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Post-Reform Medicaid Before the Court:
Discordant Advocacy Reflects Conflicting Attitudes

Nicole Huberfeld*

The United States Supreme Court heard two Medicaid cases this term that raise major questions about the program and the tensions it creates between the federal and state governments. On October 3, 2011, the Court heard oral arguments in Douglas v. Independent Living Center of Southern California, a dispute between California and its Medicaid providers regarding reimbursement cuts resulting from California's budget crisis.¹ The Medicaid providers argued that the proposed cuts are so extreme as to violate federal law and thus the Supremacy Clause of the United States Constitution. Their contention hinged on the Equal Access Provision of the Medicaid Act, which commands states to pay healthcare providers that participate in Medicaid "sufficient[ly]" to ensure that Medicaid enrollees have the same access to medical care as other citizens in their geographic area.² This provision is at the heart of Medicaid's aspirational design, which is meant to mainstream impoverished patients into the American healthcare system. Enforcement of this provision will be crucial for the success of the Medicaid expansion scheduled to begin in 2014. But, the United States' position in Douglas was decidedly deferential to states' decisions regarding Medicaid and went so far as to argue that only the Centers for Medicare and Medicaid Services (CMS) could enforce the terms of the Medicaid Act, a view that is contested by many.

On the other hand, the United States expressed a broad view of federal power when it expanded Medicaid to everyone up to 133% of the federal poverty level in the Patient Protection and Affordable Care Act (PPACA).³

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* Professor of Law at University of Kentucky College of Law. This paper grew out of her comments at the 5th Annual Symposium for Access to Healthcare on November 4, 2011 at Loyola University Chicago School of Law. Many thanks go to the participants in that symposium as well as the participants in the Loyola University Chicago School of Law's Constitutional Law Colloquium. Thanks always, DT.

3. Patient Protection and Affordable Care Act, § 2001(a) (to be codified at 42 U.S.C. § 1396(a)).
This is a major philosophical shift for Medicaid that partially federalizes a program historically deemed an exercise in cooperative federalism. The Court heard oral arguments March 26 through 28, 2012, in Florida v. Department of Health and Human Services, and though much of the media and scholarly conversation has focused on the constitutionality of the minimum services provision, the first question in the states' petition was whether the Medicaid expansion constitutes impermissible coercion under the South Dakota v. Dole test for constitutional conditions on federal spending. Thus, the greatest change to the Medicaid program since its inception could be nullified by the Supreme Court as a matter of Spending Clause interpretation, even though the federal government has exercised power to influence the states within the known bounds of the Court's spending jurisprudence.

This essay focuses on the conflicting arguments made by the United States in its briefs in Douglas and in Florida v. HHS. Douglas had the potential to close the courthouse doors to both Medicaid enrollees and providers because of the United States' deferential stance toward the states, a position consistent with longstanding states' rights concerns in the Medicaid program. Even though the Court decided Douglas quite narrowly, litigation continues in California's federal courts and could return to the high court relatively quickly. In contrast, the federal government has advocated a very broad view of federal authority under the spending power to modify and expand Medicaid despite some states' lack of support for the federalized elements of Medicaid. This position is consistent with the reinvention of Medicaid effectuated by PPACA and the statutory structure of Medicaid

This paper will evaluate the dichotomous positions the United States has advanced before the Court. First this paper will discuss the complexities of Douglas and the United States’ surprising advocacy in that case. The essay will next address the grant of certiorari regarding PPACA’s Medicaid expansion from the perspective of the United States’ power-protective posture. Finally, this essay will evaluate the tensions between the United States’ positions and will conclude that the Court’s best course of action is to decide each case as narrowly as possible so as to allow Congress and HHS latitude to resolve their conflicting attitudes toward Medicaid and conditional spending.10

I. THE LANDSCAPE OF DOUGLAS

The Court heard oral arguments in Douglas on the first day of the October 2011 term, a case that already was significant for exploring a relatively untested theory of enforcement for the Medicaid Act but that gained greater importance given the grant of certiorari regarding the Medicaid expansion. On the surface, this litigation was a dispute between the state of California and its Medicaid providers concerning reimbursement cuts due to California’s budget crisis. The Medicaid providers argued that these proposed cuts were so extreme as to violate federal law. Their contention hinged on the Equal Access Provision of the Medicaid Act, often referred to as “30A,” which commands states to pay healthcare providers that participate in Medicaid “sufficient[ly]” in an attempt to ensure that Medicaid enrollees have the same access to medical care as other citizens in their geographic area.11 This provision is at the heart of Medicaid’s goal of mainstreaming impoverished patients into the American healthcare system,12 and enforcement of this provision will be crucial for the success of the Medicaid expansion in 2014.13

Douglas was comprised of three cases consolidated by the Court, which originated in the Ninth Circuit. The controversy produced multiple decisions at the district and circuit court levels, and it will continue to do so even after the Court’s decision.14 In response to its economic crisis, Cali-
fornia passed a law reducing Medicaid reimbursement to a range of one to ten percent (depending on the type of healthcare provider) without performing an analysis regarding the access implications. Every state that participates in Medicaid must submit a State Plan to the Secretary of the Department of Health and Human Services (HHS) for approval, as well as any amendments to that plan, which must also be approved or CMS can refuse to continue to pay that state. The reimbursement reductions instituted by California occurred simultaneously with the submission of the State Plan Amendment application, which meant that the state reduced rates for as long as the Secretary took to review the amendment for compliance with the Medicaid Act. The Secretary denied the initial submission of State Plan amendments for failure to demonstrate compliance with 30A, which California appealed through proper administrative processes.

A group of California Medicaid (Medi-Cal) stakeholders, including doctors, pharmacists, and senior-citizen advocacy groups, as well as Medicaid enrollees, sought to enjoin California from instituting this legislation. They claimed that, under the methodology the Ninth Circuit had developed, California did not follow the proscribed procedure of relying on “responsible cost studies, its own or others’, that provide reliable data as a basis for its rate setting.” The plaintiffs did not claim that they suffered individual harm; rather, they claimed that the state disobeyed the federal statute, which violated the Supremacy Clause and entitled the plaintiffs to a preliminary injunction to prevent the harm that would derive from failure to comply

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15. CAL. WELF. & INST. CODE § 14105.19 (West 2012), also referred to as “California Assembly Bill X35” or “AB 5.”
17. Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly, 572 F.3d 644, 648 (9th Cir. 2009).
18. The Ninth Circuit created a rubric for states to follow to avoid running afoul of 30A when proposing cuts to Medicaid funding. See Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1496 (9th Cir. 1997) (requiring the state to consider “efficient and economical hospitals’ costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs.”). Even if the state had performed such studies, it seems the plaintiffs could claim that California violated the terms of 30A because historic studies had proven that such reductions in reimbursement lead to Medicaid provider exodus.
Even though the state failed to perform the required cost studies, the district court denied the request for a preliminary injunction, reasoning that the Equal Access provision did not create enforceable rights. In *Independent Living Center v. Shewry*, the Ninth Circuit vacated the dismissal and held that the Supremacy Clause claim was a valid cause of action that the parties could assert against the state. Subsequently, in *Independent Living Center v. Maxwell-Jolly*, the Ninth Circuit reasoned that the state did not comply with the court’s prior description of sufficiency for 30A. Additionally, the court reasoned that the plaintiffs did not seek to enforce rights by an end-run around the defunct Section 1983 scheme but rather to enforce federal law against the state. As a matter of preemption, the state enacted legislation that appeared contrary to the goals of the federal statute. Further, as a procedural matter under *Ex parte Young*, the plaintiffs appropriately filed the action against the responsible state officer for prospective injunctive relief. The state then waived its sovereign immunity by appearing in the initial state court action and then removing to federal court, thereby waiving sovereign immunity arguments.

