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Federalizing Medicaid

Notes/Citation Information

University of Pennsylvania Journal of Constitutional Law, Vol. 14, No. 2 (December 2011), pp. 431-484

FEDERALIZING MEDICAID

*Nicole Huberfeld**

I. INTRODUCTION.....	432
II. MEDICAID, THE POOR, AND THE FEDERAL-STATE	
“PARTNERSHIP”	436
A. Two Themes: Deserving Poor and States’ Rights.....	436
B. Kerr-Mills Redux: Medicaid.....	444
C. Enter: PPACA.....	450
III. THE STATES’ RIGHTS THREAD: A FEDERALISM	
CONUNDRUM	453
A. Searching for a Coherent Federalism	454
1. The “Federalism Revolution”	454
2. The Roberts Court Begins to Reveal Its	
Federalism Cards	459
B. Medicaid and Federalism in the PPACA Litigation	464
IV. CHOOSING A DIFFERENT PATH—FEDERALIZE MEDICAID	
COMPLETELY	473
A. Steps Already Taken	473
1. Federal Funding.....	473
2. Nationalized Medical Standards	476
B. Reasons to Forge a New Path	479
V. CONCLUSION	484

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I. INTRODUCTION

“[O]ne man’s pluralism is another man’s incoherence.”¹

Medicaid fosters constant tension between the federal government and the states, and that friction has been exacerbated by its expansion in the Patient Protection and Affordable Care Act of 2010 (“PPACA”).² Medicaid was passed as the caboose to Medicare’s train in 1965,³ and both federal programs protect needy populations that would be otherwise uninsured, yet Medicaid has always been treated quite differently from Medicare. Medicaid was an under-theorized and underfunded continuation of existing programs that retained two key aspects of welfare medicine as it developed: bias toward limiting government assistance to the “deserving poor,” and delivery of care through the states that resulted in a strong sense of states’ rights.⁴ These ideas regarding the deserving poor and federalism have remained constants in the program over the last forty-six years.

PPACA begins to change one of the two historic themes by expanding eligibility for Medicaid beyond the deserving poor—for the first time in Medicaid’s history—combined with almost total federal funding for the new enrollees,⁵ but it is not a complete federal capture of the Medicaid program. This major philosophical shift is a

1 U.S. DEP’T OF HEALTH, EDUC., & WELFARE, REPORT OF THE TASK FORCE ON MEDICAID AND RELATED PROGRAMS 3 (1970).

2 Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111-148, § 1 (2010). The Obama administration has been calling the law the Affordable Care Act, but that nickname seems inadequate compared to the scope of the law.

3 Medicare and Medicaid are both amendments to the Social Security Act (“SSA”), so they are sometimes referred to as Title 18 and Title 19, which are their respective sections in the SSA. THEODORE R. MARMOR WITH JAN S. MARMOR, *THE POLITICS OF MEDICARE* 1, 68, 79 (1973).

4 ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 51 (1974); see also David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of AntiPoverty Law*, 157 U. PA. L. REV. 541, 567 (2008) (noting that the United States has addressed poverty problems by decentralized, local policy whereas the prevailing approach in other developed countries has been centralized).

5 See PPACA, Pub. L. No. 111-148, § 2001.

step toward federalizing Medicaid, but it has gone largely unnoticed. While many governors claim that states need more control, they are protesting the economic aspect of the Medicaid expansion, not this philosophical about-face.⁶

As a recent empirical study has shown,⁷ Medicaid is undeniably important in terms of providing a patient safety net, supplying funding for the states, and generally supporting the healthcare system,⁸ but states fight its strictures by arguing their decision-making is compelled from a monetary and a policy perspective.⁹ Predictably, some states have not responded enthusiastically to PPACA's expansion of Medicaid. In a lawsuit filed the same day PPACA was signed, approximately twenty-six states have followed the lead of Florida's Attorney General in challenging the constitutionality of PPACA.¹⁰ The states

6 See Sarah Barr, *Governors Tell Panel Flexibility Essential; GOP Pushes for More Dramatic Changes*, 19 BUREAU OF NAT'L AFF. HEALTH CARE POLICY REPORT 346 (Mar. 7, 2011), available at <http://www.bna.com/governors-tell-panel-n8589934695/> (reporting on Republican governors' demands before the House Energy and Commerce Committee to convert Medicaid to a block grant program to give states total flexibility); Robert Pear, *Governors Fear Federal Cuts May Hobble Recovery*, N.Y. TIMES, Feb. 27, 2011, <http://www.nytimes.com/2011/02/27/us/politics/27governors.html> (reporting on Republican governors' desire for more flexibility in Medicaid and other cooperative federalism programs, including Governor Barbour's block grant proposal).

7 Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, (Nat'l Bureau of Econ. Research, Working Paper No. 17190, 2011), available at <http://www.nber.org/papers/w17190> (describing Oregon's experience with placing low-income adults into a lottery to enroll in the Medicaid program, with the result that those selected by the lottery have had substantially higher healthcare utilization, lower out-of-pocket medical expenditures, less medical debt, and notably better self-reported health).

8 Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 6 (2006) (describing Medicaid as an "essential part of the U.S. health care landscape").

9 James F. Blumstein & Frank A. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 VAND. L. REV. 125, 133 (2000) (describing cooperative federalism programs such as Medicaid as having a "political lock-in" effect because the states lose much more money than they save when programmatic cuts occur). See generally Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 901 (1990) (describing the problems the states complained of during major Medicaid modifications in the 1980s). A number of states have sued over healthcare reform, and Texas has claimed it is considering withdrawing from the Medicaid program. See Emily Ramshaw, *Lawmakers Consider Medicaid Withdrawal*, N.Y. TIMES, Nov. 7, 2010, <http://www.nytimes.com/2010/11/07/us/politics/07ttmedicaid.html> (stating that Texas lawmakers proposed dropping out of the federal Medicaid program as a solution to the state's budget shortfall).

10 See Complaint at 4, *Florida v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91 (N.D. Fla. Mar. 23, 2010) (alleging that the Act exceeds Congress's enumerated powers and violates the Tenth Amendment); see also Kevin Sack, *Florida Suit Poses a Challenge to Health Care Law*, N.Y. TIMES, May 11, 2010, at A10, available at <http://www.nytimes.com/2010/05/11/health/policy/11lawsuit.html> (describing the lawsuit filed by Republican Attorneys

have claimed, among other things, that certain aspects of PPACA violate principles of federalism and the Tenth Amendment, and that the Medicaid expansion is “an unprecedented encroachment” on the sovereignty of states.¹¹ They claim to be coerced into continuing to participate in Medicaid,¹² yet the states have asked for more and more federal funding while expecting no concurrent increase in federal rules or oversight.¹³

Continuing as a federal-state partnership has few currently recognizable benefits, but almost no one has performed a federalism-based policy analysis of the Medicaid program. Instead, as the PPACA litigation illustrates, the program is fixed in the collective consciousness as a classic example of cooperative federalism,¹⁴ but the program’s design is creating more discord than cooperation.¹⁵ Medicaid’s struc-

General from Florida and approximately nineteen other states challenging the individual mandate and other aspects of PPACA).

11 Complaint, *Florida v. United States*, *supra* note 10, at 4.

12 *Id.* at 9–10. Judge Vinson rejected the coercion argument put forth by Florida and twenty-five other states. See *Florida ex rel. Bondi v. U.S. Dep’t of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011) (declaring the minimum coverage provision unconstitutional).

13 See, e.g., Robert Pear, *Governors Get Advice for Saving on Medicaid*, N.Y. TIMES, Feb. 4, 2011, <http://www.nytimes.com/2011/02/04/us/politics/04medicaid.html> (stating that “Governors said . . . they wanted waivers of some federal requirements and relief from Congress” in response to the economic recession and the increased Medicaid enrollment that accompanied it).

14 Cooperative federalism generally means the state and the federal government work together toward a common goal that has been set forth, structured, and funded by the federal government; Medicaid is often held up as a successful example of this form of federalism. See, e.g., *Harris v. McRae*, 448 U.S. 297, 308 (1980) (describing Medicaid as a “cooperative endeavor” and the role of federal and state governments within that cooperative federalism structure); see also Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 419 n.30 (2008). Medicaid and the Children’s Health Insurance Program (“CHIP”) are essentially the same from a federalism and practical perspective, so this Article will discuss Medicaid intending that CHIP be folded into that conversation. See Alan Weil et. al., *Improving the Federal System of Health Care Coverage*, in *FEDERALISM AND HEALTH POLICY* 399, 400 (John Holahan, Alan Weil & Joshua M. Wiener eds., 2003) (“Enacted 32 years later, the State Children’s Health Insurance Program (SCHIP) reflects the identical tension built into Medicaid.”).

15 Bruce C. Vladeck, former administrator of the Health Care Financing Administration under President Clinton, has stated:

The current federal-state relationship doesn’t serve anyone’s interest particularly well. It’s become nasty, and it hasn’t produced good government or good health care. . . . [T]here’s something to be said for some kind of swap and, while it’s complicated, I think we ought to start talking about it again. I believe the way to fix long-term care is to give it to the states, but with an increased financial commitment from the federal government. When we better understand what the long-term care system should look like, we can shift it to the states. Then the case for federalizing Medicaid for (nonelderly, nondisabled) children and adults is

ture is an outgrowth of very old assumptions about the role that localities play in providing welfare-type programs. But a federalism policy analysis shows us that this is the wrong path for a variety of reasons.

This Article is one of only a small number of proposals over the past forty-six years for federalizing Medicaid.¹⁶ None of these proposals has grappled directly with the reasons that Medicaid does not satisfy federalism goals, and thus a key reason for modernizing Medicaid's structure has been ignored. Despite being an area of "traditional state concern,"¹⁷ healthcare should no longer be left to the economic and political whims of the states, as Medicaid is not an effective Brandeisian "laboratory of the states."¹⁸ Admittedly, some would oppose centralization on the ideological grounds that more federal government power is bad, and more state or local power is good. But Medicaid was built on a feeble foundation that allowed a patchwork program to continue and has been solicitous of state control over welfare programs ever since—not a strong argument for the significant medical variations and administrative costs that occur as a result of Medicaid's divided structure.¹⁹

This Article first will discuss the history and historical structure of Medicaid and its cooperative federalism approach. This section will focus on two persistent themes of states' rights and limiting benefits to the deserving poor in the creation of Medicaid and will demonstrate how PPACA has begun the federalization process. The Article will next consider the modern Supreme Court's interpretation of fe-

stronger, because the federal government knows how to provide an acute care benefit.

Michael Birnbaum, *The Landscape in 2009: A Conversation with Bruce C. Vladeck*, 34 J. HEALTH POL. POL'Y & L. 401, 411 (2009).

