*, N.Y. TIMES, Oct. 26, 2012, at A24 (quoting the executive vice president of the Kaiser Family Foundation as saying of Medicaid expenditures, “Reining in costs remains the dominant theme”).

¹⁵¹ See Theodore W. Ruger, *Of Icebergs and Glaciers: The Submerged Constitution of American Healthcare*, 75 LAW & CONTEMP. PROBS. 215, 220 (2012) (“The Congressional Budget Office . . . forecasts that, if present trends continue, overall healthcare spending will account for 25% of GDP by 2025, 37% by 2050, and 49% by 2082.”).

beneficiaries for a state's underfunding of its Medicaid obligations. It concentrated enforcement in the federal agency and gave that agency one tool to discipline the states—withdrawal of all Medicaid funding—that was so harsh it would almost never be used.¹⁵² Inadequate though this system may be to secure robust state funding for Medicaid, it preserves some measure of state control over sensitive and difficult budgeting decisions.¹⁵³

IV. CONCLUSION

Medicaid reflects our society's noblest intentions, but in practice it does not always provide meaningful access to health care. The program reimburses health providers far less than Medicare or private health insurance does, and newspapers and academic journals are filled with stories of patients who suffered dire medical consequences because they could not locate a doctor who would accept their Medicaid card.¹⁵⁴ While private enforcement of the equal access provision would almost certainly lead to more robust funding of Medicaid, it might also distort state budgeting decisions in ways neither intended by Congress nor consented to by the states. If more money should be dedicated to the program, it should happen through the political process. And there is hope for this yet. As part of the Affordable Care Act, Congress has offered the states a substantial financial inducement to extend Medicaid coverage to all adults under age sixty-five who live below 133% of the poverty line.¹⁵⁵ Should the Medicaid ranks swell, a large new pool of voters will have incentive to lobby state and federal representatives for more robust funding of the program.

¹⁵² See *Edelman v. Jordan*, 415 U.S. 651, 692 (1974) (Marshall, J., dissenting) (“The funding cutoff is a drastic sanction, one which [the Department of Health, Education, and Welfare] has proved unwilling or unable to employ to compel strict compliance with the Act and regulations.”).

¹⁵³ Indeed, concern that excessive resort to litigation was increasing the cost of the Medicaid program helped drive the repeal of the Boren Amendment, the provision of the Medicaid Act that required states to set payments at a level “reasonable and adequate to meet the costs” of providing care. See TOMMY G. THOMPSON, SEC’Y OF HEALTH & HUMAN SERVS., REPORT TO CONGRESS ON THE IMPACT OF REPEAL OF THE BOREN AMENDMENT 3-4 (2003).

¹⁵⁴ See, e.g., Rosemary B. Gultinan, Note, *Enforcing a Critical Entitlement: Preemption Claims as an Alternative Way to Protect Medicaid Recipients’ Access to Healthcare*, 51 B.C. L. REV. 1583, 1583-84 (2010) (relaying the story of a twelve-year-old boy who died in Maryland in 2007 from a brain infection caused by a tooth abscess after his mother searched in vain for a dentist who would take his Medicaid card); Devi M. Rao, Note, *“Making Medical Assistance Available”: Enforcing the Medicaid Act’s Availability Provision Through § 1983 Litigation*, 109 COLUM. L. REV. 1440, 1441 (2009) (collecting cases regarding state failures to provide access to care).

¹⁵⁵ 42 U.S.C. § 1396(a)(10)(A)(i)(VIII) (Supp. IV 2010).

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