The Supremacy Clause cause of action, though longstanding, has not been plaintiffs’ first choice in Medicaid filings. For many years, the civil rights law known as Section 1983, which created a private right of action against states for violations of rights protected by the federal constitution and laws, was the common path to the courthouse. In 2002, the Court narrowed private rights of action under Section 1983 in *Gonzaga University v. Doe*, and, subsequently, lower federal courts have found that 30A is no longer enforceable by private parties through Section 1983. Congress did not amend the Medicaid Act in response to this shift in Section 1983 jurisprudence, and it did not increase CMS’s power to enforce the Medicaid Act.

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20. Id. at *4-5.
22. Indep. Living Ctr. v. Maxwell-Jolly, 572 F.3d 644, 651-52 (9th Cir. 2009).
23. Id. at 652-53.
24. Id. at 652.
25. Id. at 660-62 (citing Lapides v. Bd. of Regents, 535 U.S. 613, 623-24 (2002)). This series of events occurred through a different district court decision and a different circuit court decision, but a summary of their reasoning is provided in the last Ninth Circuit decision, which is the basis of the grant before the Court.
against states.\textsuperscript{28} Still in need of a way to enjoin states that fail to fulfill the terms of the Medicaid bargain, Medicaid providers and enrollees have turned to the Supremacy Clause, asserting that a state that fails to comply with the terms of the Medicaid Act violates the Supremacy Clause and, therefore, must be prevented from violating the federal law.\textsuperscript{29} Thus, such plaintiffs tend to seek injunctive relief but not damages because the cause of action is not personal.

The Court’s grant of certiorari for one preliminary issue only was designed to answer whether this strategy is successful: “Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law reducing reimbursement rates? [sic]\textsuperscript{30} Because the Court granted the petition on such a broad constitutional question, \textit{Douglas} had the potential to revise longstanding interpretation of the Spending and Supremacy Clauses and to shape wide swaths of healthcare policy and spending jurisprudence. This last statement would seem alarmist but for the substantive amicus brief filed by the Acting Solicitor General for the Obama Administration.\textsuperscript{31}

The United States’ merits brief asserted that no private right of action is available for Medicaid providers or enrollees to enforce 30A against the states.\textsuperscript{32} Though acknowledging that private parties historically have had the ability to enforce federal statutes through implied rights of action under the Supremacy Clause, the United States argued that the “parallel” between spending programs and contracts dictates that, like third-party beneficiaries, those who merely benefit from the federal spending (anyone who is not the state or the federal government) do not have an implied right of action. The brief further stated that a non-statutory cause of action would be “inconsistent with the nature of the federal-state relationship in this setting.”\textsuperscript{33} In other words, if Congress does not explicitly provide a cause of action in the spending-based statute, only the federal government can enforce its terms.

The United States’ merits brief was deferential to states and to the process by which states implement reimbursement rate reductions. Even

\textsuperscript{28} See 42 U.S.C. § 1396c. CMS has the power to stop Medicaid payments to a state, but that is about all it can do.

\textsuperscript{29} See, e.g., Lankford v. Sherman, 451 F.3d 496, 509-13 (8th Cir. 2006) (accepting the theory of preemption by the Medicaid Act, but remanding for further development of the record in the case).


\textsuperscript{32} Id. at 11.

\textsuperscript{33} Id. at 10.
though the brief acknowledged how important it is for states to abide by 30A, it then pointed to the draft regulations for 30A as the source for self-enforcement.\(^{34}\) The draft regulations, discussed infra, provide some guidance for states to self-evaluate reimbursement sufficiency; however, they provide no mechanism for CMS to enforce reimbursement sufficiency against states beyond the traditional fund removal remedy.\(^{35}\) The brief also described compliance with 30A as a matter for state interpretation in the first instance that is inappropriate for judicial review.\(^{36}\) The government presented state budget cuts through reimbursement reductions as part of the state’s “implementation” of Medicaid in the context of the State’s undertaking with the federal government.\(^{37}\) The brief then expressed skepticism about the substance of the plaintiffs’ claim that providers would not be able to afford to participate in Medicaid due to the Medi-Cal rate reductions.\(^{38}\)

The United States asserted that the real question is whether Medicaid providers and enrollees can seek injunctions, which the United States claimed they cannot do for several reasons. First, no Section 1983 cause of action exists.\(^{39}\) This was not a radical observation, as all parties agreed that Section 1983 was not an open avenue for the plaintiffs.\(^{40}\) The irony of this position, though, is that Section 1983 was used regularly to enforce 30A until the Court strictly narrowed the scope of Section 1983 actions in *Gonzaga University v. Doe*.\(^{41}\) That seems to render the argument disingenuous, as *Gonzaga* was not about Medicaid interpretation or enforceability, but was a limitation on Section 1983 causes of action generally. Second, the United States’ brief stated that the Court need not revisit all causes of action arising under the Supremacy Clause, and so the United States was not asking for too much.\(^{42}\) Yet, the United States asserted that its “limitation” was cooperative federalism programs under the Social Security Act, which should be excluded from Supremacy Clause actions because Spending Clause pro-

\(^{34}\) See Brief for the United States in Douglas, supra note 31, at 31.


\(^{36}\) See id. at 15-16.

\(^{37}\) Id. at 22.

\(^{38}\) Id.

\(^{39}\) Id. at 12.

\(^{40}\) Id. (The brief further notes that the majority of appellate circuits agree that Section 1983 cannot be used to enforce private rights under 42 U.S.C. 1396a(a)(30)(A)).

\(^{41}\) Gonzaga Univ. v. Doe, 536 U.S. 273, 283, 290 (2002). The Court in *Gonzaga* insisted that only an “unambiguously conferred right” could be enforced through Section 1983, thereby severely narrowing the scope of 1983 actions.

\(^{42}\) Brief for the United States in Douglas, supra note 31, at 21.
grams are different from other preemption analyses. Third, the Solicitor General reiterated the contract analogy from *Pennhurst*, *Arlington*, and other conditional spending cases and concluded that beneficiaries of spending programs do not have enforceable rights.