- 16 As Professors Rubin and Feeley have noted, calling the United States' central government the "federal" government is a bit of a misnomer. See MALCOLM M. FEELEY & EDWARD RUBIN, *FEDERALISM: POLITICAL IDENTITY AND TRAGIC COMPROMISE* 12–14 (2008) (asserting that the United States' central government is "confusingly known as the federal government," even though "federal" means divided sovereignty). Nevertheless, that is common parlance, and so this Article will refer to "federalizing" Medicaid meaning that Medicaid should be centralized within the national government.
- 17 *United States v. Lopez*, 514 U.S. 549, 577 (1995) (Kennedy, J., concurring) (arguing that if federal government takes over the regulation of areas that are "traditional state concerns" and have nothing to do with commercial activities, the boundaries between federal and state authority would be blurred).
- 18 *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").
- 19 John Holahan et al., *Federalism and Health Policy: An Overview*, in *FEDERALISM AND HEALTH POLICY*, *supra* note 14, at 1–2 (describing Medicaid as suffering from "considerable inequity across states").

deralism to understand the current meaning of federalism as it may be implemented by the Roberts Court. Though the Medicaid expansion is, at least in terms of pages written, a small part of the challenges to PPACA, the litigation provides a vehicle for thinking through the real meaning of cooperative federalism versus dual sovereignty as explicated by the Court. The final section of the Article will suggest that medicine generally and Medicaid specifically are already on the path to nationalization and will explore the conclusion that Medicaid should be nationalized because federalism ideals are generally not served by the current structure. Indeed, as this Article goes to press, the Court has granted certiorari on the Medicaid expansion issues presented in *Florida v. HHS*.

II. MEDICAID, THE POOR, AND THE FEDERAL-STATE “PARTNERSHIP”

Medicaid was created at the same time as Medicare yet is widely acknowledged to have involved significantly less philosophical or political thought than the Medicare program, which in turn pales in comparison to its European counterparts.²⁰ The long history, which has been told well elsewhere, will be focused here to help describe the path dependence of Medicaid’s cooperative federalism structure.²¹

A. *Two Themes: Deserving Poor and States’ Rights*

Medicare, American universal health insurance for senior citizens, grew out of a push in Western Europe at the turn of the twentieth

20 STEVENS & STEVENS, *supra* note 4, at 53 (explaining that the Medicaid legislation had little commitment to any social philosophy, was politically and ideologically polarized, and even Medicare’s goals were different from the humanitarian goals of Western European programs); *see also* THOMAS W. GRANNEMANN & MARK V. PAULY, CONTROLLING MEDICAID COSTS: FEDERALISM, COMPETITION, AND CHOICE 5 (1983) (describing Medicaid as an “afterthought” to Medicare).

21 For the plenary version of this history, *see, e.g.*, TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH PROGRAMS AND A RIGHTS-BASED RESPONSE 71 (2003) (describing that the first modern American insurance entitlement program started with the Civil War pension program, which has its roots in late-eighteenth and early nineteenth century insurance programs in Europe); MARMOR & MARMOR, *supra* note 3 (providing an account of the political evolution of Medicare); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (recounting a comprehensive history of American healthcare); STEVENS & STEVENS *supra* note 4, at 5–56 (providing an account for the philosophies and public and political concerns surrounding the Medicaid program).

century to support industrial workers through social insurance, which included sickness benefits as a mechanism to prevent wage loss.²² Social insurance was driven by the philosophical ideal of solidarity, and it was based in traditional liberal principles of entitlement to civil and political rights.²³ The social insurance movement was not just about solidarity, it also furthered the economic realities that a healthier population is a more productive population and that all poor citizens could better contribute to a capitalist society if given the opportunity through government-sponsored insurance. For example, the German health insurance program was known to be both “humanistic” and “economic” because “the sooner he was cured, the sooner the employee was back at work.”²⁴ The success of social insurance in Europe, though it occurred in various countries for differing reasons, provided fodder for an analogous movement in the United States.

In the United States, the labor movement initially championed social insurance, and later it was promoted by President Theodore Roosevelt, who believed that “no country could be strong whose people were sick and poor.”²⁵ Nevertheless, the idea of social insurance, let alone medical insurance, was foreign to the United States and was not to become popular until the Great Depression, which gave President Franklin Delano Roosevelt a disaster platform from

²² See STARR, *supra* note 21, at 239–40 (describing the influence that industrial workers had on early social insurance programs in England and Germany, which Americans later followed); see also JOST, *supra* note 21, at 71 (“Medicare and our other modern social insurance programs . . . find their roots to [sic] social insurance programs that emerged in late-nineteenth- and early-twentieth-century Europe.”).

²³ See STARR, *supra* note 21, at 238–39 (describing that the advent of social insurance in the nineteenth century in Western Europe signaled not so much paternalistic protection from the state as provision of rights to healthcare benefits for workers).

²⁴ STEVENS & STEVENS, *supra* note 4, at 8–9 (noting a similar rationale in England).

²⁵ STARR, *supra* note 21, at 243; see also MARMOR & MARMOR, *supra* note 3, at 7 (explaining that the impetus in the early efforts for American government insurance programs came from the American Association for Labor Legislation). The American Association for Labor Legislation had proposed government health insurance in the early 1900s, but the American Medical Association, as well as the Pharmaceutical Manufacturers Association, combated that movement, especially after learning that local physicians were opposed to any form of health insurance, let alone government sponsored health insurance. *Id.*; see also JOST, *supra* note 21, at 73 (illustrating that the successful movements for national insurance programs in the 1910s were led by the American Association for Labor Legislation); STARR, *supra* note 21, at 248 (describing that despite initial cooperation with the American Association for Labor Legislation’s push for insurance, the American Medical Association did not garner support from its membership). Physicians were not able to block the advent of health insurance for long, as Blue Cross was created for hospitals and Blue Shield for physicians by the end of the Second World War. *Id.* at 295–310. Blue Cross was created by the American Hospital Association and Blue Shield was created by local medical societies so that healthcare providers controlled the health insurance rather than the other way around. *Id.* at 306–10.

which to support government-sponsored insurance. His efforts resulted in the successful passage of the Social Security Act but in failure to pass proposals for universal health insurance.²⁶ In fact, universal, government-sponsored health insurance was promoted consistently until the Johnson administration enacted Medicare and Medicaid.²⁷

Given its philosophical roots, and that almost every president from Roosevelt to Johnson had promoted universal health insurance for all citizens, Medicare was a compromise because it only provided insurance for the elderly. Its foundation was solid, however, and the polity supported the notion that everyone would someday be old; thus we could and should insure the entire population against the vagaries of medical expenses that had impoverished many elderly and their families. Because all citizens contribute federal payroll taxes into Medicare, the public feels a sense of stewardship about the program and a sense of security that this insurance will exist when age sixty-five arrives.²⁸ Medicare is not only philosophically and financially more sound than Medicaid, but also, it has always been a federal program with centralized funding, rules, and administration.²⁹

In contrast to Medicare, Medicaid was built upon a set of preexisting biases and assumptions, and its historical foundation contains two threads that carry forward to the modern program: notions regarding who constitutes the “deserving poor” and obeisance to states’

26 MARMOR & MARMOR, *supra* note 3, at 8–9 (explaining that the vigor that proponents had for the passage of the Social Security Act marginalized the support for universal health insurance, which became “[a]n orphan of the New Deal”).

27 STARR, *supra* note 21, at 257–369; MARMOR & MARMOR, *supra* note 3, at 1 (noting that universal insurance was fought over by many groups through the Roosevelt, Truman, Eisenhower, Kennedy, and Johnson administrations).

28 STARR, *supra* note 21, at 368 (noting that the “contributory nature” of social security made Medicare feel familiar and more popular from the outset). Some would point out that Medicare is not described as financially sound these days, though increasing costs are not the same as fiscal jeopardy. See Jackie Calms, *Obama’s Budget Focuses on Path to Rein in Deficit*, N.Y. TIMES, Feb. 15, 2011, <http://www.nytimes.com/2011/02/15/us/politics/15obama.html> (describing the perceived increasing costs of Medicare and Medicaid in relation to the President’s proposed budget). It is interesting to note that one great contributor to the question of Medicare “solvency” is that life expectancy in 1965 was 70 years, compared to 78 years today. Thus, the program had an average lifespan of five years for beneficiaries at its inception but now has a lifespan closer to fifteen years for many beneficiaries. MARMOR & MARMOR, *supra* note 3, at 5–6 (“The demand for medical care has increased both through improved capacity and heightened expectations among longer-living populations.”).

29 42 U.S.C. § 1395 (2006) (regional contractors assist in administration).

rights.³⁰ Each of these threads has been remarkably tenacious and reveals the path-dependent nature of the Medicaid program.³¹

Certain categories of blameless or “deserving” poor have been assisted by local, state, or federal government since the turn of the twentieth century and consistently have included women (widows) and their children, the blind, the disabled, and impoverished elderly.³² To understand the categories of deserving poor, it helps to identify where American welfare policies began. Starting in the colonial period, states provided various forms of welfare assistance to so-called deserving poor based upon that particular state’s colonial policy as adopted from Elizabethan Poor Laws.³³ Historically, poverty assistance had been provided in localities or parishes in European countries as well, though that methodology changed drastically with the advent of social insurance at the turn of the twentieth century.³⁴ In the United States, however, local responsibility for the poor remained

³⁰ STEVENS & STEVENS, *supra* note 4, at 6, 8 (noting a “strong commitment, both in Congress and in the states, to states’ rights in the provision of public assistance”).

³¹ “Path dependence” is a way to describe the idea that not only does history matter, but it may prescribe a set of rules regarding a particular choice that make the choice much less deliberate than it might have been without the initial set of decisions creating the item at issue. The idea is often traced to Professor Paul David’s 1985 essay describing path dependence through the now-classic example of the continued use of the inefficient QWERTY keyboard. Paul A. David, *Clio and the Economics of QWERTY*, 75 AM. ECON. REV. 332 (1985). Professor David wrote: “A *path-dependent* sequence of economic changes is one of which important influences upon the eventual outcome can be exerted by temporally remote events, including happenings dominated by chance elements rather than systemic forces.” *Id.* at 332. Path dependence has been translated from mathematics and economics into political science and law and roughly correlates to the reliance on precedent on which our common law system depends. See Stefanie A. Lindquist & Frank B. Cross, *Empirically Testing Dworkin’s Chain Novel Theory: Studying the Path of Precedent*, 80 N.Y.U. L. REV. 1156, 1166, 1169–70 (2005) (describing how use of precedent is considered inherently path-dependent). In this context, I use path dependence to indicate the aspect of this theory that conveys that “past decisions will significantly influence future decisions” in such a way that prior decisions may not ever be revisited. See *id.* at 1171 (defining this version of path dependence as “sequencing path dependence” because the “order in which alternatives are considered can determine the outcomes of those choices”).

