No. 20-1263

In the Supreme Court of the United States

GIANINNA GALLARDO, BY AND THROUGH HER PARENTS PILAR VASSALO AND WALTER GALLARDO,

Petitioner,

v.

SIMONE MARSTILLER, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

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

BRIEF OF *AMICI CURIAE* STATES OF UTAH, OHIO, AND 12 OTHER STATES IN SUPPORT OF RESPONDENT

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STATEMENT OF *AMICI* INTEREST

This case requires the Court to answer a question of great importance to the States. In particular: When the portion of a Medicaid recipient's tort settlement that is for past medical care is insufficient to reimburse a State for the care it paid for, does the Medicaid Act permit reimbursement from the portion of the settlement that is for future care? This Court should hold that the answer is "yes," and the *amici* States are submitting this brief to urge that result.

In answering that question, however, the Court must be careful not to inadvertently resolve another. That second question is this: Does federal law empower Medicaid recipients to sue for an injunction barring a State from reimbursing itself from the portion of a tort settlement set aside for future care? The petitioners in this case are guardians of a child injured in an accident. The guardians sued the party responsible for the injuries, settling the case. The guardians brought this case to enjoin the Florida Agency for Health Care Administration from reimbursing itself using any money from the portion of the settlement directed toward future care, as opposed to past injuries. But the federal law afforded them no basis for doing so: Congress has not empowered Medicaid recipients to bring suits like this, and the federal courts cannot properly use their equitable authority to craft a cause of action that Congress has withheld.

This second question is not properly presented in this case. The respondents long ago forfeited any argument to this effect. And even if it were properly presented, it would be best not to reach it: The States urgently need an answer to the question this Court granted certiorari to decide. Precisely because the

issue is not before the Court, the Court should be careful to answer the question it agreed to decide without inadvertently suggesting that Medicaid beneficiaries like the petitioners have a cause of action. The *amici* States are filing this brief in part to show why the Court should exercise caution here.

SUMMARY OF ARGUMENT

I. Medicaid is a federal health-insurance program jointly operated by the States and the federal government. Congress created the program under its Spending Clause power. That is, it offered the States' funding for Medicaid in exchange for their agreeing to run the program in accordance with federal rules.

One such rule appears in 42 U.S.C. §1396a(a)(45). That provision requires that state Medicaid plans "provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k." Section 1396k, for its part, says that before an individual can receive "medical assistance under the State plan," he or she must "assign the State any rights … to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party." §1396k(a)(1)(A). This provision ensures the solvency of the Medicaid program. It ensures that, to the extent a third party is responsible for a beneficiary's needing medical care, the third party pays back the Medicaid program. This ensures that funds are available in the future for those who need them.

When Medicaid beneficiaries are injured, they will often sue the person who injures them. Many of those cases settle. And in the settlement, the parties often allocate some portion of the settlement amount to past

care (that is, care received already) and another portion to future care (care expected to be needed in the future).

This case presents the following question: May a State recoup from *both* pots of money the amount that it spent providing medical care for a Medicaid beneficiary? That is, does the Medicaid Act allow the States to recoup the costs of medical care already rendered from settlement amounts allocated to *future* care?

Yes, it does. Again, §1396a(a)(45) says that state Medicaid plans must "provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with §1396k." And again, §1396k requires that Medicaid beneficiaries "assign the State any rights … to support … and to payment for medical care from any third party." §1396k(a)(1)(A). This provision requires the State to seek reimbursement from payments for "medical care," and it does so without distinguishing between past and future medical care. *Id.*; *see also Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 633 (2013). Because nothing in the Medicaid Act limits the assignment to payments for *past* medical care, nothing bars the States from recouping dollars spent providing medical care from settlement funds allocated toward future care.

This interpretation is bolstered by the principle that a "textually permissible interpretation that furthers rather than obstructs" a statute's objective "purpose should be favored." A. Scalia & B. Garner, *Reading Law: The Interpretation of Legal Texts* 63 (2012). Allowing States to reimburse their expenditure from funds allocated toward future medical care furthers the purpose of the provisions in the Medicaid Act

allowing or requiring assignment of the beneficiaries' rights and actions against responsible third parties. Medicaid is a tremendously expensive program: combined federal and state costs in 2019, the last year for which data is available, reached $613.5 billion. *See* Ctrs. for Medicare & Medicaid Servs., *Nat'l Health Expenditures 2019 Highlights* at 2, https://perma.cc/9BRA-BD3S. The state and federal governments support this program with taxpayer money. But tax dollars are not available in an infinite supply. To keep the program solvent, Congress "intended that Medicaid be a 'payer of last resort.'" *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 291 (2006) (quoting S. Rep. No. 99-146, p 313 (1985)). That is why the Medicaid Act requires that States find, and collect reimbursement from, third parties that cause beneficiaries to suffer injuries treated with care paid for by Medicaid. Enabling the States to recoup the full value of the medical care for which they paid furthers the objective of preserving Medicaid's solvency. A contrary reading does not.

Because the Eleventh Circuit held that Florida may lawfully recoup its past expenditure on medical care from funds allocated toward future care, this Court should affirm.