The merits brief indicated in a number of ways that the federal government and the states are equal partners in Medicaid, even though it is a federal program funded primarily with federal money that states receive only when they agree to a federal superstructure. The United States’ brief was surprising for at least four reasons. First, when the Court solicited the view of the Solicitor General, the office recommended that the Court deny the petition for certiorari. The Acting Solicitor General reasoned that HHS was in the process of drafting regulations that would address the ambiguities in the 30A sufficiency language that led to a circuit split regarding the meaning of this statute; the State Plan amendments submitted by California regarding the payment reductions had been denied by CMS; and no other circuit had decided whether Supremacy Clause causes of action were viable, leaving the Court with no dispute between circuits to settle on that question. Even though the Solicitor General’s office is often described as the most influential litigant before the Court, frequently referred to as the “Tenth Justice,” the Court granted the petition for certiorari on the Supremacy Clause question.

Second, the Solicitor General’s merits brief supported California’s contention that the state should be free from private litigation, but for much broader reasons than California asserted. California claimed that the Medicaid Act itself does not confer a cause of action on providers or enrollees. Further, California articulated that states do not have clear notice of private causes of action under the Medicaid Act as required by the *South Dakota v. Dole* conditional spending test, a point of focus and reiteration during oral argument. The United States’ brief, which was not joined by HHS, ar-

43. *Id.* at 17.
46. *Id.* at 28.
47. To wit, see the lengthy requirements for submitting a successful State Plan at 42 U.S.C.A. § 1396a (West 2011).
49. *Id.* at 10-21.
gued that spending statutes cannot create a private right of action unless Congress has clearly stated that private parties may abrogate state sovereign immunity in cooperative federalism programs. Instead, the Acting Solicitor General opined that the only remedy available is for CMS to review the state’s amendments to its State Plan and either reject or accept them.\textsuperscript{52}

This was the alarming aspect of the United States’ brief. Though the Acting Solicitor General acknowledged that, for example, Justice Kennedy rejected this view in his dissent in \textit{Golden State Transit},\textsuperscript{53} the brief relied on opinions by statutory strict constructionist justices who have articulated the view that cooperative federalism programs should never be judicially enforceable.\textsuperscript{54} Thus, the brief not only sided with California, it essentially adopted the conservative position advanced in concurrences by Justices Scalia and Thomas in \textit{PhRMA v. Walsh} and by Justice Scalia in \textit{Blessing v. Freestone}. Their viewpoint, largely ignored by courts, is that no private right of action can exist for beneficiaries of spending programs to enforce federal standards against states without a clear statement in the language of the statute that such a right of action exists.\textsuperscript{55} In other words, implied rights of action do not exist for beneficiaries of spending programs.\textsuperscript{56}

This position is reminiscent of the renegade district court opinion in \textit{Westside Mothers v. Haveman}, wherein Judge Cleland held that enrollees could not challenge state failure to comply with mandatory elements of Medicaid because spending programs are mere contracts that cannot be enforced by third party beneficiaries (an analysis rejected by the Sixth Circuit on appeal).\textsuperscript{57} Though the Court has analogized conditional spending to a contract between the federal government and the state receiving the spending, the contract idea has always been just that, an analogy, not the rule of law for interpreting the spending power. Though the Court has considered the contract analogy for some time, it has never gone so far as to treat laws generated under the power to spend as different from (or less than) other

\textsuperscript{52} Brief for the United States in \textit{Maxwell-Jolly}, supra note 48, at 18-19.

\textsuperscript{53} Id. at 15 (citing \textit{Golden State Transit Corp. v. City of L.A.}, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting)).

\textsuperscript{54} \textit{Id.} (citing \textit{Pharm. Research \\& Mfrs. of Am. v. Walsh}, 538 U.S. 644, 683 (2003) (Thomas, J., concurring)). The brief quotes Justice Thomas stating that there are “serious questions as to whether third parties may sue to enforce Spending Clause legislation – through preemption or otherwise.”

\textsuperscript{55} \textit{Pharm. Research \\& Mfrs. of Am.}, 538 U.S. at 674-83 (2003) (Scalia, J., concurring and Thomas, J. concurring).


Article I enumerated powers. The Solicitor General’s brief thus took a much stronger, and broader, position on private parties’ ability to enforce the Medicaid Act against states than anyone would have predicted.

Third, the Solicitor General’s merits brief supported the current perverse incentives of the Equal Access provision and laid too much in the lap of CMS and the Secretary of HHS. If states pay Medicaid providers less than “sufficient[ly],” the federal government saves money by states paying out fewer Medicaid dollars that the federal government must match. Thus, CMS has little motivation to enforce the Equal Access provision or to shift its attention away from fraud prosecution, which has long been the focus of the agency’s limited resources. Though CMS can withdraw Medicaid funding from noncompliant states, that penalty would harm the very populations intended to be helped. Additionally, total funding withdrawal has never happened, seemingly because CMS recognizes the draconian and counterproductive nature of penalizing states in this way. The problem for CMS is not only perverse incentives, but also lack of resources and appropriate authority.

Counsel for HHS did not participate in the Solicitor General’s brief, a departure from the amicus brief filed at the petition stage that appears to reflect deep disagreement between the Solicitor General’s Office and HHS regarding the position taken by the United States. Though HHS itself did not file an amicus brief, former HHS officials filed their own brief refuting the points made by the Solicitor General’s office. That separate amicus

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59. Though the Secretary of HHS is given the power to grant or deny applications for amending State Plans, in reality CMS is responsible for every day administration and enforcement of the Medicaid Act. The Brief of Former HHS Administrators discusses the enforcement problems as being problems for HHS generally and CMS specifically, as CMS is a sub-agency of HHS. Thus, this essay discusses both HHS and CMS in describing the enforcement problem.


62. Brief of Former HHS Officials, supra note 35; see also Pear, supra note 61 (describing the Solicitor General’s position and the reactions of “dismay” to the conservative view advanced by the Obama Administration).
brief asserted that CMS has relied on private rights of action to ensure that states comply with their Medicaid obligations. The former officials attested that CMS is under-funded and under-staffed and could never police the states in the way that the Solicitor General’s office posited. The former officials further stated that CMS has come to rely on private causes of action to help flag states that have reduced payment rates inappropriately, either with or without amendments to the State Plan. The states refuted this position (more than half of the states weighed in for the petitioners). Further, they seemed to be denying that Medicaid is a federal program that states must administer appropriately if they accept federal funds, which is clearly incorrect from both a statutory and a federalism perspective. In short, CMS does not have the resources to administratively rein in the states as the United States envisions, but the states do need the kind of oversight that private causes of action provide.