³² JOST, *supra* note 21, at 80 (listing the beneficiaries of federal/state public assistance programs); STEVENS & STEVENS, *supra* note 4, at 6–7 (identifying traditional groups that were the target of special assistance programs during the early twentieth century).

³³ See JOST, *supra* note 21, at 67–68 (describing the Elizabethan Poor Laws of 1597 to 1601); STEVENS & STEVENS, *supra* note 4, at 5–6 (stating that general assistance to paupers during the Colonial era had roots in the Elizabethan Poor Laws); Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid’s History*, 26 GA. ST. U. L. REV. 937, 940 (2010) (noting that public welfare was rooted in the English Poor Laws).

³⁴ STARR, *supra* note 21, at 238–39 (describing social insurance as a new form of destitution management in the newly industrialized and capitalistic societies of Germany, England, and France).

entrenched, despite the centralization of welfare and other social policy during the Great Depression. The colonies and then the states viewed poverty as something to be discouraged, and welfare laws reflected this attitude.³⁵ The advent of poorhouses, which were suspiciously similar to prisons (and yet also the precursor to hospitals), reflected hostility toward the non-working poor, who were called “paupers.”³⁶ The prevailing belief was that working poor deserved assistance, and those who engaged in pauperism did not.³⁷

The decentralized condition of American government during the early part of its history fragmented the approach to welfare assistance and facilitated the early differences between welfare, meaning charitable aid to the poor, and social insurance, meaning universal worker benefits. States and localities were responsible for wide swaths of social policy, and no one challenged their approach to public assistance, which was punitive in nature.³⁸ Few attempted to address public health through the power of the central, federal government prior to FDR’s New Deal, and any attempts were rejected as constitutionally untenable.³⁹

In historical and constitutional context, it is not surprising that states continued to dominate welfare policy; it was part of traditional state powers, and the country arguably was not centralized until industrialization and urbanization occurred at the turn of the twentieth

³⁵ JOST, *supra* note 21, at 68 (describing the general attitude toward public assistance as “conditions of the poor should be kept so miserable that no one would prefer relief to work”).

³⁶ See STEVENS & STEVENS, *supra* note 4, at 5 (explaining that the colonial attitude toward pauperism was that it was a form of “social disease and degeneracy”). Poorhouses were the precursors to hospitals and their charitable orientation, as hospitals at their origin were places where the sick poor went to die. The wealthy were attended by physicians at home. See STARR, *supra* note 21, at 151 (“Early hospitals were considered, at best, unhappy necessities.”). Attitudes about the poor have often reflected racism, anti-immigrant attitudes, religious discrimination, and a general desire to force those deemed “able bodied” to work. See JOST, *supra* note 21, at 66–67, 173 (explaining that those hostile to the poor believe no one has an excuse to be poor when the United States has such abundant resources).

³⁷ See STEVENS & STEVENS, *supra* note 4, at 11 (describing the clear division between contributing work-related social insurance to workers and giving to the “poor”).

³⁸ See JOST, *supra* note 21, at 68–69 (describing if a pension recipient misspent or wasted benefits, the state director could take the benefit away, for which the beneficiary had no legal recourse).

³⁹ See *id.* at 74 (quoting President Franklin Pierce saying, “I cannot find any authority in the Constitution for making the Federal Government the great almoner of public charity throughout the United States”). Professor Jost provides the example of Dorothea Dix’s attempt to help states establish hospitals for the mentally ill through federal funding, legislation that passed Congress but that President Franklin Pierce vetoed for perceived lack of federal power. *Id.* at 73–74.

century. Industrialization facilitated societal changes that included expanded travel, broader and stronger national markets for commodities, and a greater need for medical treatment for work-related injuries.⁴⁰ These factors, in combination with events such as the World Wars and world-wide depressions, created a need for laws to be responsive to national problems rather than a patchwork of local measures. Thus, the New Deal brought important change at the federal level from a legislative and a constitutional interpretation perspective as well as from a public problem-solving perspective.⁴¹

Although it did not produce national health insurance, the Social Security Act of 1935 (“SSA”) was part of the increasing understanding of federal power during that era and an important step on the path to national programs such as Medicare and Medicaid. The SSA was, at heart, a federal income protection mechanism that partially embraced European models of social insurance. Unlike the European prototype, though, the SSA continued state and local governmental responsibility for welfare programs.⁴² The SSA adopted and codified states’ categories of deserving poor into federal law by protecting the elderly, children, widows and widowers, blind, those otherwise disabled, and the unemployed through income security.⁴³ The SSA bill contained a directive to the Social Security Board to study health insurance, which could have afforded an opportunity to consider national remedies for increased medical needs.⁴⁴ The American Medical Association (“AMA”) was so adamantly opposed to this study and to the specter of government-sponsored health insurance that this proposal had to be removed from the SSA lest the entire bill fail.⁴⁵

⁴⁰ See STARR, *supra* note 21, at 201 (explaining that the expansion of the railroads led to the development of extensive employee medical programs).

⁴¹ See, e.g., *Wickard v. Filburn*, 317 U.S. 111, 128 (1942) (upholding application of the Agricultural Adjustment Act to a farmer who exceeded the wheat allocations designed to regulate the national wheat market); *United States v. Darby*, 312 U.S. 100, 125–26 (1941) (upholding the application of the Fair Labor Standards Act to production of lumber shipped in interstate commerce); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 19, 49 (1937) (upholding an application of the National Labor Relations Act to labor for a national steel company).

⁴² MARMOR & MARMOR, *supra* note 3, at 2.

⁴³ See *id.* at 8–9.

⁴⁴ See *id.* at 8 (stating that the original social security bill contained one line that commanded the Social Security Board to study the health insurance problem and report to Congress).

⁴⁵ See MARMOR & MARMOR, *supra* note 3, at 8 (claiming that Edwin Witte, the executive director of the drafting committee for the social security bill, as well as President Roosevelt, believed that the Social Security Board study and the issue of government health insurance could endanger the whole bill); STARR, *supra* note 21, at 268–69 (describing the

This pattern of healthcare reform being folded into a national debate about health insurance and then defeated by the AMA has occurred through the remainder of the twentieth century and into the twenty-first.⁴⁶

In addition to federalizing the categories of deserving poor, the SSA contained an early form of cooperative federalism in its public assistance configuration, which laid the foundation for a hallmark of Medicaid's structure and the second important thread in its history. The SSA provided federal funding to support state-based programs, but the states were not asked to alter their public assistance mechanisms to receive that funding.⁴⁷ In other words, the states were free to implement federal funding as they saw fit, which could be described loosely as a system of federal-state cooperation but was really a set of federal grants to the states to continue providing assistance to the deserving poor with no conditions attached to the federal spending. Despite this lenient form of federal-state programmatic cooperation, concerns about states' rights were articulated even at SSA bill-writing hearings.⁴⁸ States were the locus of much economic and moral regulation, and the ideas of national health insurance or national welfare programs were alien. It is not surprising that the states retained control over welfare-type programs at that time.

The two threads of deserving poor and states' rights continued beyond the New Deal. The call for universal health insurance was defeated in part by the advent of employer-sponsored medical insurance as a tax benefit to both the employer and the employee during World War II.⁴⁹ The middle class no longer needed government-sponsored medical benefits, as they had during the Great Depression, which allowed the poor to be treated as a group with lesser needs that could be met differently from the rest of the population.⁵⁰ Thus, the SSA amendments passed in 1950 were in part a response to rejection of the need for national health insurance (and the red scare).⁵¹ One

steps that the AMA took to denounce compulsory health insurance and the sentiment among lawmakers that any health insurance amendment would defeat the entire bill).

46 STARR, *supra* note 21, at 296–98.

47 STEVENS & STEVENS, *supra* note 4, at 11 (describing the federal government as “merely a paymaster” and the Act as a “hodgepodge” of state and federal programs).

48 *See id.* at 12 (dismissing the fear of federal control over public assistance that was voiced during hearings on the 1935 legislation).

49 *See id.* at 23 (stating that better health services through available public assistance schemes was a viable political alternative to national health insurance in the 1940s).

50 STARR, *supra* note 21, at 270–71.

51 *See* STEVENS & STEVENS, *supra* note 4, at 23 (characterizing the passage of the Social Security Amendments of 1950 as a “temporary victory for those opposing national health insurance”).

new feature of the 1950 amendments was larger federal grants that required the states to create medical insurance for certain kinds of healthcare services such as hospital stays and physician visits. In return, state welfare agencies received funds that they were able to pay directly to doctors and hospitals, called “vendor payments.”⁵² Vendor payments were limited to welfare recipients’ services, which continued the use of categories of deserving poor for benefit eligibility and increased federal oversight of state-based welfare programs very slightly.

The years after the 1950 SSA amendments witnessed focused interest on the medical and financial problems of the elderly, who were widely considered to qualify as deserving poor and who were increasingly politically powerful. While the elderly pushed for health insurance benefits that would mirror the SSA workers’ insurance program, a political willingness to assist impoverished (if not all) elderly emerged and became the program that immediately preceded Medicaid, referred to as Kerr-Mills.⁵³

Kerr-Mills was part of the 1960 amendments to the SSA and was yet another state-based program for providing healthcare to certain needy citizens.⁵⁴ Kerr-Mills essentially extended the vendor payments of the 1950 SSA amendments, which had provided federal grants with few conditions on the spending.⁵⁵ Kerr-Mills continued states’ limited help to the deserving poor, as well as states’ historical responsibility for welfare programs, while including little in the way of federal guidance or demands for the provision of medical care.⁵⁶ Kerr-Mills also strengthened the connection between welfare and healthcare, a correlation that had no medical basis,⁵⁷ and continued the federal gov-

⁵² JOST, *supra* note 21, at 80.

⁵³ *See id.* at 81 (expounding how the Social Security Act Amendments of 1960 created the Kerr-Mills program and its expanded coverage of the “medically needy”).

⁵⁴ STEVENS & STEVENS, *supra* note 4, at 28.

⁵⁵ STARR, *supra* note 21, at 368–69.

⁵⁶ *See* STEVENS & STEVENS, *supra* note 4, at 29 (describing the Kerr-Mills structure as an “open-ended federal cost-sharing” program where cost control was left to the states). Kerr-Mills contained a number of features that carried over into Medicaid, such as requiring certain hospital and physician benefits, and providing all benefits state-wide. *Id.* at 30 (explaining that the program required all administrative subdivisions of a state to be covered); *see also* JOST, *supra* note 21, at 81 (claiming that the requirements for statewide coverage, found in the 1965 Medicaid Act, were found in the Kerr-Mills program).