II. In resolving this case, the Court should not suggest that the petitioners in this case had a valid cause of action.

The petitioners sued in federal court to enjoin Florida officials from enforcing a state law that would permit the State to recover funds allocated toward future care. Nothing empowered the petitioners to bring that lawsuit. The Supremacy Clause itself "does not create a cause of action." *Armstrong v. Exceptional Child*

Ctr., Inc., 575 U.S. 320, 325 (2015). Nor does the Medicaid Act. To the contrary, instead of allowing citizens to sue for orders mandating compliance with the Act's requirements, Congress vested enforcement power in the Secretary of Health and Human Services, who can withhold funds from non-compliant States. 42 U.S.C. §1396c; *see also Armstrong*, 575 U.S. at 331–32 (plurality op.). To the extent the petitioners believed 42 U.S.C. §1983 entitled them to sue, they were wrong. That section permits individuals to sue only for the violations of rights that federal law "unambiguously confer[s]." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002). The Medicaid Act does not *unambiguously* confer individual rights, in part for the reasons just discussed.

The petitioners perhaps believed they could seek relief under judge-made equitable doctrines. And it is true that courts have long allowed parties to sue in equity "to enjoin unconstitutional actions by state and federal officers." *Armstrong*, 575 U.S. at 327 (majority op.). But courts cannot grant equitable relief that Congress has decided to foreclose. *Id.* at 327–28; *I.N.S. v. Pangilinan*, 486 U.S. 875, 883 (1988). And here, all indications are that Congress intended to foreclose courts from mandating compliance with the Medicaid Act through equitable awards. First, because Congress passed the Medicaid Act pursuant to its Spending Clause power, and because conditions imposed on the States through Spending Clause legislation must be unambiguous, *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006), Congress's failure to unambiguously permit private enforcement implies that it intended to foreclose private enforcement. This inference is bolstered by the fact that the Medicaid Act expressly empowers the

Secretary to enforce the Act's requirements by withholding funds from States that fail to comply with Medicaid's requirements. "The express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others." *Alexander v. Sandoval*, 532 U.S. 275, 290 (2001).

Although the petitioners lacked any valid cause of action, this case provides the Court with no opportunity to say so. The respondents long ago forfeited this argument by failing to raise it. And even if the Court *could* reach the issue, the States need an answer to the question the Court granted *certiorari* to decide. The *amici* States thus urge the Court to decide the question presented, rather than to affirm the Eleventh Circuit based on the absence of any cause of action. But in answering the question presented, the Court should be careful not to suggest that parties in the petitioners' position have any legitimate cause of action.

ARGUMENT

This case presents the question whether the Medicaid Act preempts state laws that permit the State to recover from settlement payments for future care. The answer is "no." This brief explains why, emphasizing the importance of answering the question without suggesting that federal law gave the petitioners any right to bring this suit.

I. The Medicaid Act does not preempt Florida's reimbursement practices.

A. The Medicaid program.

Healthcare is expensive, and many Americans "cannot afford to pay their own medical costs." *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S.

268, 275 (2006). The Medicaid program addresses some of that need. Medicaid is a public health insurance program that Congress passed under the Spending Clause. *See Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 323 (2015). The program is an example of "cooperative" federalism—the federal and State governments all play a role in helping to implement it. *Ahlborn*, 547 U.S. at 275. This section explores those roles.

1. Medicaid forms a contract between the States and the federal government. "Congress provides federal funds in exchange for the States' agreement to spend them in accordance with congressionally imposed conditions." *Armstrong*, 575 U.S. at 323. Most of those conditions appear in 42 U.S.C. §1396a(a). Four such provisions governing this contract bear on this case.

First, Section 1396p includes two prohibitions: (1) States must not impose a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan"; and (2) States must not recover or retroactively adjust "any medical assistance correctly paid on behalf of an individual under the State plan." §1396p(a)(1) & (b)(1).)

Second, §1396a(a)(25)(A)–(B). This provision requires States to "take all reasonable measures" to identify third parties that are liable "to pay for care and services available under the plan." §1396a(a)(25)(A). The State plan must also provide that, in "any case where such [third-party] liability is found to exist after medical assistance has been made available on behalf of the individual," the State "will seek reimbursement for such assistance to the extent

of such legal liability." §1396a(a)(25)(B).

Third, §1396a(a)(25)(H). This provision requires a State plan to provide that "the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services."

Finally, there is §1396a(a)(45). This section says that State plans must "provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k." Section 1396k, in turn, says that before an individual can receive "medical assistance under the State plan," he or she must "assign the State *any rights … to support* (specified as support for the purpose of medical care by a court or administrative order) *and to payment for medical care from any third party*." §1396k(a)(1)(A) (emphasis added).

In addition to these four provisions, the Medicaid Act imposes requirements relating to plan-approval and enforcement. States submit their plans to the Secretary of Health and Human Services. If a State plan "fulfills the conditions" listed in §1396a(a), the Secretary "shall approve" it. §1396a(b). Federal funds will then become available to that State. *See* §1396-1.

If a State (a) changes its plan such "that it no longer complies with the provisions of section 1396a," or (b) fails to "comply substantially with any such provision" in the administration of its plan, then "the Secretary shall notify such State … that further payments will not be made to the State …, until the Secretary is satisfied that there will no longer be any such

failure to comply." §1396c. The Secretary's decision to withhold funds remains subject to judicial review in federal court. §1316(a)(3). Notably, this represents "the sole remedy Congress provided for a State's failure to comply with Medicaid's requirements." *Armstrong*, 575 U.S. at 328.