Further, administrative enforcement failings are not ameliorated by the draft regulations designed to help CMS implement the Equal Access provision. The draft regulations define “sufficien[cy]” for purposes of the Equal Access mandate and provide states with methods to measure sufficiency and to report their findings to CMS. States are also required to perform an “access review” anytime rate reductions are submitted as part of a State Plan Amendment, the results of which must be “made available to the public . . . and to CMS upon request.” But, CMS has no apparent remedy if sufficiency is not achieved, apart from rejecting the proposed amendment to the State Plan. The trouble is that CMS has been granted the same limited yet formidable remedy as the enabling statute contains. And, states are responsible for monitoring their own reimbursement sufficiency, self-reporting deficiencies, and creating action plans for correcting access problems. Further, major elements of Medicaid’s current care delivery, such as managed care reimbursement, are not included in the review standards, as managed care is addressed in a separate Part of the Code of Federal Reg-

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65. States cannot participate in Medicaid unless they submit a State Plan that is approved by the Secretary of HHS and that complies with the terms of the Medicaid Act. 42 U.S.C. §§ 1396, 1396a(a)(10) (2010), amended by 126 Stat. 156 (2012).
67. Id. at 26345, 26361.
68. Id. at 26361.
69. See id.
70. Id.
ulations. This is a gaping hole in the enforcement scheme, as the vast majority (approximately seventy percent) of Medicaid enrollees are in Medicaid programs administered by private managed care organizations. Thus, for a variety of reasons, the United States' position is at odds with the reality of Medicaid administration.

Fourth, the United States' amicus brief asserted that Congress intended to foreclose private rights of action to enforce the Equal Access provision against the states, but this position directly contradicted the Brief of Members of Congress. The Solicitor General asserted that Congress decided not to include a private cause of action to enforce the Medicaid Act against states. Therefore, to allow a cause of action under the Supremacy Clause would contradict congressional intent. But the members of the House and Senate stressed that Congress has relied on private actions to enforce the Medicaid Act and that Congress deliberately has not amended 30A to prevent private rights of action, even though such an amendment was considered. Further, the members of Congress recognized that a spending program enforced by federal agencies benefits from private enforcement, which “provides a middle ground between doing nothing and cutting off funding.”

Lack of compliance with the Equal Access provision will become a more pressing problem in 2014, when the universal insurance coverage provisions of PPACA become effective in part through the Medicaid expansion (discussed further below). CMS does not have the resources to police each state. Further, according to the Congressional Budget Office, the Medicaid population is estimated to expand by about sixteen million adults. Though entry into Medicaid will be simplified by the new single application system effectuated by PPACA, entry is not the problem. More enrollees require more providers and more reimbursement (albeit at much lower state contri-
Once the total federal funding disappears, if states underfund the Medicaid expansion, it could be ineffectual, as the population of providers willing to accept Medicaid patients is already small due to low reimbursement rates. That small population will be overwhelmed by the burden of the new enrollees, and provider attrition due to overwork and underpayment may become a real possibility. Though PPACA requires reimbursement of primary care physicians at Medicare rates, this boon to Medicaid providers will only last for two years under PPACA as enacted.\(^7\)

A notable postscript occurred when CMS approved some of the rate reductions proposed by California, the same reductions that are at issue in *Douglas*.\(^8\) As soon as the rate reductions were approved, more claims for injunctive relief were filed by the California Hospital Association, the California Medical Association, and other Medi-Cal providers.\(^9\) The claims appear to echo the payment issues in *Douglas*. In addition, on November 29, 2011, a similar case was filed in Arizona whereby hospitals sought to enjoin a rate reduction of five percent that has since been approved by CMS.\(^10\) That complaint was also based on 30A violations and invoked both the Supremacy Clause and Section 1983.\(^11\)

The Court asked the parties for additional briefing regarding the impact of the CMS approval on *Douglas*.\(^12\) The United States responded that the case was not moot, despite the amendment approval, because the Ninth Circuit’s injunctions were not dependent upon the presence or absence of CMS approval of the reductions. Additionally, the Court’s grant of certiorari was based upon the cause of action question, not a determination as to the actual

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7. The Medicaid expansion provides for complete federal funding at the outset of the expansion, which phases down to ninety cents on the Medicaid dollar by 2020, a match that is still more generous than traditional Medicaid. 42 U.S.C. § 1396d(y), amended by 126 Stat. 156 (2012).


sufficiency of the state’s reductions.\textsuperscript{85}

Despite the Solicitor General’s request that the Court decide the Supremacy Clause question, the decision in \textit{Douglas} was quite narrow (and issued earlier than many anticipated).\textsuperscript{86} The five-justice majority opinion, penned by Justice Breyer, vacated and remanded the case to the Ninth Circuit.\textsuperscript{87} The Court displayed concern for the functioning of the Medicaid program and a sense that the Supremacy Clause question might be avoided due to agency review and judicial deference.\textsuperscript{88} The pithy opinion began with an explanation of the Medicaid program and review of the manner in which CMS reviews State Plans and proposed amendments. The Court noted that the case had not become moot but that the posture of the case was quite different from when certiorari was granted.\textsuperscript{89} Justice Breyer then explained that CMS’s approval of some California rate cuts indicated that administrative law principles might govern the outcome of the case, and at a minimum, would impact the assessment of the Supremacy Clause right of action.\textsuperscript{90}

The majority also closely echoed the concerns articulated by the justices during oral arguments; namely, Justice Breyer questioned the parties about primary jurisdiction, which indicated he sought a narrow holding; and, Justice Kennedy specifically noted the position of the ex-administrators of HHS that the agency relies on private rights of action.\textsuperscript{91} This concern may have kept Justice Kennedy from joining the dissent’s powerful rejection of Supremacy Clause rights of action for spending legislation.\textsuperscript{92}

In contrast to the program-centric majority opinion, the dissent’s opinion, authored by Chief Justice Roberts, focused on federalism, constitutional questions,\textsuperscript{93} and legislative clear statement rules.\textsuperscript{94} Whereas the majority

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  \item \textsuperscript{86} Douglas v. Indep. Living Ctr. of S. Cal., Inc., 132 S. Ct. 1204, 1207-08 (2012) (noting that circumstances have changed, which led the majority to vacate and remand for proceedings consistent with CMS’s approval of California rate changes).
  \item \textsuperscript{87} \textit{Id.}
  \item \textsuperscript{88} \textit{Id.}
  \item \textsuperscript{89} \textit{Id.} at 1210.
  \item \textsuperscript{90} \textit{Id.}
  \item \textsuperscript{92} Douglas, 132 S.Ct. at 1213.
  \item \textsuperscript{93} \textit{Id.} (Roberts, J., dissenting) (“Here the law established by Congress is that there is no remedy available to private parties to enforce the federal rules against the State. For equitable powers would raise the most serious concerns regarding both the separation of powers (Congress, not the Judiciary, decides whether there is a private right of action to enforce a
wrote about the nature and requirements of the Medicaid program, the dissent quickly moved to describe the Medicaid Act as “Spending Clause legislation” that does not provide anyone with a private cause of action to enforce 30A. The dissent rejected the assertions of the Members of Congress amicus brief and the Ex-Administrators brief that Congress and HHS intend for Medicaid’s requirements to be enforced privately. Instead, Chief Justice Roberts would have held that Congress did not intend to supply a right of action because the language of the statute contains no such right, and, therefore, the plaintiffs cannot maintain the “end-run” cause of action under the Supremacy Clause.