⁵⁷ This connection was broken by the Personal Responsibility and Work Opportunity Act of 1996, which changed welfare into a “workfare” block grant program of limited benefits for enrollees and for states. Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”), Pub. L. No. 104-193, § 103 (1996). Though breaking the tie between Medicaid and welfare made sense in many ways, it increased states’ administrative burden by decoupling what had been a streamlined process for entering the fed-

ernment's deferential posture toward state and local programs.⁵⁸ Aside from recurring proposals for universal health insurance, however, no federal plan for healthcare delivery or health insurance existed. The ongoing medley of amendments to the SSA reflected the lack of programmatic coherence.

Even with Kerr-Mills' open-ended grants, states were uninterested or ultimately unable to sustain the costs of either traditional welfare programs or medical welfare programs.⁵⁹ The states had requested and received money from the federal government to facilitate the continuation of medical welfare programs, but the voluntary nature of Kerr-Mills resulted in wealthier states fully using the federal funding while poorer states ignored it, and in the meantime healthcare costs grew while access diminished.⁶⁰ In creating Kerr-Mills, the federal government hoped to alleviate states' burdens while taking little responsibility for indigent populations and at the same time desired to contain costs of medical care—goals that were quixotic given how little procedural and substantive help Kerr-Mills actually extended to the poor and to the states in which they resided. The will to look past state theories of pauperism and state responsibility for medicine remained elusive.⁶¹

B. *Kerr-Mills Redux: Medicaid*

By the time Medicaid was created as part of the 1965 SSA amendments, the underlying features of its predecessor spending programs were ingrained. Most of the political will was directed toward the creation of Medicare, which was relatively uncontroversial in its response to popular demand.⁶² Medicaid was an afterthought and plainly an extension of the existing Kerr-Mills modifications to the

eral welfare system. PRWORA is the model for many governors who are demanding Medicaid be changed into a block grant program (as is the Children's Health Insurance Program).

58 See STEVENS & STEVENS, *supra* note 4, at 36 (noting that Kerr-Mills addressed both medical needs of the lower and middle classes and the cash needs of those on welfare).

59 Watson, *supra* note 33, at 950–51 (noting that poor states were afraid they could not afford the program, even with a generous 80% federal match).

60 STARR, *supra* note 21, at 369 (noting that three years after the passage of Kerr-Mills, five large industrial states were receiving 90% of the federal funds under the program).

61 *Id.* at 366–67 (noting that the war on poverty did not include health insurance despite the well documented connection between poverty status and health status).

62 See *id.* at 368 (describing Medicare as the “overriding political issue” in the late 1950s and early 1960s that led to the passage of Kerr-Mills).

SSA.⁶³ Medicaid contained many of the features of prior federal funding for medical care for the poor, including a sense that welfare was “gratuitous.”⁶⁴ Perhaps most importantly, the Medicaid Act continued the two themes of deserving poor and states’ rights. The concern for states’ role in welfare had been articulated since the early federal assistance programs of the 1930s and, as was described above, continued in every iteration of the SSA amendments.⁶⁵ This division of authority was codified in the Medicaid Act.⁶⁶ The 1965 SSA amendments also carried forward the tie between welfare and government-sponsored payments for healthcare, a connection that was convenient but that was a mechanical continuation of the outdated views regarding pauperism. Only certain poor were deemed worthy of government assistance, and they were not worthy enough for healthcare providers to be paid as much as they were for privately insured patients.⁶⁷

Medicaid included improvements over the minimalist Kerr-Mills program, and it has persevered as the key healthcare safety net in this nation, but the extended life of Medicaid has also become a part of its weakness because of our path dependence. The program is complex, and a brief overview is helpful for understanding the import of PPACA’s Medicaid modifications.

Medicaid was created as and continues to be open-ended federal funding to the states so long as they comply with the superstructure of the Medicaid Act.⁶⁸ Medicaid was more generous than Kerr-Mills, and the vast majority of states were participating in the program within a few years of its advent (all states now take part).⁶⁹ When Medicaid was created, it was targeted to cover the deserving poor, meaning the elderly, disabled, blind, pregnant women, and children—the

63 See STEVENS & STEVENS, *supra* note 4, at 51 (“[T]he section of the Senate report dealing with Title XIX was entitled, ‘Improvement and Extension of Kerr-Mills Medical Assistance Program.’”).

64 JOST, *supra* note 21, at 65.

65 STEVENS & STEVENS, *supra* note 4, at 8, 12, 45 (noting the strong role of both Congress and the states in various public assistance programs passed since the 1930s, including the FERA program in 1935, OAI (“Old-Age Insurance”) in 1939, and Kerr-Mills in 1960).

66 See Medicaid and CHIP Payment Access Commission, 42 U.S.C. § 1396 (2006).

67 See STEVENS & STEVENS, *supra* note 4, at 35 (noting that Kerr-Mills made lower payments than other health insurers and the disparity grew as healthcare costs increased).

68 Efforts to metamorphose Medicaid into a capped block grant have failed. See, e.g., Jeanne M. Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 MILBANK Q. 41, 46–47 (2005) (outlining the efforts of Newt Gingrich and George Bush to make a capped block grant part of federal Medicaid funding).

69 Arizona and Alaska were holdouts, with Arizona joining Medicaid in 1982 and Alaska joining in 1972.

same categories of sympathetic poverty that have existed all along. Medicaid simply extended the “principle of ‘medical indigency’ to all welfare categories.”⁷⁰ The Medicaid Act created low poverty thresholds for eligibility that varied by welfare category.

Notwithstanding the continued reliance on notions of the deserving poor, the Medicaid Act ensured equality for Medicaid enrollees in ways that generally had not been included in predecessor programs. An applicant who meets standards for poverty level and categorical eligibility receives Medicaid coverage in the form of baseline medical assistance.⁷¹ Baseline medical assistance is facilitated through statutory mechanisms that, for example, promise medical equality,⁷² provide benefits throughout the state with no local variation,⁷³ and allow enrollees to select their healthcare providers.⁷⁴ States are supposed to mainstream Medicaid enrollees, may not select among the mandatory categories of deserving poor, and are supposed to pay healthcare providers reasonably so that beneficiaries do not receive substandard care.⁷⁵ Notably, as a condition of receiving federal funding, states must accept all applicants who meet both categorical eligibility and financial eligibility, regardless of the state’s ability to pay for the medical assistance (which becomes especially important during economic downturns).⁷⁶

⁷⁰ STEVENS & STEVENS, *supra* note 4, at 51.

⁷¹ 42 U.S.C. § 1396a(a)(8), (10) (2006). Many people who are eligible for Medicaid are not in the program. See Benjamin D. Sommers & Arnold M. Epstein, *Medicaid Expansion—The Soft Underbelly of Health Care Reform?*, 363 NEW ENG. J. MED. 2085, 2085–87 (2010) (reporting study results showing that 61.7% of eligible adults are enrolled in Medicaid nationwide and highly variable from state to state).

⁷² See 42 U.S.C. § 1396a(a)(10)(B) (2006) (mandating that medical assistance for Medicaid enrollees be equal in amount, scope, and duration to the assistance given to any other individual).

⁷³ 42 U.S.C. § 1396a(a)(1) (2006) (providing that a state medical assistance plan must “be in effect in all political subdivisions of that state”); see also STEVENS & STEVENS, *supra* note 4, at 58 (“[T]o become eligible for matching funds, a state plan had to be in effect in all political subdivisions of the state.”).

⁷⁴ See 42 U.S.C. § 1396a(a)(23) (2006) (allowing Medicaid enrollees to choose their own practitioners and medical facilities). “Freedom of choice” is at issue in states that are denying Medicaid funding to Planned Parenthood. See, e.g., Brad Cooper, *Planned Parenthood Asks Judge to Block Cut in Funding*, THE KANSAS CITY STAR, June 27, 2011, at B4 (describing litigation concerning new budget provisions in Kansas that would limit funding to planned parenthood).

⁷⁵ See Huberfeld, *Bizarre Love Triangle*, *supra* note 14, at 418–26 (explaining these aspects of Medicaid more fully).

⁷⁶ The equalizing aspects of the Medicaid Act have been the basis for enforcing Medicaid entitlements through section 1983. *Id.* at 421–22; Rosenbaum, *supra* note 8, at 11 (describing that states cannot create queues, they must accept all eligible applicants).

The Medicaid Act created new entitlements for the states as well, offering matching federal money in exchange for states' agreement to fulfill certain conditions on those funds by providing medical assistance to mandatory categories of deserving poor.⁷⁷ The federal match ranges from 50% to 75% and is based, loosely, on the amount of money the state spends on Medicaid and the state's per capita income.⁷⁸ The state must submit a "State Plan" to participate in Medicaid, which explains how the state will comply with mandatory elements of Medicaid and the optional elements it chooses to engage.⁷⁹ Once the State Plan is in place, states administer Medicaid with little to no oversight, but the federal government pays a large portion of state administrative expenses. Generally administrative activities receive a 50% federal match, but some receive higher matching rates,⁸⁰ such as 75% match for training and compensating medical professionals that work at the state Medicaid agency, 75% match for translators assisting in enrolling non-English-speaking families, 100% of costs for implementing use of immigration verification systems, and a Medicaid Fraud Control Unit ("MCFU") special match of 90%.⁸¹ Thus, the federal government not only pays about 60% of Medicaid medical expenses on average, but it also pays more than 50% of Medicaid's administrative costs in the states, in addition to the costs of running the Centers for Medicare and Medicaid Services, the federal agency responsible for Medicaid.

The original structure of Medicaid was modified so that the Secretary of the Department of Health and Human Services ("HHS") was given authority to issue "waivers" that allow states to vary from the Medicaid Act; waivers often establish managed care administration of Medicaid.⁸² A number of waiver possibilities exist because the states

77 See 42 U.S.C. § 1396a (2006) (listing who must receive Medicaid services from the state); The Bipartisan Commission on the Medicaid Act of 2005, H.R. 985, 109th Cong. § 2(13) (2005) ("Medicaid is the single largest Federal grant-in-aid program to the States, accounting for over 40 percent of all Federal grants to States.").

78 FMAP calculations are published in the Federal Register each year. See 76 Fed. Reg. 5811-3 (Feb. 2, 2011) (calculating the adjusted Federal Medical Assistance Percentage for the first quarter of the fiscal year 2011).

79 42 U.S.C. § 1396a(a) (2006). Additional services also can receive matching funds. See 42 U.S.C. § 1396d(a) (2006) (defining services that qualify as "medical assistance" and therefore receive funding).

80 See 42 U.S.C. § 1396b(a) (2006) (listing the percentage of the state spending the federal government will match depending on the type of expenditure).

81 *Id.*; see also 42 C.F.R. § 433.15 (1979) (listing federal match rates for administration of Medicaid).