2. Every State participates in Medicaid. *Ahlborn*, 547 U.S. at 275. That means the Secretary approved fifty different plans for medical assistance. While each State plan satisfies the conditions described in §1396a, those plans can and do differ. That being said, most States, if not all, have provisions that are similar to those provisions of Florida law that are at issue in this case. *See, e.g.*, N.Y. Social Serv. Law §104-b; Ohio Rev. Code §5160.37;; Okla. Stat. Ann. tit. 63, §5051.1; 62 Penn. Stat. §1409; Utah Code §§ 26-19-201, -401.

Consistent with its obligations under federal law, Florida requires Medicaid "to be repaid in full" whenever a third party is liable for medical expenses that have already been paid. Fla. Stat. §409.910(1). Florida "shall seek reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, *but not in excess of the amount of medical assistance paid by Medicaid*." *Id.*, §409.910(4) (emphasis added). Additionally, Florida requires beneficiaries to assign to the State "any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law." *Id.*, §409.910(6)(b). And once benefits are disbursed, Florida "automatically" acquires "any rights" that a beneficiary "has to any third-party benefit for the full amount of medical assistance provided by Medicaid." *Id.*, §409.910(6)(a). To ensure repayment, Florida

gave itself "an automatic lien for the full amount of medical assistance provided by Medicaid … as a result of any covered injury or illness for which a third party is or may be liable." *Id.*, §409.910(6)(c).

Although Florida law aims to "recover the *full amount* of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits," *id.*, §409.910(7) (emphasis added), it sometimes recovers less. For instance, when a Medicaid beneficiary sues a third party and obtains a settlement, Florida is entitled to *either*: (a) half of that settlement, after it is reduced by 25 percent for fees and costs; *or* (b) the full amount of medical assistance that was provided, whichever amount is less. *Id.*, §409.910(11)(f). (Florida allows the Medicaid beneficiary to challenge this allocation formula through an administrative process. *See id.*, §409.910(17)(b); *see Wos v. E.M.A. ex rel. Johnson,* 568 U.S. 627, 639 (2013). The Eleventh Circuit upheld that process, *see* Pet.App.25–27, and the petitioner did not seek *certiorari* on that issue, *see* Pet.i.)

B. The Medicaid Act does not preempt laws requiring the States to seek reimbursement for past and future medical care payments.

The Medicaid Act does not preempt the States from seeking reimbursement for Medicaid benefits from the portions of settlement agreements that represent payment for medical care.

1. Federal law is "the supreme Law of the Land." U.S. Const. art. VI, cl.2. Accordingly, Congress can preempt state law either expressly or impliedly. *Kansas v. Garcia*, 140 S. Ct. 791, 801 (2020). But even claims of implied preemption, like the claim here, rise

and fall with the plain language of the statute. A state law is preempted when Congress intended to preempt laws like the one at issue. And congressional intent "must be grounded in the text and structure of the statute at issue." *Id.* at 804 (quotation omitted). Thus, the words chosen by Congress are the "ultimate touchstone in every pre-emption case." *Wyeth v. Levine*, 555 U.S. 555, 565 (2009) (quotation omitted).

The question for this Court, therefore, is this: Does Florida law "directly conflict" with the Medicaid Act? *Wos*, 568 U.S. at 636 (quotation omitted). In particular, suppose a Medicaid recipient enters into a tort settlement with an individual who injured her. Suppose the portion of that settlement directed to *past* medical care is insufficient to reimburse the State for the money it expended on the beneficiary's past care. In these circumstances, does the Medicaid Act prohibit Florida's practice of reimbursing itself using money that the settlement directs to future care?

No, it does not. This follows from §1396a(a)(45). Under that provision, state Medicaid plans "*must*— … provide for mandatory assignment of rights of payment *for medical support and other medical care* owed to recipients, in accordance with §1396k." §1396a(a)(45) (emphasis added). And §1396k—the section of the Medicaid Act to which §1396a(a)(45) refers—says that individuals cannot receive Medicaid coverage unless they "assign the State any rights … to support … and to payment for medical care from any third party." §1396k(a)(1)(A). The same section requires the State to return the remainder—the amount the recipient received for medical care minus the amount the State paid for medical care—over to the

recipient. §1396k(b).

This provision draws a line between medical care and non-medical care. *Wos*, 568 U.S. at 633–34 (citing *Ahlborn*, 547 U.S. at 282). With respect to "medical support and other medical care," §1396a(a)(45) *requires* the State to obtain an "assignment … of payment." And §1396k requires beneficiaries to assign to the State their right to "payment for medical care." These statutes do not distinguish between *types* of covered medical care. Most relevant here, they do not speak to the assignment of payments for "*past*" medical care or "*future*" medical care. They simply require the State to seek the ability to reimburse itself, *only* up to the amount it actually expended, using a tortfeasors' payments for medical care.

This resolves the dispute. The States must recover Medicaid benefits, capped at the amount expended, from those portions of settlement agreements that represent payment for medical care. If, for example, a State expends $5,000 in Medicaid benefits and a settlement sets aside $10,000 for medical care, then the State can recover its full $5,000, leaving $5,000 for the recipient. That holds true even if the settlement designates $1 for *past* medical care and the remaining $9,999 for *future* medical care. Both types of payment, after all, are "payment for medical support and other medical care owed to recipients" by third parties. And §1396a(a)(45) requires assignment of such payments.