Even though a majority of the Court rejected it, the government’s position contained the dangerous assumption that the states could self-police one of the most important aspects of the Medicaid program, even though it would be against their self-interest. The United States also asserted that CMS could put an end to any inappropriate reimbursement cuts, even though it rarely does so. These views seem to be at odds with the unrestrained federal power the United States has advocated in *Florida v. HHS*.

II. MEDICAID EXPANSION BEFORE THE COURT

An increasingly large number of Americans rely on Medicaid for access to healthcare, a high of sixty-nine million in 2010. This number will grow significantly due to PPACA (sixteen million new enrollees according to the Congressional Budget Office), which expands Medicaid eligibility to everyone up to 133% of the federal poverty level. This expansion constitutes an important philosophical change in Medicaid – one that federalizes the definition of Medicaid eligibility by rejecting the idea that only the “deserving poor” qualify for Medicaid, a criterion long used by state welfare programs that dates to Elizabethan Poor Laws. The Medicaid expansion re-
sults in a second element of federalization, the total federal funding of the expansion population that reduces to 90% in 2020.101 These two steps toward federalization of Medicaid comprise a philosophical renewal of this long-standing federal spending program that received surprisingly little debate or attention in the course of creating healthcare reform. PPACA also facilitates increased enrollment, because the minimum coverage provision will encourage those who have avoided the stigma of Medicaid (despite their eligibility) to enroll in the program through a new single application mechanism.102

Led by Florida, twenty-four states, the attorney general of Michigan, and the governor of Iowa challenged the constitutionality of PPACA by focusing on two major aspects of the law: the minimum insurance coverage requirement, and the Medicaid expansion.103 The Supreme Court granted certiorari on these questions and a few related ones as well, which were combined for six and a half hours of oral argument from March 26–28, 2012.104 The petitions resulted from the Eleventh Circuit’s decision in Florida ex rel. Bondi v. Dept. of Health and Human Services, the only major PPACA challenge to raise the issue of whether Medicaid’s expansion is constitutional.105

The states in Florida v. HHS claimed that the Medicaid expansion constitutes impermissible coercion under South Dakota v. Dole’s test for constitutional conditional spending. The Dole test contains four elements: (1) the spending must be for the general welfare; (2) the conditions placed on spending must be clear and unambiguous; (3) the conditions must be germane to the purposes of the spending; and (4) the conditions must not be

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101. *Id.* at 451.
102. PPACA, Pub. L. 111-148 (enacted March 23, 2010), § 2201 (to be codified at 42 U.S.C.A. § 1396w-3 (2010)) (This section of PPACA requires states, as a matter of Medicaid participation, to create an internet-based enrollment process by which the poor can apply for Medicaid, the Children’s Health Insurance Program, and subsidies in the exchanges, all in one application.).
105. See Elizabeth Stawicki, *Minnesota Appeals Court Hears Case Challenging Health Law*, KAISER HEALTH NEWS (Oct. 21, 2011), http://www.kaiserhealthnews.org/Stories/2011/October/21/appeals-court-minnesota-legal-challenge-insurance-mandate.aspx (noting that the PPACA litigation in the Eighth Circuit also raised questions regarding the constitutionality of the Medicaid expansion, but the case was dismissed at the district court level and the appeal has only advanced to oral arguments).
unconstitutional themselves. The Court articulated a fifth concept in dicta, that theoretically federal spending could reach a point at which pressure becomes compulsion that impermissibly coerces the state into accepting the federal funds. Though the Court did not specify the source of this concern, it seems clear that it must be the Tenth Amendment. No lower federal court has found coercion to be a persuasive reason to set aside a federal spending statute, though some have attempted to analyze the idea of coercion and have acknowledged its existence. Consequently, the states are providing the Court with a platform to expand on this thorny issue: either coercion is a meaningful fifth requirement for constitutional conditional spending supported by a judicially enforced Tenth Amendment, or it is not and the coercion theory should be put to rest.

The district court and the Eleventh Circuit both validated the coercion theory but rejected its application for different reasons. Judge Vinson seemed to eliminate the justiciability of coercion, a surprise given the conservative tenor of the opinion. The Eleventh Circuit evaluated coercion in its analysis but found that this Medicaid expansion is not coercive, primarily because the states have ample notice before the effective date of 2014, and because the federal government initially completely funds (and later very generously funds) the expansion.

The United States has refuted the coercion theory by painting Congress’s Spending Clause power expansively throughout the litigation. The merits brief assessed the federal government’s power to spend as “broad” because it encompasses Congress’s constitutional responsibility to appropriate funds from the federal treasury and as containing the ability to place conditions on that spending to make federal policy (especially under the current jurispru-

106. Dole, 483 U.S. at 207-08.
107. Id. at 206.
109. See Florida ex rel. Atty. Gen. v. U.S. Dep’t of Health and Human Servs., 648 F.3d 1235, 1264-68 (11th Cir. 2011). The opinion also reasoned that the Medicaid Act makes it clear that the federal government retains the power to amend the terms of the Medicaid program at will and that the Secretary of HHS has authority to withhold all funds but also to withhold less than that. See id.
Consequently, the United States has asserted that it has "wide latitude" to create conditions for Medicaid. The Medicaid Act has always specified who states must cover in the Medicaid program as well as which services must be provided to Medicaid enrollees. Thus, the United States has argued that expanding the mandatory Medicaid eligible population to everyone up to 133% of the federal poverty level is completely consistent with Medicaid's statutory scheme. The United States has also noted that if a state submits a Plan to participate in Medicaid, and the Secretary of HHS accepts the State Plan, then the state must abide by federal rules (but the reward is fifty to eighty-three cents on the state's Medicaid dollar; the federal government does most of the funding). Further, the Medicaid Act gives the federal government reserved power to "alter, amend, or repeal any provision" of the law. All of this was clear when states agreed to participate in Medicaid.