82 See 42 U.S.C. § 1396n (2006) (allowing the Secretary to waive the requirements of section 1396a if it is cost effective and efficient and not inconsistent with the purposes of the Act).

are always seeking more flexibility in Medicaid. Section 1915(b) waivers were the first permitted deviation from the Medicaid Act and were passed as part of the Omnibus Budget Reconciliation Act of 1981.⁸³ Home and Community Based Waivers, known as Section 1915(c) waivers, were also created in 1981.⁸⁴ The third type of waiver, the Section 1115 waiver, offers the most flexibility and allows state experiments to cover the uninsured so long as states do not increase costs to the federal government.⁸⁵ The Balanced Budget Act of 1997 allowed states to simply amend their State Plans to implement managed care rather than requiring them to seek waivers.⁸⁶ In 2005, the Deficit Reduction Act intended to afford states “unprecedented flexibility.”⁸⁷ States were permitted to provide only “benchmark coverage,”⁸⁸ which meant that the equalizing services were not required;⁸⁹ or states could provide “benchmark-equivalent coverage,” which also relieved states of the traditional mandatory services.⁹⁰ PPACA restricts state waiver flexibility to a degree, as it requires new forms of waiver oversight such as public hearings and annual reports.⁹¹

Thus, despite its equalizing elements, Medicaid varies greatly from state to state, and studies show that waivers tend to decrease the amount and quality of care for Medicaid enrollees, particularly waivers occurring in the last decade or so.⁹² To be fair, some states have

⁸³ See *id.* (recognizing waivers and incorporating them in to the Medicaid program).

⁸⁴ See generally 42 C.F.R. § 441.300 (1992) (explaining that the purpose of 1915(c) waivers is to provide home and community based services that will allow individuals to avoid institutionalization).

⁸⁵ See 42 U.S.C. § 1315(a) (1994) (amending the Social Security Act, 42 U.S.C. § 1115) (giving the Secretary discretion to appropriate funds for experimental projects not otherwise covered).

⁸⁶ See 42 U.S.C. § 1396u-2(a) (2005) (allowing states to force Medicaid participants to enroll in managed care as long as the requirement meets certain conditions).

⁸⁷ Medicaid Program; State Flexibility for Medicaid Benefit Packages, 73 Fed. Reg. 9714, 9715 (Feb. 22, 2008).

⁸⁸ See 42 U.S.C. § 1396u-7(a)(1) (giving states the option of providing only “benchmark benefits” to certain populations).

⁸⁹ See Medicaid Program; State Flexibility for Medicaid Benefit Packages, *supra* note 87, at 9715, 9718, 9721, 9727 (“A State has the option to amend its State plan to provide benchmark or benchmark-equivalent coverage without regard to comparability . . . and other requirements in order to tailor and provide the coverage to the individuals.”).

⁹⁰ See *id.* at 9715 (incorporating alternative benchmark packages in place of mandatory services); see also 42 U.S.C. § 1396u-7(a)(1), (b)(2)–(3) (permitting and defining “benchmark” coverage). Additionally, Medicaid enrollees may be treated differently within eligibility categories. See Rosenbaum, *supra* note 8, at 33 (detailing state governments’ desire to provide certain “optional populations” with only benchmark coverage).

⁹¹ See PPACA § 10201 (adding reporting requirements to Section 1115 waivers, both at the state and the federal levels).

⁹² See Kaiser Comm’n on Medicaid & the Uninsured, *The Role of Section 1115 Waivers in Medicaid and CHIP: Looking Back and Looking Forward*, THE HENRY J. KAISER FAMILY

been able to do more with waivers, especially Section 1115 waivers.⁹³ New York stands out as a state that has maximized enrollment through Section 1115 waivers, as does Massachusetts in its pursuit of universal coverage.⁹⁴

Notably, when senior citizens were lobbying Congress for a stronger program than Kerr-Mills, they deliberately rejected state-by-state variation in the benefits they were seeking.⁹⁵ The AMA forwarded a proposal to expand the Kerr-Mills federal-state structure, but the more popular and successful proposal was to create “compulsory health insurance” through Social Security taxes. The idea was to create a hospital insurance program for all elderly people that was a mechanism of income protection and a product of compassion, empathy, and political power. Though the idea of state-based deviation was rejected for the elderly, who comprised one of the historic categories of deserving poor (and were to become elevated permanently by Medicare’s social insurance program), the poor were still subject to state-by-state variation in benefits.

Thus, Medicaid’s cooperative federalism structure could be described as a tenacious, yet basically unplanned, institutional structure. This jointly shared responsibility was not a thoughtful way to highlight Our Federalism’s journey from dual sovereignty to cooperative federalism. The states had been dealing with welfare-type issues, and the federal government did not traditionally intervene in such matters, and so Medicaid built on what came before; the program was remarkably path dependent.

FOUNDATION, 1, 6 (Mar. 2009), <http://www.kff.org/medicaid/upload/7874.pdf> (“However, states had limited interest and success in expanding coverage under HIFA, and waivers instead began to increasingly focus on cost control as the nation moved into an economic downturn.”); see also Dayna Bowen Matthew, *The “New Federalism” Approach to Medicaid: Empirical Evidence That Ceding Inherently Federal Authority to the States Harms Public Health*, 90 Ky. L.J. 973, 982–83 (2001–2002) (criticizing increased state control over Medicaid because it leads to less access to medical care and worse care when provided).

93 A list of waivers organized by state, waiver type, and date of approval is available on the CMS website. *Medicaid Waivers and Demonstrations List*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp> (last visited Oct. 23, 2011).

94 See generally Kaiser Comm’n on Medicaid & the Uninsured, *supra* note 92, at 7 (reviewing the success of different Section 1115 waivers and praising the expansion in coverage created by the Massachusetts waiver plan).

95 STEVENS & STEVENS, *supra* note 4, at 45 (explaining that the elderly pressured Congress for a social security benefit “free of variations by state”).

C. Enter: PPACA

PPACA is more than just another amendment to the SSA that tinkers with Medicaid's original structure. At the meta level, PPACA facilitates access to healthcare by targeting the problems of America's fifty million uninsured.⁹⁶ The Act regulates private insurance practices that serve as barriers to health insurance enrollment and ensures that those restrictions on health insurance will not be insurmountably expensive by penalizing people who do not elect to obtain health insurance in the newly open market.⁹⁷ Recognizing that private insurance is not a straightforward option for the poor, even with subsidies,⁹⁸ PPACA created what is arguably the biggest philosophical change in Medicaid since its inception and a start for federalization of the program: PPACA eliminated the "deserving poor" requirement.⁹⁹

PPACA reformulated Medicaid so that all Americans up to 133% of the federal poverty level are eligible as of 2014.¹⁰⁰ Single, childless adults who are not elderly or disabled are eligible for Medicaid for the first time in its history. This philosophical shift is historic and yet appears to have occurred with little debate in Congress. Until PPACA was enacted, only the deserving poor were eligible for Medicaid and all of its predecessor programs, one of the two immutable threads described above. Considering that the welfare/deserving poor/medical assistance connection dates to colonial America, this is a sea change. The expansion results in two steps toward federalizing Medicaid.

First, PPACA essentially has federalized the definition of deserving poor by rejecting states' restrictive categorizations. Thus far, no states' rights outcry has accompanied this change. States have challenged the constitutionality of PPACA only based on the economics, rather than the philosophy, of the Medicaid expansion. Admittedly, the "categories" of poverty have not disappeared entirely, as they are still relevant for the federal match, covered benefits, and other ad-

96 CARMAN DENAVAS-WALT ET. AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 22 (2010), available at <http://www.census.gov/prod/2010pubs/p60-238.pdf> (reporting the number of uninsured at an all-time high of 50.7 million, 16.7% of the population, in 2009).

97 See PPACA § 1501, 26 U.S.C. § 5000A(e)(1) (prohibiting a penalty against those who cannot afford insurance).

98 See *id.* (waiving mandatory minimum coverage for people with income below a certain level).

99 See PPACA § 2001, 42 U.S.C. § 1936a (2010) (expanding Medicaid to include not only "deserving poor" but also everyone else whose income is below 133% of the poverty level).

100 *Id.* (giving states the option to increase eligibility before 2014).

ministrative matters.¹⁰¹ But, the federal government has ceased Medicaid's reliance on outdated notions of deserving poor vis-à-vis pauperism.

Second, PPACA further federalizes Medicaid by creating a “supermatch” of federal funding for the newly eligible Medicaid population.¹⁰² PPACA provides an initial 100% payment for the new enrollees that phases down to a 90% federal match by 2020 and remains at that level indefinitely.¹⁰³ The supermatch only applies to the newly covered population, which is substantial in terms of raw numbers (projected to be 18 million new enrollees).¹⁰⁴ Thus, states have to pay for only a small percentage of the cost of the new Medicaid population. Even with the generous match, states have claimed in highly publicized litigation that the expansion of Medicaid is coercive and unconstitutional, which will be discussed further below.¹⁰⁵

Before now, it appears that serious discussions to federalize Medicaid had not occurred since the 1970s and early 1980s. In 1970, the McNerney Report suggested creating a stronger federal framework for Medicaid, including total federal financing for a set minimum of benefits and phasing out categorical eligibility requirements (a proposal that came to fruition a mere forty years after the report).¹⁰⁶ Senators Long and Ribicoff also proposed federalization of Medicaid

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- 101 See *Medicaid and Children's Health Insurance Program Provisions: America's Affordable Health Choices Act & America's Healthy Future Act*, KAISER FAMILY FOUND., <http://www.kff.org/healthreform/> (last updated Oct. 15, 2009) (analyzing the provisions of recent health care legislation that relate to Medicaid and the Children's Health Insurance Program).
- 102 CHIP also has a very generous federal match, which helped to create the precedent for the supermatch structure in PPACA. See 42 U.S.C. § 1397ee (2010) (promising that the Secretary will pay the state an amount equal to the enhanced FMAP for certain categories of expenditure).
- 103 See Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. § 1201 (2010) (tying up some of the loose ends from the PPACA negotiations).
- 104 See Memorandum from Richard S. Foster, Chief Actuary, Dep't of Health & Human Serv., Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended, 3 (Apr. 22, 2010), https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (estimating financial and coverage effects of certain provisions of the PPACA through the year 2019).
- 105 See *Virginia v. Sebelius*, 728 F. Supp. 2d 768, 771–72 (E.D. Va. 2010) (challenging the minimum essential coverage provision as unconstitutional because it is outside the scope of the Commerce Clause authority, is not a legitimate exercise of the power to tax, and is in direct conflict with Virginia state law); see also *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011) (granting summary judgment and declaring PPACA unconstitutional).
- 106 WALTER J. MCNERNEY, REPORT OF THE TASK FORCE ON MEDICAID AND RELATED PROGRAMS 13–14 (1970) [hereinafter MCNERNEY REPORT]; STEVENS & STEVENS, *supra* note 4, at 15–16 (explaining the history of government involvement in providing “essential services” to certain members of the population).

in 1970–1971.¹⁰⁷ The states supported federalizing Medicaid in the early 1970s.¹⁰⁸ President Reagan proposed federalizing Medicaid to Congress and the states in 1982, but this proposal was part of an effort to shrink the program through federal control, and the states were not interested in the programmatic “trade” that Mr. Reagan desired, which would have involved passing welfare and food stamps to the states.¹⁰⁹ More recently, the nonprofit Urban Institute reviewed the New Federalism movement of the 1990s in a series of essays that revealed the more modern failings of the joint federal-state structure of Medicaid and that ultimately suggested a larger federal role in Medicaid.¹¹⁰ It seems strange that Medicaid’s path dependent institutional structure has not been attacked more frequently.