Reading §1396a(a)(45) otherwise would empower settling parties to gerrymander around the States' right to recovery by labeling the entire (or nearly the entire) settlement a payment for "future care." Indeed, counsel may feel obligated as zealous advocates to structure the settlement to be heavily weighted to

future care in order to maximize their client's take-home recovery. True, in *Ahlborn*, the Court noted that such settlement manipulation could be avoided by "obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." 547 U.S. at 288. But this ignores the reality of the inherently speculative nature of "future care," as well as the pressures States face to accept proposed settlements and avoid expending resources to litigate allocation.

Florida's interpretation of §1396k finds additional support from the fact that Congress, when it wished to refer to past medical care, "knew how to do so." *Custis v. United States*, 511 U.S. 485, 492 (1994). One provision within the Medicaid Act, for example, speaks of "medical assistance payments *made on behalf of an individual*." §1396k(b) (emphasis added). Another speaks of "medical assistance for health care items or services *furnished to an individual,*" §1396a(a)(25)(H). Congress could have included similar language in §1396a(a)(45). The provision might have required that States obtain an "assignment of rights of payment of medical support and other medical care *furnished to an individual*." But Congress included no such language. "The statute says what it says—or perhaps better put here, does not say what it does not say." *Cyan, Inc. v. Beaver Cty. Emps. Ret. Fund*, 138 S. Ct. 1061, 1069 (2018).

Florida law complies with these rules. The Court will find no "direct conflict." *Wos*, 568 U.S. at 636. It should therefore affirm the Eleventh Circuit's judgment.

2. Gallardo makes two counterarguments resting on the statutory language. Neither changes the

outcome.

First, Gallardo argues that §1396a(a)(45) permits States to seek reimbursement *only* from payments for past medical care. She points to a provision in §1396k. (Remember, §1396a(a)(45) requires assignments "in accordance with" that section.) In particular, Gallardo relies on §1396k(a). That provision says what "a State plan for medical assistance shall" do "[f]or the purpose of assisting in the collection of medical support payments and other payments for medical care *owed to recipients* of medical assistance under the State plan." (emphasis added). Gallardo homes in on the word "owed." Because beneficiaries are not "owed" coverage for future care, the argument goes, §1396k must be limited to past medical care.

This argument fails because "owed to recipients of medical assistance under the State plan" does not mean, as Gallardo thinks, "owed pursuant to the State Medicaid plan to Medicaid recipients." If that were what the law said, it would be incoherent, because it would require that States take action "for the purpose of assisting in the collection of" payments *the States themselves* are making. To avoid this incoherence, the phrase "owed to recipients of medical assistance under the State plan" must be read to mean: "owed to individuals who receive medical assistance under the plan." Read in this manner, the statute is coherent: it covers payments owed to these individuals by third parties. Because the statute requires that States take steps to collect payments for "medical care" without distinguishing between past and future care, *see above* 7–8, 11–13, this statute supports the States, not Gallardo.

Gallardo also points to §1396k(a)(1)(C), but that

subsection is no more helpful to her argument. It requires that recipients: "cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." It is unclear why Gallardo thinks this helps her. This provision simply identifies whom the recipient must help the State track down; it does not speak to the scope of the rights assigned to the State.

Second, Gallardo takes a fallback position. If §1396a(a)(45) requires assignment of payments for future medical care, she says, then it contradicts §1396a(a)(25)(H) . And in the event of a conflict, she says, §1396a(a)(25)(H) wins, because it was enacted later in time and more specifically addresses the reimbursement issue presented.

This argument fails. Section 1396a(a)(25)(H) requires the State to have "in effect laws under which, to the extent that payment *has been made* under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services." 42 U.S.C. §1396a(a)(25)(H) (emphasis added). This provision thus requires the States to have backwards-looking laws—laws that allow them to assert the beneficiaries' rights against third parties that arise automatically when Medicaid payments have already "been made" for services and items "furnished."

Two provisions in the same act must be read "as a harmonious whole rather than at war with one another." *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1619 (2018); *see* A. Scalia & B. Garner, *Reading Law: The*

Interpretation of Legal Texts 180 (2012). Here, that is easy to do. Section 1396a(a)(45) and §1396a(a)(25)(H) work together to achieve a core goal of Medicaid: ensuring that third parties pay before Medicaid does, thus ensuring that the program's limited funds go to those who need them most. Section 1396a(a)(45) requires States to acquire*, by assignment*, certain rights from Medicaid recipients—namely, their rights to payments by third parties liable for medical care. Section 1396a(a)(25)(H) adds another layer of protection. It requires States to acquire, *automatically*, certain rights against third parties. This allows the State to pursue claims against third-party tortfeasors liable for the costs of past-medical care. *Pivonka v. Corcoran*, 165 N.E.3d 1098, 1101–02 (Ohio 2020). And by requiring laws giving the States the right to collect automatically when a payment is made, it protects the States from insurers who might argue that anti-assignment provisions in their insurance plans negate the beneficiaries' contractual assignments to the States. *See* Br. for the United States as Amicus Curiae 28–29; Resp. Br. 28-29, 32-35.