The United States has described the four elements of the Dole test and noted that the complaining states did not take issue with any of the four enumerated requirements of that test. Instead, the states claim that they receive so much money from the federal government that it would be too hard to extricate themselves from the program, and, therefore, Congress has gone too far in creating conditions on Medicaid spending. The states claim to be coerced into remaining in a spending program that contains terms to which they no longer agree.
However, according to the United States, no aspect of the Medicaid program is more essential than who it covers.\textsuperscript{121} The United States briefs have described this as a "basic feature" of the spending program that the federal government must be able to control lest it lose the ability to "fix the terms on which it shall disburse federal money to the States."\textsuperscript{122} The federal government would then allow states to fix the terms upon which they receive federal funds; this is essentially where Medicaid started in the early grants to states for medical welfare under the Social Security Act of 1935.\textsuperscript{123}

This robust enunciation of the congressional power to spend and to place conditions on spending is not unexpected for at least four reasons. First, the Medicaid expansion is a philosophical change in the basic, elemental structure of the program, the kind of change the federal government effectuates to ensure all states meet national policy standards for the program. This is much like the program's expansion to pregnant women and children in the 1980s or the expansion to the permanently disabled Social Security Income (SSI) population in the 1970s.\textsuperscript{124} This type of floor-raising extension has occurred before, though in the past, the antiquated "deserving poor" categories were always preserved.

Second, this view is consistent with the Court's jurisprudence regarding the Spending Clause, underdeveloped though it may be. Even though the Court has used a contract analogy to parse spending questions, the Court has always limited the analogy to that and nothing more. The Court must limit the contract analogy, as the federal government and the states are not equals in the conditional spending bargain – the Supremacy Clause tells us that the federal law trumps the state's actions. Further, practically speaking, the federal government has more power in the bargain, as it is the party offering enough money to influence state policy (which \textit{New York v. United States} permits). States are not co-equal in the cooperative federalism context, as states abandon some sovereignty when they agree to federal funding with conditions. The Court has always deemed this trade-off to be permissible.

Third, for all of its options, Medicaid has always had mandatory ele-

\begin{footnotes}
\textsuperscript{121} Medicaid Brief for Respondents, supra note 110, at 24.
\textsuperscript{122} Consolidated Brief for Respondents, supra note 110, at 16-17 (citing \textit{New York v. United States}, 505 U.S. at 158 (internal citation omitted)).
\textsuperscript{123} See Huberfeld, supra note 4, at 441-42 (relaying the early history of the Medicaid program and failures due to lack of federal controls over monies disbursed to the states).
\end{footnotes}
ments, unlike some of its predecessor programs. While earlier versions of federal aid for welfare medicine contained few or no conditions, each amendment of the Social Security Act that provided more money for the states also provided more conditions for the states that accepted federal funding.\textsuperscript{125} When Medicaid was enacted in 1965, it was clear that the program had turned a corner in the mandatory conditions on spending, as the Medicaid Act contained numerous mandatory elements.\textsuperscript{126} Despite those mandatory elements, every state has been participating in Medicaid since 1972. Of course, although Medicaid has morphed through the years, the states have continued to agree to new mandatory elements of the program.

Fourth, the states often say in one breath that they need more money for their Medicaid populations but that they want fewer rules so that they can have flexibility. This dichotomy is displayed in the Medicaid expansion. In the years leading up to the passage of PPACA, a major recession swelled the Medicaid rolls and led to state budget crises. The federal government responded to states’ cries for help with the American Recovery and Reinvestment Act (ARRA), which provided “state fiscal relief” in the form of additional federal matching money to help states maintain their Medicaid programs.\textsuperscript{127} Much like the Medicaid expansion,\textsuperscript{128} the ARRA contained a maintenance-of-effort provision,\textsuperscript{129} which signaled to the states that the new funding is not a free-for-all. When PPACA was negotiated, the ARRA was a specter, as the states continued to suffer from the Great Recession but ARRA funds were going to expire.\textsuperscript{130}

Thus, while the Medicaid expansion was a method for making all Americans insurable and thus getting them through the healthcare gateway, it also was a way to provide relief to the states. As initially envisioned, the Medicaid expansion population was going to be fully funded by the federal government; but, for cost control reasons, the federal match decreases slightly over time (though it is still a supermatch of 90% once it phases down).\textsuperscript{131} Many states lack deficit-spending capabilities due to balanced budget provi-

\textsuperscript{125} See Huberfeld, supra note 4, at 442-43.
\textsuperscript{126} See generally 42 U.S.C. § 1396 et seq.
\textsuperscript{129} ARRA, Pub. L. No. 111-5, § 5001(f).
\textsuperscript{130} See Andrew Villegas, Sebelius To Governors: Extra Medicaid Money Comes With A String Attached, KAISER HEALTH NEWS (Aug. 19, 2010), http://www.kaiserhealthnews.org/Stories/2010/August/19/Sebelius-Writes-Letter-To-Governors.aspx (explaining that the ARRA Medicaid supplemental funding was due to expire at the end of 2010 but was extended until June 2011 at states’ request).
sions in their constitutions. The federal government, on the other hand, can engage in counter-cyclical spending and, in so doing, rescues the states. The states would never relinquish control over their own funds in the way that they ask the federal government to do; the federal government learned long ago that it should not do so either, especially in the Medicaid context. 132

The United States’ assertion of broad spending power in the context of the Medicaid expansion seems more consistent with existing precedent, the philosophical nature of the Medicaid program, and with the statutory structure of Medicaid than the stance adopted in Douglas. The question becomes how to reconcile these conflicting messages.

III. TENSIONS, AND A TENTATIVE RESOLUTION

The United States has engaged in discordant advocacy in the two Medicaid cases before the Court. On the one hand, the United States was deferential, even protective, toward the states in Douglas, characterizing the states as equals in the Medicaid program. On the other hand, the United States has interpreted congressional power under the Spending Clause quite broadly in the briefs for Florida v. HHS. PPACA replaces the deserving poor frame for Medicaid by eliminating the long-standing categorical requirements for fitting within a category of sympathetic characteristics in addition to poverty for eligibility. PPACA further reinvents Medicaid by fully funding the newly eligible enrollees for the first several years they are in the Medicaid population (though, this is not a major statutory change). 133 These are two steps toward centralization, toward full federalization of Medicaid, as well as philosophically new approaches to Medicaid eligibility and financing. 134 These changes also arguably move away from old notions of who is responsible for welfare medicine.

In contrast, the draft regulations designed to actualize the Equal Access provision, and upon which the Acting Solicitor General’s brief relied, reveal the kind of path dependence that has kept Medicaid serving only the deserving poor and maintaining solicitousness toward states’ rights for forty-seven years. The regulations do not sanction CMS authority to enforce

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133. Even though the Medicaid expansion and supermatch are important modernizations of the Medicaid program, they are completely consistent with Medicaid’s existing statutory structure, as such improvements are exactly the kind that Congress has enacted time and again since 1965. See Health Law Professors’ Amicus Brief, supra note 111, at 4-13.