107 See *National Health Insurance—A Brief History of Reform Efforts in the U.S.*, KAISER FAMILY FOUND. 5 (Mar. 2009), <http://www.kff.org/healthreform/upload/7871.pdf> (providing a timeline of healthcare reform efforts in the United States and discussing the proposal of Senators Long and Ribicoff more fully).

108 STEVENS & STEVENS, *supra* note 4, at 237 (“[T]here were few advocates of states’ rights pressing for returning welfare medicine to the states.”).

109 See generally *President’s Federalism Initiative: Hearing Before the S. Comm. on Governmental Affairs*, 97th Cong. 1 (1982) (debating and criticizing the President’s proposal to adjust the balance of power between the federal government and state governments); Timothy J. Conlan, *Ambivalent Federalism: Intergovernmental Policy in the Reagan Administration*, in *ADMINISTERING THE NEW FEDERALISM* 15, 21–22 (Lewis G. Bender & James A. Stever, eds., 1986) (describing Reagan’s plans to federalize Medicaid and devolve responsibility for other programs to the states); see also GRANNEMANN & PAULY, *supra* note 20, at 95 (exploring and quickly rejecting the idea of federalizing Medicaid fully in favor of a strengthened cooperative federalism program). One of the reasons Grannemann and Pauly rejected federalizing Medicaid was the “difficulty of structuring benefits to account for differences in local medical care prices and local delivery systems, as well as the need to satisfy the desires of some voters for provision of extra benefits to the poor in their own geographic area.” *Id.* The book was written, however, before the prospective payment system was instituted for Medicare, a system that accounts for variations in local wages and other costs that can be affected by geography. See Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65 (1983) (codified at 42 U.S.C. § 1395ww) (“[T]he secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs, of the national and regional DRG prospective payment rates computer under subparagraph (G) for area differences in hospital wage levels . . .”). The prospective payment system is not perfect, but it does address this concern. See, e.g., *Bellevue Hosp. Ctr. v. Leavitt*, 443 F.3d 163, 168–69 (2d Cir. 2006) (recognizing that the Secretary must calculate payments based in part on the geographic area of the health care provider).

110 See *FEDERALISM & HEALTH POLICY*, *supra* note 14; John Holahan, Alan Weil & Joshua M. Wiener, *Which Way for Federalism and Health Policy?*, 22 HEALTH AFF. 1, 326–29 (2003) (drawing on *Federalism and Health Policy* and suggesting options to improve the federal-state Medicaid relationship, including reform that maintains the current structure for long-term care but nationalizes the financing and administration of acute-care services); Alan Weil, *There’s Something about Medicaid*, 22 HEALTH AFF. 13, 26 (2003) (recognizing the benefit of shifting Medicaid costs to the federal government because of stability and a broader tax base). There have been several other proposals relating to this question. See

PPACA was another failed attempt (albeit a weak one) at national health insurance, and Medicaid modifications have historically died when national insurance debates have failed.¹¹¹ But this time, Medicaid has been fundamentally altered. Nevertheless, although PPACA federalizes the Medicaid program in two ways, it continues the unthinking divided governmental responsibility for the Medicaid population, which has the states decrying the legislation as violating federalism principles.

III. THE STATES' RIGHTS THREAD: A FEDERALISM CONUNDRUM

The thread of states' rights continues to be a part of the program's institutional architecture. To evaluate this path dependence, this section explores the traditional arguments for the value of federalism as expressed by the modern Supreme Court. States' rights frequently arise in debates about the Medicaid program, but as Justice Black famously explained, Our Federalism does not require that the

Rosemary Barber-Madden & Jonathan B. Kotch, *Maternity Care Financing: Universal Access of Universal Care?*, 15 J. HEALTH POL. POL'Y & L. 797, 808 (1990) (recommending federalization of Medicaid in the context of a universal maternity care plan); see also Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement*, 22 HEALTH AFF. 145, 152 (2003) (posing the possibility of nationalizing Medicaid as a response to federal court shut down of section 1983 causes of action, but only in passing); Sara Rosenbaum & Kathleen A. Malloy, *The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and Its Impact on Medicaid for Families with Children*, 60 OHIO ST. L.J. 1443, 1470 (1999) (mentioning in conclusion that Congress could choose to federalize Medicaid to simplify the problems of PWORA); Rosenbaum, *supra* note 8, at 27 (stating that "the Medicaid funding formula has resulted in an unworkable distribution of financial obligations, devolving too much responsibility to states, whose economies are relatively ill-equipped to withstand the punishment of rapidly rising health care costs" but not proposing a solution to the problem). See generally Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 48 (2001) (discussing the difficulties involved with allocating more responsibilities to the federal government, including the federal budget along with opposition to strengthening a direct government entitlement program).

111 Even hints of a federally sponsored government plan in the state-based exchanges received cries of "socialized medicine," the classic attack on any form of national health insurance in the United States. See STARR, *supra*, note 21, at 55 (explaining the history of the term socialized medicine); Uwe E. Reinhardt, *What Is 'Socialized Medicine'?: A Taxonomy of Health Care Systems*, N.Y. TIMES ECONOMIX BLOG (May 8, 2009, 6:48 AM), <http://economix.blogs.nytimes.com/2009/05/08/what-is-socialized-medicine-a-taxonomy-of-health-care-systems> (describing different schemes of social and health insurance in the context of the health reform debate); see also Jacob S. Hacker, *Let's Try a Dose. We're Bound to Feel Better.*, WASH. POST, Mar. 23, 2008, http://www.washingtonpost.com/wp-dyn/content/article/2008/03/21/AR2008032102743_pf.html (describing and debunking the long history of rejecting governmental healthcare solutions as "socialized medicine").

states automatically win.¹¹² Nevertheless, federalism plays an important role in the litigation regarding the Medicaid expansion, which will also be discussed in this section for purposes of understanding the federalization that has already occurred as well as the federalization that will be suggested in Part IV.

A. *Searching for a Coherent Federalism*

1. *The “Federalism Revolution”*

The modern Supreme Court has revived federalism as a doctrine that protects states from overreaching by the federal government.¹¹³ Restoring federalism as an active limit on the enumerated powers of

112 *Younger v. Harris*, 401 U.S. 37 (1971). Justice Black coined the phrase “Our Federalism” in this case, and he wrote:

[Our Federalism] 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

Id. at 44; *see also* ALISON L. LACROIX, *THE IDEOLOGICAL ORIGINS OF AMERICAN FEDERALISM* 30–67, 136–66 (2010) (tracing the ideological roots of American federalism and describing the parliamentary power over the colonies that formed a theoretical basis for allowing a two-tiered government). Although the colonies were understood to be skeptical of a centralized government after various injustices imposed by the British from afar, according to Professor LaCroix, the notion that a central government and local governments can have concurrent and independent power was deliberate, not an accident of the colonies becoming a nation. *Id.* at 30–67. Professor LaCroix also explains that “[o]ur Federalism” inherently requires the supreme power of the federal government and compellingly describes the “federal negative” that would have given Congress the ability to negate state laws, an idea that was rejected for stronger federal judicial review but that also helps to explain why federalism should not automatically be equated to states’ rights. *Id.* at 136–66.

113 Addressing the multiple concepts of federalism in an article this length is impossible. But, it is helpful to have a working definition of federalism, and Professors Feeley and Rubin provide a pithy version: “Federalism, as the term is used in political science and legal scholarship, refers to a means of governing a polity that grants partial autonomy to geographically defined subdivisions of the polity.” FEELEY & RUBIN, *supra* note 16, at 12. Professor Kramer wrote a longer, also useful, definition:

A federal system is one in which political power is divided between central and subordinate authorities. . . . [It] is distinguished from other decentralized setups by the additional fact that leaders in its subordinate units don’t depend on the central government for their political authority. Most definitions of federalism assume further that the subordinate units possess enclaves of jurisdiction that cannot be invaded by the central government. . . . But so long as the subordinate units are able successfully to obtain some share of governmental power, it’s not important that their jurisdiction be fixed over any particular area. Rather, the critical feature of a federal system is that officials of the subordinate units are not appointed, and cannot be fired, by officials of the central government.

Larry Kramer, *Understanding Federalism*, 47 VAND. L. REV. 1485, 1488 n.5 (1994) (citations omitted).

Congress was one of Justice Rehnquist's projects,¹¹⁴ but the resulting case law is not totally coherent. One consistent theme has been dual sovereignty as an enforcing principle,¹¹⁵ seen in *Gregory v. Ashcroft*, *New York v. United States*, and *Printz v. United States*.¹¹⁶ Indeed, the "federalism revolution" arguably began with *Gregory*, a case that is cited frequently for its enumeration of federalism's virtues.¹¹⁷

In *Gregory*, Justice O'Connor famously described the historic and structural nature of federalism as "dual sovereignty" and the virtues of federalism as having four highlights:

This federalist structure of joint sovereigns preserves to the people numerous advantages. It assures a decentralized government that will be more sensitive to the diverse needs of a heterogeneous society; it increases opportunity for citizen involvement in democratic processes; it allows for more innovation and experimentation in government; and it makes government more responsive by putting the States in competition for a mobile citizenry.¹¹⁸

The "dual sovereignty" terminology was notable because many had described the United States as having abandoned the founding concept of "layer cake" dual sovereignty for "marble cake" federalism, an allusion to the modern prevalence of cooperative federalism.¹¹⁹ The

114 See JEFFREY TOOBIN, *THE NINE: INSIDE THE SECRET WORLD OF THE SUPREME COURT* 101 (2007) ("Throughout the 1990s, Rehnquist, Kennedy, and (as ever) O'Connor tried to revitalize the doctrine of states' rights, ruling that several federal laws impinged on aspects of state sovereignty. These developments were sometimes called a 'federalism revolution,' but that now seems an exaggeration.")