Gallardo's contrary argument mostly boils down to this: it seems odd that the scope of §1396a(a)(45) may differ in one respect from the scope of §1396a(a)(25)(H). *But see* Resp. Br. 30-31 (arguing that they do not so differ). Even if Gallardo is right about that, there is nothing particularly strange about two different provisions having different scopes. And in any event, the supposed oddity does not cause the two provisions to conflict. So both apply, and neither trumps the other. *Gallardo v. Dudek*, 963 F.3d 1167, 1178 n.15 (11th Cir. 2020). Because §1396a(a)(45) allows Florida to claim reimbursement from that portion of the settlement directed to future medical care,

it does not matter whether §1396a(a)(25)(H) would allow the same.

Incidentally, if the provisions conflict, they are unconstitutional. Spending Clause conditions must be unambiguous. *South Dakota v. Dole*, 483 U.S. 203, 207 (1987). If "Congress intends to impose a condition on the grant of federal moneys, it must … speak with a clear voice, … enabl[ing] the States to exercise their choice knowingly, cognizant of the consequences of their participation." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Contradictory conditions do not clear that bar. To avoid this constitutional problem, the Court should read the provisions as Florida and the *amici* States suggest. *See Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

C. The Eleventh Circuit's decision accords with the purpose of the Medicaid Act's reimbursement requirements.

Medicaid makes critical health care services available to millions of the nation's and the States' most vulnerable individuals. The program comes at enormous taxpayer expense. In 2019, the latest year for which data are available, total Federal and State Medicaid costs reached $613.5 billion. *See* Ctrs. for Medicare & Medicaid Servs., *Nat'l Health Expenditures 2019 Highlights* at 2, https://perma.cc/9BRA-BD3S. The Federal Government and the States share those costs, but the split varies by State because Congress based the funding formula on each State's per-capita income. *See* 42 U.S.C. §1396d(b). From federal fiscal years 2016 to the present, the federal government paid between 50% to almost 80% of each State's Medicaid costs. Cong. Research Serv., *Medicaid's Federal*

Medical Assistance Percentage (FMAP) at 16–17 (updated July 29, 2020), https://perma.cc/L6AB-HBCZ. In Florida, federal assistance accounted for about 61% of the State's Medicaid costs. *Id.* at 16. In Utah, the contribution rate varied from essentially 70% to 67%. *Id.* at 17.

Whatever the split, both federal and state governments spend massive amounts of money—collected in large part from state and federal taxpayers—funding Medicaid services. A more populous State like Florida spent $25.9 billion—more than 31% of total state expenditures—on Medicaid in 2019. Nat'l Assoc. of State Budget Offices, *State Expenditure Report* at 54–55 (2020), https://perma.cc/WBE2-BLQM. Even a smaller state like Utah had $2.99 billion in federal and state Medicaid expenditures in 2019—18% of its overall expenses. *Id.*

"Congress, in crafting the Medicaid legislation, intended that Medicaid be a 'payer of last resort.'" *Ahlborn*, 547 U.S. at 291 (quoting S. Rep. No. 99-146, p 313 (1985)). Thus, a critical component of Medicaid is requiring participating States to find, and collect reimbursements from, liable third parties. These collection efforts obviously do not, and were not meant to, offset all Medicaid costs. But they still add up to put meaningful money back into federal and state fiscs. For example, since Utah's 2010 fiscal year, the State has collected more than $40 million in Medicaid reimbursements from third-party tortfeasors. *See Soc. Servs. Appropriations Subcomm. Meeting*, 2021 Leg., Gen. Sess., Jan. 26, 2021 (Utah 2021) (report from Office of Recovery Servs., Medicaid Recovery Program, *History of Third-Party Liability (TPL) Outcomes & Expenditures* (reporting annual collections for casualty claims)), https://perma.cc/4TVM-SRKW.

The reimbursements also serve equitable ends. They avoid double payments or potential windfalls for Medicaid recipients. And they more fairly place financial responsibility where it should be—on any tortfeasor responsible for the Medicaid recipient's injury. Both results honor taxpayers—the ultimate source of Medicaid funding—by preserving Medicaid monies for services only Medicaid can pay for or using the recouped moneys for other government needs. Either way, the reimbursement requirements save millions of dollars each year.

Those savings won't survive under Gallardo's and the United States' interpretation of the reimbursement provisions. Limiting a State's assignment to the portion of settlements allocable only to past medical expenses will significantly decrease the actual dollars States can recover under Medicaid's third-party liability provisions.

Take this case. Florida paid $862,688.77 in Medicaid funds for Gallardo's medical expenses. Pet. Br. at 16-17; JA 26, 32. But Gallardo settled her claims with the tortfeasor for $800,000 and explicitly allocated only $35,367.52 for past medical expenses. Pet. Br. at 16; JA 27, 38; Pet. App. 4. Gallardo reasoned that because she settled for 4% of her total damages, her settlement included only 4% of her past medical expenses. Pet. App. 4, n.5. But under Florida's Medicaid reimbursement statutes, Florida was entitled to about $300,000 of the settlement funds to reimburse the State for the more than $800,000 in Medicaid payments. Pet. Br. at 17. That means Gallardo's only-past-medical-expenses argument reduces Florida's already reduced reimbursement claim by almost 90%.

And that sort of drastic, ratio-based reduction is

not uncommon for the only-past-medical-expenses proponents. In a recent case, the Utah Supreme Court wrongly decided that the State could be reimbursed only from the portion of the Medicaid recipient's settlement that was fairly allocated to past medical expenses. *Latham v. Office of Recovery Servs.*, 448 P.3d 1241, 1248 (Utah 2019). The Medicaid recipient argued that the State should recover only 11% of the Medicaid reimbursement it sought because the recipient settled her claim for 11% of its value. *Id.* at 1243. While the Utah Supreme Court said that this drastic ratio-based formula was not required to determine past medical expenses, the court said such a formula could still be appropriate on remand if the district court so determined. *Id.* at 1249.