134. Huberfeld, supra note 4, at 450-51.
the sufficiency requirement against the states. This renders the United States' position that states know best how to set their own reimbursement rates, backed up by CMS enforcement, confounding and disingenuous. If a state sets extremely low reimbursement rates, CMS is unlikely to cut the state off from its Medicaid funding because the remedy available under the Medicaid Act would also be harmful to enrollees, who would suffer the most from a sudden loss of federal funding. But the position the United States has advocated would deny private enforcement and thus end the more moderate remedy of simply ceasing the offending state behavior by injunction. And so the states have a sort of shield from the very federal power they are protesting in *Florida v. HHS*, as judicial enforcement would be limited and executive enforcement is ineffective or nonexistent.

How can these tensions be resolved? One way would be for the Court to decide the narrowest possible issue in each case, thereby allowing Congress and HHS to work through their Medicaid inconsistencies. In *Douglas*, no circuit split existed, so the earliest incarnations of this essay suggested that the Court could decide the case narrowly by upholding the injunction granted by the Ninth Circuit without addressing the larger Supremacy Clause issues raised by Medi-Cal or the United States.\(^{135}\) The majority opinion, authored by Justice Breyer, chose a path quite close to this prescription by vacating and remanding the case to the Ninth Circuit in light of the Secretary's approval of California's across-the-board cuts.\(^ {136}\) Perhaps HHS will have adequate motivation and time to fix the draft regulations that have been heavily criticized and begin to enforce the Equal Access provision in a more substantive manner; however, it seems unlikely given the work that is required to implement PPACA. Additionally, the draft regulations do not facilitate CMS enforcement, as the agency would need much more in terms of people, money, regulatory authority, and resources, would need to turn some focus away from fraud prosecution, and would have to stop being deferential to states' reimbursement decisions.

If CMS does not improve the draft regulations, the status quo is troubling, because *Gonzaga* has made it so that states are virtually unaccountable for certain violations of the Medicaid Act, though not every Section 1983 cause of action was eliminated after *Gonzaga*.\(^ {137}\) Granted, vacating

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135. This resolution would allow the Court to engage the doctrine of constitutional avoidance, which Chief Justice Roberts represented as important during his confirmation hearings, and is an important aspect of separation of powers. See, e.g., Richard L. Hasen, *Constitutional Avoidance and Anti-Avoidance by the Roberts Court*, 2009 SUP. CT. REV. 181 (quantifying and qualifying the Roberts Court's reliance on the avoidance doctrine).


137. Huberfeld, *supra* note 27, at 442-58 (explaining the inconsistent causes of action
and remanding to the Ninth Circuit may expose states to more Equal Access litigation; the Douglas plaintiffs have continued to advocate their position, adding the Secretary to the named parties in the litigation and claiming that HHS acted arbitrarily in approving California’s reimbursement reductions. The question of private rights of action has been left open and, undoubtedly, it will be tested another day.

Given that it was decided narrowly, Douglas seems to say little about Florida v. HHS and the Medicaid expansion; but, this narrow holding just defers hard questions rather than answer them. The Medicaid expansion will introduce millions of citizens into Medicaid, and the single application process will introduce the uninsured into the insurance exchanges with federal subsidies. States that complain about the cost of the expansion are more likely to cut reimbursement for Medicaid providers, which in turn could undermine the Medicaid expansion because the newly enrolled population would not have sufficient physicians and other providers to serve their medical needs. CMS already does not actively enforce the Equal Access Provision, and it seems like the strain on financial and staffing resources will be exacerbated by increased enrollment. Again, this analysis assumes that the Equal Access draft regulations remain the same, i.e., they do not empower CMS to police states more than information gathering and amendment denial.

If the Court were to eliminate Supremacy Clause rights of action in another case, or upon rehearing Douglas, perhaps CMS would be motivated to focus on enforcing 30A. However, Congress, too, would have to act, not just for Medicaid but also for all spending statutes with beneficiaries that have traditionally turned to federal courts to enforce their rights. Blocking private rights of action would protect states from being hailed into federal courts but would also devolve responsibility to the states for their own interpretation of federal law with little to no oversight and no remedy for violations of federal laws other than to withdraw all beneficial aspects of the law. This is not what Justice Black meant by “Our Federalism.”


140. Younger v. Harris, 401 U.S. 37, 44 (1971). Justice Black is widely credited with
A delayed but more broadly decided Douglas decision could also affect private insurance aspects of PPACA. Those who enroll in private insurance through the exchanges facilitated by PPACA are likely participating in federal spending, though they may not know it. In states that form their own exchanges, the initial exchange formation will be funded with federal dollars. If a state does not administer the exchange properly, private parties would likely try to hail the state into federal court to enforce the federal rules for the exchanges against the state. In states that do not form their own exchanges, this problem diminishes, as the federal government must run the exchange according to PPACA. Private parties would then be seeking to enforce federal law against the federal government, which does not implicate the federalism issues present in Douglas or Ex parte Young.

Any Douglas-type decision that considers the Supremacy Clause issue will make it so that anyone who benefits from a federal conditional spending program that a state fails to deliver appropriately will be denied access to the courthouse. The justices recognized this potential sweep during oral arguments, noting that all conditional spending, not just Medicaid, is at issue in the United States' amicus brief. A number of the justices, in particular Justice Breyer, appeared to be seeking the narrowest possible holding in the case, which helps to explain the majority opinion that he wrote, as discussed in Part I. During oral arguments, certain justices posited that the narrowest path would be to maintain the injunction so that CMS could respond to the State Plan Amendment. Vacating and remanding was a

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coining this phrase to describe our divided style of government by writing: This, perhaps for lack of a better and clearer way to describe it, is referred to by many as ‘Our Federalism,’ and one familiar with the profound debates that ushered our Federal Constitution into existence is bound to respect those who remain loyal to the ideals and dreams of ‘Our Federalism.’ The concept does not mean blind deference to ‘States’ Rights’ any more than it means centralization of control over every important issue in our National Government and its courts. The Framers rejected both these courses. What the concept does represent is a system in which there is sensitivity to the legitimate interests of both State and National Governments, and in which the National Government, anxious though it may be to vindicate and protect federal rights and federal interests, always endeavors to do so in ways that will not unduly interfere with the legitimate activities of the States.

141. Because of this, the False Claims Act has been expanded to apply to the exchanges. See PPACA, Pub. L. 111-148, § 1313.
143. See generally Erwin Chemerinsky, Closing the Courthouse Doors: October Term 2010, 14 GREEN BAG 2d 375 (2011) (summarizing the October 2010 term as notably being inhospitable to plaintiffs, thereby “closing the courthouse doors”).
144. See Oral Argument, supra note 91.
145. See id. Justice Breyer was also skeptical about the Court narrowing Section 1983 doctrine in Gonzaga. See Gonzaga Univ. v. Doe, 536 U.S. at 291 (Breyer, J., concurring).
slightly less narrow decision. It seems the Court wanted to allow CMS to exercise primary jurisdiction and applied constitutional avoidance to allow the lower courts to work through CMS’s decision. The trouble is that lower federal courts have now held CMS’s approval to be arbitrary and capricious, so this narrow holding may not stem the tide for long.\(^{147}\)

Similarly, the Court should decide the Medicaid expansion coercion question narrowly by avoiding the constitutional question. This would mean refusing to expand the coercion prong of the Dole test, or alternatively, defining coercion but rejecting the application of coercion to the Medicaid expansion despite any enlarged understanding of states’ rights. Certain justices of the Roberts Court have signaled interest in revisiting Spending Clause precedent to expand the judicially enforced Tenth Amendment to that clause,\(^{148}\) so it is possible the Court will extend the coercion theory to render limits on the spending power judicially enforceable.