115 After World War II and the New Deal, dual sovereignty seemed an obsolete conception of federalism. See Edward S. Corwin, *The Passing of Dual Federalism*, 36 VA. L. REV. 1, 1-4 (1950) (describing how dual federalism came to a natural end after the world wars and the industrialization of America). The idea of dual federalism, as articulated by the Supreme Court in the early twentieth century, was not protective of states' rights. *Id.* at 15-17. Cooperative federalism eventually grew under a stronger, centralized national government. *Id.* at 19-23.

116 *Printz v. United States*, 521 U.S. 898 (1997); *New York v. United States*, 505 U.S. 144 (1992); *Gregory v. Ashcroft*, 501 U.S. 452 (1991).

117 *Gregory*, 501 U.S. at 458; see also FEELEY & RUBIN, *supra* note 16, at 22 (describing *Gregory* as "perhaps the U.S. Supreme Court's leading statement on the virtues of federalism"). *Gregory* and subsequent federalism decisions were foreshadowed by Justice O'Connor's concurrence/dissent in *FERC v. Mississippi*, which extolled the virtues of the "experiment of the states" and described the importance of dual sovereignty. See *FERC v. Mississippi*, 456 U.S. 742, 789-90 (1982) (O'Connor, J., concurring in part and dissenting in part).

118 *Gregory*, 501 U.S. at 458; see also FEELEY & RUBIN, *supra* note 16, at 22-29 (deconstructing the advantages of federalism for the United States).

119 See Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and "Dual Sovereignty" Doesn't*, 96 MICH. L. REV. 813, 815 (1998) ("It is commonplace to observe that 'dual federalism' is dead, replaced by something variously called 'cooperative federalism,' 'intergovernmental relations,' or 'marble cake federalism.'"); see also FEELEY & RUBIN, *supra* note 16, at 75 (describing the idea of "marble cake" cooperative federalism).

use of federal funding to incentivize nationally determined policy at the state level seems to undercut the divided and divisive nature of “dual sovereignty,” which seems not to consider the possibility of intergovernmental collaboration.¹²⁰

In the next federalism revolution decision, *New York v. United States*, the Court re-emphasized the divided nature of dual sovereignty that it had underlined in *Gregory* but also described that Congress had two major mechanisms for “influencing” state policy: spending for the general welfare, and regulating activity under the Commerce Clause by preempting state law.¹²¹ The majority noted, “[w]here the recipient of federal funds is a State . . . the conditions attached to the funds by Congress may influence a State’s legislative choices.”¹²² Paradoxically, this federalism analysis aggrandizes congressional authority because Congress need not include state legislatures in federal policymaking.¹²³ Ultimately, the Court struck down the law at issue as impermissible “commandeering” of state legislative function that either exceeded Commerce Clause authority or violated the Tenth Amendment by “coercing” the states to comply with a federal scheme rather than merely “encouraging” compliance.¹²⁴

Thus, the federalism revolution approved of cooperative federalism while at the same time underlining the importance of dual sove-

120 Hills, Jr., *supra* note 119, at 826 (explaining that the arguments for dual sovereignty prove too much by failing to acknowledge the utility of federal-state voluntary cooperation).

121 *New York*, 505 U.S. at 167–68 (describing approvingly examples of regulatory schemes under the Spending Clause and the Commerce Clause that adhere to the idea of a partnership between the federal government and the states); *id.* at 171–72 (upholding aspects of the Low-Level Radioactive Waste Policy Act as being consistent with cooperative federalism).

122 *Id.* at 165–67. The majority reiterated this point: “[T]he Constitution . . . permits the Federal Government to hold out incentives to the States as a means of encouraging them to adopt suggested regulatory schemes.” *Id.* at 188.

123 *Id.* at 210 (White, J., dissenting) (“The ultimate irony of the decision today is that in its formalistically rigid obeisance to ‘federalism,’ the Court gives Congress fewer incentives to defer to the wishes of state officials in achieving local solutions to local problems.”).

124 *See id.* at 175–77. A few years later, the decision in *Printz* underlined the same themes as *New York*, though *Printz* involved executive officer “dragooning” rather than legislative act “commandeering.” *Printz v. United States*, 521 U.S. 898, 918–19 (1997) (describing the structural requirement of dual sovereignty in the Constitution); *id.* at 928 (stating that ministerial tasks do not improve the concern that state officers are “dragooned” into administering federal law). Interestingly, Justice O’Connor’s concurrence/dissent in *FERC v. Mississippi* previewed the “conscriptio” concerns addressed by the *Printz* majority. *FERC v. Mississippi*, 456 U.S. 742, 784 (1982) (O’Connor, J., concurring in part and dissenting in part). Professor Hills has urged that the way to understand *New York* and *Printz* is protecting state autonomy, not outdated dual sovereignty; thus, it is permissible for the federal government to purchase state cooperation just as it would purchase services from any private actor. *See* Hills, Jr., *supra* note 119, at 815–17, 824.

reignty. The Court described cooperative federalism as “a partnership between the States and the Federal Government, animated by a shared objective” that could be pursued either through spending or preemption.¹²⁵ In other words, the federal government could buy state collaboration, or in the face of state objections, the federal government could go it alone. Many expected cooperative federalism to also be reined in by the Rehnquist Court, and hopes were high that the spending power too would be subject to Tenth Amendment restrictions. But, while the Rehnquist Court revived a judicially enforced Tenth Amendment juxtaposed with the Commerce Clause power, it did not do so with the Spending Clause power. In fact, even though *South Dakota v. Dole* created a five-part test for limiting federal conditions on spending, the Court has not limited the spending power by the Tenth Amendment since 1936.¹²⁶ The reluctance to apply the Tenth Amendment to spending programs will be important for the Medicaid expansion litigation.¹²⁷

The merits of federalism through the experiment of the states was oft repeated and is worth mentioning in its own right, as it is the justification most likely to be cited for continuing the current Medicaid cooperative federalism structure. Justice O’Connor in particular favored the laboratory of the states theory (even when a case did not hinge on federalism). For instance, in *Cruzan v. Director, Missouri Department of Health*,¹²⁸ the majority was concerned primarily with the constitutional question of the right to refuse medical treatment,¹²⁹ but

¹²⁵ *New York*, 505 U.S. at 167 (citing *Arkansas v. Oklahoma*, 503 U.S. 91, 101 (1992)).

¹²⁶ *United States v. Butler*, 297 U.S. 1, 66, 74–75 (1936) (reading the Spending Clause broadly to be a separate enumerated power in the Hamiltonian sense, but then striking down the tax penalties of the Agricultural Adjustment Act under the aegis of the Tenth Amendment). This issue has also been mentioned by Justice Scalia in a more recent case. See *Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 686–87 (1999) (“Congress has no obligation to use its Spending Clause power to disburse funds to the States; such funds are gifts. . . . [I]n cases involving conditions attached to federal funding, we have acknowledged that the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’ (internal quotation marks omitted)). This statement provides insight into the deference to the exercises of the spending power, given the perception that Congress’s choice to spend is a “gift.”

¹²⁷ Justice Kennedy’s concurrence in *United States v. Comstock* obliquely indicated interest in limiting the Spending Power more. See 130 S. Ct. 1949, 1967–68 (2010) (Kennedy, J., concurring).

¹²⁸ 497 U.S. 261, 282 (1990) (acknowledging a competent patient’s right to refuse medical treatment and a state’s ability to demand clear and convincing evidence of an incompetent patient’s desire to have treatment withdrawn).

¹²⁹ *Id.* at 277 (“This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in the common parlance referred to as a ‘right to die.’”).

Justice O'Connor's concurrence was protective of states' right to be "laborator[ies]" for "crafting appropriate procedures for safeguarding incompetents' liberty interests" in order to find consensus on the appropriate procedures.¹³⁰ Likewise, Justice O'Connor reiterated the desirability of the laboratory of the states in *Washington v. Glucksburg*.¹³¹ Her brief concurrence noted that states were studying whether physician-assisted death should be permitted, approved of these state experiments, and reiterated that this was an "appropriate task" for the "laboratory" of the states in "the first instance."¹³²

Justices Kennedy and O'Connor concurred jointly in *United States v. Lopez*¹³³ and here too articulated the desirability of the laboratory of the states, writing:

While it is doubtful that any State . . . would argue that it is wise policy to allow students to carry guns on school premises, considerable disagreement exists about how best to accomplish that goal. In this circumstance, the theory and utility of our federalism are revealed, for the States may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear.¹³⁴

Justice O'Connor, as a former state legislator, clearly believed wholeheartedly in the spirit of the laboratory of the states.¹³⁵ She wrote another such comment in *Gonzales v. Raich*, wherein she lamented that upholding the federal power to enforce the Controlled Substances Act "extinguishes that experiment" (of legalizing medical marijuana for pain).¹³⁶

In many of these cases, the state was struggling with new policy questions such as physician-assisted death, medical marijuana for pain, or the right to refuse advanced and invasive medical technologies. States were often wrestling with policy that the federal government had not tackled (even in *Raich*, this was true, as the National Institutes of Health have barely studied medical marijuana). Small scale experiments may make sense in such circumstances. There is

130 *Id.* at 292 (O'Connor, J., concurring).

131 521 U.S. 702 (1997). The majority's opinion declined to find a right famously framed as "a right to commit suicide which itself includes a right to assistance in doing so." *Id.* at 723.

132 *Id.* at 737 (O'Connor, J., concurring).

133 514 U.S. 549, 568–83 (1995) (Kennedy, J., concurring).

134 *Id.* at 581.

135 See TOOBIN, *supra* note 114, at 46–47 (describing Justice O'Connor's personal history).

136 *Gonzales v. Raich*, 545 U.S. 1, 43 (2005) (O'Connor, J., dissenting); see also Robert A. Mikos, *On the Limits of Supremacy: Medical Marijuana and the States' Overlooked Power to Legalize Federal Crime*, 62 VAND. L. REV. 1421, 1438 (2009) (explaining why state policy regarding medical marijuana is not necessarily trumped by federal law, despite Justice O'Connor's "bleak appraisal of state power" in her dissent).

little analysis, however, as to the actual value of such experiments, the possibility that a national standard would be superior, or any acknowledgement that such experiments could have negative effects, but the experiments were at least within the understood concept of state “laboratories.”

On the other hand, cooperative federalism programs inherently involve centralized policy. If a state agrees to comply with federal policy in exchange for funding to facilitate compliance with that national policy, then it seems the state is inherently giving up its “right” to experiment. Protecting dual sovereignty in this context makes little sense, especially if the Court places few limits on the spending power. Further, the states want to have their cake and eat it too—seeking money and rejecting restrictions on those funds. In the case of Medicaid, as I will discuss further below, this is especially true.