These examples leave no doubt that Gallardo's arguments undermine State Medicaid reimbursement requirements and will undoubtedly decrease the monies collected over time. The Medicaid reimbursement arc should not be spiraling down as Medicaid enrollment and costs shoot up. *See* U.S. Dep't of Health and Human Servs., *2016 Actuarial Report on the Financial Outlook for Medicaid*, at iv, https://perma.cc/LY4M-NGU3 (projecting Medicaid expenditures to grow 5.7 percent a year and reach $957.5 billion by 2025 and enrollment to increase 1.5 percent a year and reach 81.6 million people by 2025).

The United States' solution to all of this—States can just negotiate past-medical-expenses in any settlement agreements or litigate the issue—ignores the problem and reality. U.S. Br. at 29-30. If this Court shrinks the Medicaid reimbursement pot from all medical expenses to only past medical expenses as a matter of law, no amount of settlements or litigation can enlarge the pool.

Nor are settlements likely to maximize the amount of past medical expenses States recover. The fact that this Court has had to resolve three Medicaid reimbursement disputes within the last 20 years—*Ahlborn, Wos,* and now *Gallardo*—suggests mutually agreeable settlements are not so easy to reach. And it remains unclear why Medicaid recipients would suddenly want to maximize the States' reimbursements for past medical expenses at the recipients' expense.

Consider Utah's *Latham* case again. Utah approved Latham's settlement to capture the defendants' $800,000 offer—an amount not guaranteed to survive a trial. *Latham*, 448 P.3d at 1243. Before approving that settlement, the State tried to negotiate with Latham over what portion of it should be allocated to *all* medical expenses *generally*. But Latham or his lawyers would not even agree with Utah on that *broader* allocation. Indeed, that's why Latham sued in Utah state district court—to determine "how much [the State] was entitled to collect from his settlement award." *Id.*

It strains credulity to think that Latham would have agreed to allocate more money to *past* medical expenses when he in fact refused to stipulate to an allocation of *all* medical expenses. His decision is not surprising, however, since *Ahlborn* itself creates incentives for Medicaid recipients *not* to stipulate; it expressly contemplates that a State and Medicaid recipient can, "if necessary, . . . submit[]" allocation disputes "to a court." 547 U.S. at 288.

But more litigation also seems an unlikely fix. It makes no economic sense for States to start pouring more time, money, and resources into fights about how much of a shrinking reimbursement pie they

should get. Spending more and more for less Medicaid reimbursements will not help the States' situation, especially when "Medicaid spending is [already] the largest component of most state budgets." *Wos*, 568 U.S. at 654 (Roberts, C.J., dissenting).

II. The Court should decide this case without suggesting that petitioners had any right to bring it.

On its face, this is a preemption case. A Medicaid beneficiary claims that the Medicaid Act preempts Florida law. But the beneficiary here wields preemption offensively—she sued to enjoin Florida from enforcing its allegedly preempted law against her. That gives rise to the question whether the Medicaid Act, or any other law, supplied the beneficiary with a cause of action.

The answer to that question is "no." Neither the Constitution, the Medicaid Act, 42 U.S.C. §1983, nor principles of equity justify enforcement of the Medicaid Act in federal court by a beneficiary. The respondents long ago forfeited any argument to this effect. (The question whether the plaintiff has a cause of action is a non-jurisdictional issue that can be waived or forfeited. *See Arbaugh v. Y&H Corp.*, 546 U.S. 500, 514 (2006).) For that reason, and because the States badly need an answer to the question this Court granted *certiorari* to decide, this Court should not decide this case on the ground that the petitioners lack a cause of action. It should, however, take great care to decide this case without suggesting that Medicaid beneficiaries have any right to bring a suit like this.

A. Plaintiffs wishing to wield the Constitution as

a sword in litigation need to identify some cause of action enabling them to do so. *See Armstrong*, 575 U.S. at 324 (requiring a cause of action "to seek injunctive relief against the enforcement or implementation of state legislation") (quotation omitted). But no cause of action empowers Medicaid recipients to sue for an injunction of reimbursement practices alleged to violate the Medicaid Act.

Start with the obvious. The Supremacy Clause "does not create a cause of action." *Id.* at 325. In this case then, where a beneficiary claims that the Medicaid Act preempts Florida law, that Clause provides no hook for enforcement in the courts. *Id.* at 325–27.

Neither does the Medicaid Act itself. Congress did not include—either in the original law or in any of the numerous amendments—a citizen-suit provision. Instead, Congress vested the enforcement power *only* in a federal agency; it empowered the Secretary to withhold funds. §1396c. As this Court has recognized previously, Congress "phrased" each of the conditions listed in §1396a(a), including §1396a(a)(18) and §1396a(a)(25)(H) , "as a directive to the federal agency charged with approving state Medicaid plans, not as a conferral of the right to sue upon the beneficiaries of the State's decision to participate in Medicaid." *Armstrong*, 575 U.S. at 331 (plurality op.). And when such directives are coupled with §1396c—"the sole remedy Congress provided for a State's failure to comply with Medicaid's requirements," *id.* at 328 (majority op.)—the absence of a "congressional intent to create a private right of action" is apparent, *id.* at 331 (plurality op.) (quoting *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001)).