Granting the question regarding coercion indicates that the Court is seriously considering reinforcing the coercion theory. Justice Kennedy was given an opportunity to reiterate his federalism project in Bond v. United States last term,\(^{149}\) and he further stated belief that the power to spend should be limited by the Tenth Amendment in Comstock v. United States two terms ago.\(^{150}\) If Justice Kennedy acts as the swing vote that many observe him to be,\(^{151}\) then Florida was smart to tailor its coercion arguments to his concerns. Given Kennedy’s articulated interests, and the ongoing conservative goal of limiting the spending power by judicially enforced Tenth Amendment principles,\(^{152}\) it seems unlikely that the Court will eliminate the coercion concept from Dole.

Questioning during oral arguments also indicated interest in expanding

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\(^{147}\) See, e.g., Cal. Med. Ass’n v. Douglas, CV 11-9688 CAS, 2012 WL 273768, at *16 (granting a preliminary injunction against Director Douglas and Secretary Sebelius of the Department of Health and Human Services because the agency’s decision to permit deep reimbursement cuts does not receive Chevron deference and appears arbitrary and capricious).

\(^{148}\) United States v. Comstock, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring) ("The limits upon the spending power have not been much discussed, but if the relevant standard is parallel to the Commerce Clause cases, then the limits and the analytic approach in those precedents should be respected.").

\(^{149}\) Bond v. United States, 131 S. Ct. 2355 (2011).

\(^{150}\) Comstock, 130 S. Ct. at 1967-68 (Kennedy, J., concurring).


the coercion theory into a doctrine that may be decided with an eye toward reinforcing federalism ideals such as those recently articulated in Bond.\textsuperscript{153} Chief Justice Roberts and Justice Kennedy appeared to be exploring a political "accountability" framework for coercion, which derives from Justice O'Connor's observations New York v. United States.\textsuperscript{154} In New York, the Court explained that the federal government may not "commandeer" the states because voters supposedly will not know which elected officials to penalize if they do not like the legislation enacted at the federal government's command. Setting aside the viability of the theory of accountability, which Justice Kennedy reiterated in his Lopez concurrence,\textsuperscript{155} this accountability overlay would misread New York's explicit acceptance of federal spending as a way to influence states and would be a bad fit for conditional spending programs (which inherently require the federal government to offer the states enough money that they will want to participate in, and often enact laws to advance, a federal policy goal).\textsuperscript{156} Even if the federal government offers states very large sums of money, it does not mask the state's choice to accept that money. And, if the federal government must cut funding, then the state has a reason to leave the program. Either way, state voters know that the federal government is driving the Medicaid program changes.

A decision that expands coercion theory in Florida v. HHS could be far-reaching, because so many major public programs rely upon conditional spending laws. A decision that both expands coercion theory and strikes down the Medicaid expansion as coercive could force a major overhaul of Medicaid, which could be difficult in today's political climate, even given the consistent poll results showing that Medicaid is a popular program.\textsuperscript{157} Though I have advocated elsewhere for federalizing Medicaid, I am not hopeful that a broad coercion decision in Florida v. HHS would lead to centralization. The more left-leaning justices appeared to understand the expansive implications of the plaintiffs' coercion arguments, and they asked 


\textsuperscript{155} United States v. Lopez, 514 U.S. 549, 576-77 (1995) (expressing concern for political accountability where the federal government regulates in the traditional areas of state police power).


\textsuperscript{157} KAISER FAMILY FOUNDATION, KAISER HEALTH TRACKING POLL MAY 2011, http://www.kff.org/kaiserpolls/upload/8190-F.pdf (reporting that the majority of the public polled support Medicaid as is and do not favor converting the program to block grants).
hard questions of the states and expressed total skepticism of the coercion revival attempt. However, it is impossible to know if their understanding will carry the Court.

Ironically, an expanded coercion theory could backfire if the goal is to intensify federalism (meaning state sovereignty) protections. An expanded coercion doctrine would introduce the possibility of enforcing the Tenth Amendment against the power to spend. In Bond, the Court recently articulated that individuals can have standing to enforce the principles of the Tenth Amendment against the federal government because federalism exists to protect not just the states but also individuals.\(^\text{158}\) Thus, an expanded coercion theory could re-introduce Medicaid plaintiffs into the federal court system, the very thing that the United States and the states are trying to avoid in Douglas, thereby inhibiting the states’ desired protection from federal court interference.

Finally, constitutional avoidance would serve a particularly important purpose in Florida v. HHS. The United States has shown an inability to be consistent in its advocacy this term that reflects a dissociation about Medicaid as a program, as an exercise of spending power, and as a matter of federalism. Congress and the executive branch should resolve this tension without unnecessary pressure from the Court to avoid a nebulous concept of coercion in the process. Separation of powers militates toward allowing the elected branches to unravel the Medicaid problem, as many of the issues laid before the Court have been illuminated as deeply political through the briefing process. Neither case has been briefed in such a way as to allow the Court to clarify the gaping holes in spending jurisprudence (such as what “clear notice” means in a forty-seven year old program), nor do the cases contain a clear vision of the Medicaid program from the perspective of ensuring its stability and success through agency leadership. The Court should allow Congress to address the enforcement deficiencies in the program rather than dismantle it through coercion theory.

IV. CONCLUSION

Congress has acted in ways that are contradictory regarding Medicaid throughout the program’s history, and those conflicting attitudes have been accentuated by the executive branch’s litigation strategies this Term. On the one hand, Congress has expanded the Medicaid program through PPACA in a historic manner, federalizing the definition of eligibility and the funding for that new population. On the other hand, Medicaid has long been regarded as a program that requires cost containment.\(^\text{159}\) These ten-

\(^{158}\) Bond v. United States, 131 S. Ct. 2355, 2364 (2011).

\(^{159}\) Eleanor D. Kinney, The Role of Judicial Review Regarding Medicare and Medi-
sions reflect how Medicaid has been treated over the years. Though the Court cannot solve that problem, it could minimize confusion with narrow holdings in both Douglas and Florida v. HHS. To do otherwise could instigate changes for which both Congress and the executive branch appear to be unprepared.

Medicaid Program Policy: Past Experience and Future Expectations, 35 St. Louis U. L.J. 759, 789 (1991) (observing that the states and federal government have approached Medicaid from a cost-containment perspective since the 1970s).