Section 1983 of Title 42 likewise paves no path into

court. That statute does not confer an unqualified right to sue whenever "a state actor violates a federal law." *City of Rancho Palos Verdes, Cal. v. Abrams*, 544 U.S. 113, 119 (2005). Instead, it permits *only* suits to enforce individual rights that are "unambiguously conferred" by federal law. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002). Spending Clause legislation rarely confers "individual rights" with a "clear voice." *Id.* at 280 (quotation omitted). Indeed, over the last "three decades," this Court "has repeatedly declined" to allow private plaintiffs to sue under §1983 to enforce laws "that set conditions on federal funding of state programs." *Nasello v. Eagleson*, 977 F.3d 599, 601 (7th Cir. 2020).

Here, Congress did not unambiguously create any individual rights in exercising its spending power. Recall that §1396a(a)(18) and §1396a(a)(25)(H) are just two items on a long checklist that the Secretary must review before approving a State plan for medical assistance. *See* §1396a(a)(1)–(87). If a State plan satisfies these conditions, then the Secretary "shall approve" it. §1396a(b). And if a State fails to comply with these conditions after approval, then the Secretary "shall" withhold funds. §1396c. In that sense, §1396a(a)(18) and §1396a(a)(25)(H) are "two steps removed" from any interest a Medicaid beneficiary might have. *Gonzaga*, 536 U.S. at 287. They "speak only to" the Secretary, instructing when State plans shall be approved and when federal dollars must be withheld. *Id.* This "context" sheds light on how §1396a(a)(18) and §1396a(a)(25)(H) fit in the "overall statutory scheme." *Util. Air. Regul. Grp. v. EPA*, 573 U.S. 302, 320 (2014) (quotation omitted). They serve as guideposts for the Secretary and as obligations on

the States—not as rights for individuals.

Even if one overlooks this context, an isolated reading of §1396a(a)(18) and §1396a(a)(25)(H) would lead to the same conclusion. That is because both provisions "focus on the [entity] regulated rather than the individuals protected." *Alexander*, 532 U.S. at 289. Under §1396a(a)(18), a "*State plan* for medical assistance *must*— … *comply* with the provisions of section 1396p." (emphasis added). (More on §1396p in a moment.) And under §1396a(a)(25)(H) , a "*State plan*" must provide "that … *the State* has in effect" certain laws. (emphasis added). These provisions, even when viewed without regard to the Medicaid Act's overall context, are still a "step … removed" from those individuals that stand to gain from their State's participation in Medicaid. *Alexander*, 532 U.S. at 289. That is because the States are the focus, not the Medicaid beneficiaries. One searches in vain for *any* "individually focused terminology" in §1396a(a)(18) and §1396a(a)(25)(H) . *Gonzaga*, 536 U.S. at 287. These conditions for federal funding thus "create no implication of an intent to confer rights" on private persons. *Alexander*, 532 U.S. at 289 (quotation omitted).

Similarly, the recovery obligation in §1396p cannot be read to create a "clear and unambiguous" individual right. *Gonzaga*, 536 U.S. at 290. Start with the statutory context. Section 1396p is not a standalone provision. It is yet another item on the checklist that the Secretary must consider when deciding whether to withhold funds. Under §1396c, the Secretary "shall" withhold federal dollars from any State that fails to "comply substantially" with "the provisions of 1396a," which includes §1396a(a)(18). And under §1396a(a)(18), States "must— … comply" with §1396p. So the *only way* that the Secretary can

determine whether a State is complying with §1396a(a)(18), entitling it to continued federal funding, is by verifying that the State is complying with §1396p. Everything is interconnected.

Context notwithstanding, §1396p is best read as an order to the States, as opposed to a conferral of individual rights. Section 1396p prohibits *States* from recovering Medicaid benefits that were correctly paid to a beneficiary, and from imposing a lien against the property of a beneficiary on account of such benefits being correctly paid. *See* §1396p(a)(1) & (b)(1). True, these provisions refer to individuals that have received Medicaid benefits from a State. But beneficiaries are not the "unmistakable focus" of §1396p—the States are. *Gonzaga*, 536 U.S. at 287 (quotation omitted). And even if one could arguably infer an individual right from §1396p, that still is not enough. For "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." *Id.* at 280 (emphasis added; quotation omitted). Section 1396p lacks the requisite clarity, meaning it fails to confer individual rights.

Finally, the fact that Medicaid recipients are intended beneficiaries of the Spending Clause contract changes nothing. For one thing, intended benefits are not rights that can be enforced under §1983. *See Gonzaga*, 536 U.S. at 283. Further, whatever jurisprudence supports the notion that an intended beneficiary can sue to enforce a contract to which it is not a party, those principles do not apply "to contracts between two governments." *Armstrong*, 575 U.S. at 332 (plurality op.). The main reason why is that Congress, when drafting a Spending Clause legislation, must

speak in a "clear voice" if it intends to "confer individual rights." *Gonzaga*, 536 U.S. at 280 (quotation omitted). Here, Congress did not clearly give beneficiaries a right to enforce the Medicaid Act, and no common-law theory of contracts can change that.

In sum, private individuals cannot sue in a court of law to enforce §1396a(a)(18) and §1396a(a)(25)(H) of the Medicaid Act.

B. The petitioners fare no better when the matter is viewed through the lens of equity.

As a general matter, federal courts of equity can hear certain cases and issue certain remedies. For example, if a would-be defendant in a legal action preemptively asserts in equity that federal law shields him from state law, then a federal court may review that claim and, when the situation calls for it, enjoin state officials from enforcing the preempted law. *See Ex parte Young*, 209 U.S. 123 (1908).

But the "ability to sue to enjoin unconstitutional actions by state and federal officers is the creation of courts of equity"—a judge-made remedy "tracing back to England." *Armstrong*, 575 U.S. at 327. And judge-made creations must give way to statutory law. *Rees v. City of Watertown*, 19 Wall. 107, 122 (1874); *see also Brunner v. Ohio Republican Party*, 555 U.S. 5, 6 (2008) (*per curiam*); *Michigan Corr. Org. v. Mich. Dep't of Corrections*, 774 F.3d 895, 906 (6th Cir. 2014) (per Sutton, J.). Courts of equity cannot "disregard" the law's bounds. *I.N.S. v. Pangilinan*, 486 U.S. 875, 883 (1988) (quotation omitted). Thus, equity stops "where the letter of the law stops." 1 J. Story, Commentaries on Equity Jurisprudence §14 (14th ed. 1918); *accord* 1 J. Pomeroy, A Treatise on Equity Jurisprudence §425 (3d ed. 1905).

Here, two aspects of the Medicaid Act indicate that Congress has foreclosed the availability of equitable relief for plaintiffs in the petitioners' position.

First, Congress enacted these laws pursuant to its Spending Clause power without clearly authorizing private enforcement. Exercising its power under the Spending Clause, U.S. Const., art. I, §8, cl.1, Congress can offer States money in exchange for their agreement to abide by conditions. But those conditions must be unambiguous. *Dole*, 483 U.S. at 207; *Pennhurst*, 451 U.S. at 17. One consequence the States care about is whether accepting federal money exposes them to private lawsuits. Thus, Congress's Spending Clause legislation can expose the States to suit *only* if it makes clear that this is one consequence of taking the money. *Arlington Cent. Sch. Dist. Bd. of Educ.*, 548 U.S. at 296. When a law passed pursuant to the Spending Clause includes no such statement, that is a sign that Congress has barred the law's private enforcement. That sign becomes stronger still when the law empowers the government to withhold funds from non-compliant States; Congress's inclusion of one remedy makes its failure to permit others that much more telling. *Armstrong*, 575 U.S. at 328.

Second, the nature of the challenged provisions "establish[es] Congress's 'intent to foreclose' equitable relief." *Id*. (quoting *Verizon Md., Inc. v. Public Serv. Comm'n of Md.*, 535 U.S. at 635, 647 (2002)). The Court has recognized that Congress's inclusion of one enforcement mechanism may not, "by itself," foreclose the possibility of equitable suits. *Id*. But that, combined with some other indication of an intent not to permit private enforcement, can. In *Armstrong*, for example, the Court held one provision in the Medicaid Act unenforceable based on "two" of the law's aspects:

(1) the existence of a separate enforcement mechanism; and (2) the "judicially unadministrable" nature of the provision's requirements. *Id.*

Here too, the statute involves more than merely a mechanism to withhold federal funds. Section 1396a(a)(45) and §1396a(a)(25)(H) contemplate a State process designed to resolve disagreements about the proper allocation of settlement funds, such as a "judicial or administrative proceeding." *Wos*, 568 U.S. at 638. Gallardo can raise her preemption argument in these proceedings. *Giraldo v. Agency for Health Care Admin.*, 248 So. 3d 53, 54 (Fla. 2018). Indeed, had Gallardo taken that route, instead of seeking a federal forum, she would likely have received the ruling she now requests. The Supreme Court of Florida reads the provisions the same way she does, showing that a federal venue is not always necessary to challenge state Medicaid decisions. *Id.* at 56.

In sum, invoking equity here would entail an expansion of the Medicaid Act's "express and implied" constraints. *Armstrong*, 575 U.S. at 237. Congress made two key decisions when enacting (and repeatedly amending) the Medicaid Act. *First*, Congress chose not to give individuals enforceable rights. This certainly is true for §1396a(a)(18) and §1396a(a)(25)(H) . *See above* 24-25. And it likely is true for every other provision, given that "Medicaid does not establish anyone's entitlement to receive medical care (or particular payments)." *Nasello*, 977 F.3d at 601. *Second*, Congress chose not to give individuals enforceable remedies. States that fail to comply with the Medicaid Act, whether by refusing to act as federal law requires or by engaging in conduct that federal law prohibits, answer *only* to the Secretary. §1396c. This absence of both rights and

remedies for Medicaid recipients establishes "Congress's intent to foreclose" not just legal relief, but also equitable relief. *Armstrong*, 575 U.S. at 328 (quotation omitted). The law stops short of extending rights and remedies to beneficiaries. Because equity cannot be used to extend the law, the federal courts may not create a judge-made right to equitable relief. It is Congress—not the courts—that decides who may step foot in federal court. *See Green Valley Special Util. Dist. v. City of Schertz, Tex.*, 969 F.3d 460, 494–502 (5th Cir. 2020) (*en banc*) (Oldham, J., concurring).

CONCLUSION

The Court should affirm the Eleventh Circuit's judgment.

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