2. *The Roberts Court Begins to Reveal Its Federalism Cards*

Although the Rehnquist Court’s federalism revolution has been much discussed, until recently observers have found the Roberts Court’s approach to federalism to be opaque, as the Court had not issued an opinion that luxuriates in federalism like the Rehnquist Court had done.¹³⁷ This vagueness changed with a case decided late in the October 2010 term, *Bond v. United States*.¹³⁸ *Bond* posed the issue of whether a criminal defendant has standing to challenge the constitutionality of the statute under which she is charged by raising Tenth Amendment concerns, which are typically expressed by states.¹³⁹ Justice Kennedy, writing for a unanimous Court, held that the defendant had standing to raise the Tenth Amendment question, even though no state was party to the case, because “[f]ederalism is more than an exercise in setting the boundary between different institutions of government for their own integrity. ‘State sovereignty is not just an end in itself: “Rather, federalism secures to citizens the liberties that derive from the diffusion of sovereign power.”’¹⁴⁰ The

137 See Minutes from a Convention of the Federalist Society, *The Roberts Court and Federalism*, 4 N.Y.U. J.L. & LIBERTY 330 (2009) (discussing the Roberts Court’s treatment of federalism issues); see generally Robin Kundis Craig, *Administrative Law in the Roberts Court: The First Four Years*, 62 ADMIN. L. REV. 69 (2010) (analyzing the Roberts Court’s administrative law-related decisions and cases addressing federalism); Robert A. Schapiro, *Not Old or Borrowed: The Truly New Blue Federalism*, 3 HARV. L. & POL’Y REV. 33 (2009) (outlining changing conceptions of federalism throughout history).

138 *Bond v. United States*, No. 09–1227, slip op. at 1 (U.S. June 16, 2011) (majority opinion).

139 *Id.* at 1.

140 *Id.* at 9 (citing *New York v. United States*, 505 U.S. 144, 181 (1992)).

Court quoted the four virtues of federalism from *Gregory*, then continued,

the individual liberty secured by federalism is not simply derivative of the rights of the States.

....

. . . An individual has a direct interest in objecting to laws that upset the constitutional balance between the National Government and the States when the enforcement of those laws causes injury . . . Fidelity to principles of federalism is not for the States alone to vindicate.¹⁴¹

Given that the defendant was challenging the constitutionality of the statute under which she was charged, it is unsurprising that the Court held that she had standing. As Justice Ginsburg's concurrence noted, due process instructs us that an unconstitutional law cannot create a crime under which a person may be convicted.¹⁴² Notably, Justice Ginsburg wrote her analysis in about two pages and with no reference to principles of federalism.¹⁴³ It appears that Justice Kennedy was keen on reiterating the Rehnquist Court's principles of federalism; his opinion virtually basks in it. Though this analysis may not be surprising for a Court that is considered to be quite conservative, the timing is notable. The dicta regarding federalism in *Bond* reflects quite closely some of the arguments being made in the challenges to PPACA's constitutionality.

Bond can be read in conjunction with at least three other cases to help us understand the Roberts Court's interpretation of federalism. Decided during the 2005 term before Justice O'Connor retired, Justice Kennedy's majority in *Gonzales v. Oregon* could be read as a laboratory of the states decision, much in the nature of his concurrence with Justice O'Connor in *Lopez*.¹⁴⁴ In *Oregon*, the Court struck down Attorney General Ashcroft's interpretation of the Controlled Substances Act ("CSA") to render state physician assisted death laws illegal. Such laws generally exempt physicians from state criminal liability when particular procedures are followed that lead to prescribing death-inducing drugs for terminally ill patients. The majority engaged in statutory interpretation and spent little time actually discussing state autonomy, as Justice Thomas's dissent pointedly noted.¹⁴⁵ Nevertheless, practically speaking, states' ability to experi-

141 *Id.* at 9–10.

142 *Id.* at 1 (Ginsburg, J., concurring).

143 *Id.* at 1–2.

144 *Gonzales v. Oregon*, 546 U.S. 243 (2006); see Craig, *supra* note 137, at 112 (describing the Court's reliance on a states' rights analysis).

145 *Oregon*, 546 U.S. at 301 (Thomas, J., dissenting). Justice Kennedy wrote:

ment with physician-assisted death was protected by the decision, a result that aligns with Justice O'Connor's *Glucksberg* concurrence.

The first Spending Clause case the Roberts Court decided, *Arlington Central School District Board of Education v. Murphy*, was very protective of states in cooperative federalism programs.¹⁴⁶ The majority in *Arlington* described the *Dole* test as requiring "clear notice" for conditions on spending so that states would fully understand the implications of accepting federal funds. This was a deliberate narrowing of the "unambiguous[]" conditions language and more protective of states receiving federal funding than the original language of *Dole*.¹⁴⁷

The 2010 decision in *United States v. Comstock* was anticipated to be a major federalism decision, but Justice Breyer's majority, which included Chief Justice Roberts, largely dismissed federalism concerns based on the federal law's "accommodation of state interests."¹⁴⁸ Writing that the federal government had the power to create the civil detention statute in question under Necessary and Proper Clause authority, Justice Breyer reiterated language from *New York* that if Congress has an enumerated power, then the Tenth Amendment intrinsically is not an issue.¹⁴⁹ The majority further noted that the federal government had accounted for the states in its statutory scheme, which contained a preference for state detention of released federal felons.¹⁵⁰ In this instance, it appears the states did not want to "expe-

[T]he statute manifests no intent to regulate the practice of medicine generally. The silence is understandable given the structure and limitations of federalism, which allow the States great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons. The structure and operation of the CSA presume and rely upon a functioning medical profession regulated under the States' police powers. . . . Even though regulation of health and safety is primarily, and historically, a matter of local concern, there is no question that the Federal Government can set uniform national standards in these areas.

Id. at 270–71 (citations omitted) (internal quotation marks omitted).

146 See *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (looking at the federal offer of funding from the state's point of view and demanding clear notice regarding any conditions on the funds); see also Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L.J. 345, 350–51 (2008) (explaining that in *Arlington* the court "went out if its way" to highlight the "clear notice" principle); Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. REV. 441 (2008) (discussing the Court's ruling in *Arlington* and its effect of requiring Congress to provide a clear notice to the states of conditions on federal spending).

147 *Arlington*, 548 U.S. at 296 (citation omitted); *South Dakota v. Dole*, 483 U.S. 203, 206–07 (1987).

148 *United States v. Comstock*, 130 S. Ct. 1949, 1962–63 (2010) (Kennedy, J., concurring).

149 *Id.* at 1962.

150 *Id.* at 1962–63.

rimment,” as a majority of states supported the federal government’s responsibility for released prisoners.¹⁵¹

Justice Thomas’s dissent, joined by Justice Scalia, read federal power quite narrowly and made much of the five-part analysis the majority used to analyze the federal statute in *Comstock*,¹⁵² but Justice Kennedy’s concurrence may be the most noteworthy in terms of federalism, especially in relation to the Spending Clause.¹⁵³ Justice Kennedy wrote that the majority relied on a spending case for part of its Necessary and Proper Clause analysis,¹⁵⁴ and then stated that the “spending power is not designated as such in the Constitution” but is part of the General Welfare Clause.¹⁵⁵ Justice Kennedy then continued: “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.”¹⁵⁶ Justice Kennedy then expressed concern about the Court’s limited reading of the Tenth Amendment, a concern that was perhaps alleviated with his opinion in *Bond*.

Arguably the Kennedy concurrence was trying to draw lines between the various enumerated powers Congress can exercise and how they may play out differently through the Necessary and Proper Clause, but the narrow reading of the Spending Clause seems to go beyond interpreting the Necessary and Proper Clause to a broader statement about the nature of the power itself and yet-to-be-found limits on that power. Supporters of the constitutionality of PPACA point to the majority’s broad analysis of the Necessary and Proper Clause in *Comstock*, which may be interpreted as the Court deferring to the federal government with little concern for protecting an area of traditional state regulation. But Justice Kennedy’s comments on the Spending Clause read as an invitation for a spending power case so that the Court can rein in Congress’s power. While this may not matter for the minimum coverage aspect of the ongoing PPACA litigation, it will be vastly important for the Medicaid aspect of the expansion challenge.

To sum up, the Rehnquist Court began a federalism revolution that now has been at least partially adopted by the Roberts Court. Recent cases give us reason to believe that the Tenth Amendment will

151 *Id.* at 1970. (Alito, J., concurring).

152 *Id.* (Thomas, J., dissenting).

153 *Id.* at 1965–68 (Kennedy, J., concurring).

154 *Id.* at 1967 (citing *Sabri v. United States*, 541 U.S. 600 (2004)).

155 *Id.*

156 *Id.*

continue to be judicially enforced. Further, some signs indicate that the Roberts Court may be willing to limit Congress's spending power by the Tenth Amendment. Such a change would alter not only the structure and substance of cooperative federalism as it was approved by the Court in *New York*, it could also fundamentally alter dozens of federal spending programs.

In the Medicaid context, states' rights are often raised as a protest against expansions of federal requirements and defined in terms of the value of the "laboratory of the states," which Justice O'Connor extolled in *Gregory*.¹⁵⁷ On the other hand, Medicaid has been described by the Court as a system of cooperative federalism,¹⁵⁸ as have the welfare programs upon which Medicaid was built.¹⁵⁹ Thus, the clash of dual sovereignty against cooperative federalism can be witnessed in the Medicaid program, which is now the subject of major litigation due to the expansion effectuated by PPACA.

157 Justice O'Connor also covered this ground in her concurrence/dissent in *FERC*, where she wrote:

Courts and commentators frequently have recognized that the 50 States serve as laboratories for the development of new social, economic, and political ideas. This state innovation is no judicial myth. . . . [Federal law], which commands state agencies to spend their time evaluating federally proposed standards and defending their decisions to adopt or reject those standards, will retard this creative experimentation.

FERC v. Mississippi, 456 U.S. 742, 788–89 (1982) (O'Connor, J., concurring in part and dissenting in part) (footnote omitted) (citations omitted). Justice O'Connor also explained the merits of cooperative federalism in this opinion. *Id.* at 783.

158 *Harris v. McRae*, 448 U.S. 297, 308 (1980). The Court described Medicaid thusly:

The Medicaid program created by Title XIX is a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons. Under this system of "cooperative federalism," if a State agrees to establish a Medicaid plan that satisfies the requirements of Title XIX . . . the Federal Government agrees to pay a specified percentage of "the total amount expended as medical assistance under the State plan." The cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State. . . . [T]he purpose of Congress in enacting Title XIX was to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan.

Id. (citations omitted).

159 *King v. Smith*, 392 U.S. 309, 316 (1968). The Court wrote:

The AFDC program is based on a scheme of cooperative federalism. It is financed largely by the Federal Government, on a matching fund basis, and is administered by the States. States are not required to participate in the program, but those which desire to take advantage of the substantial federal funds available for distribution to needy children are required to submit an AFDC plan for the approval of the Secretary of Health, Education, and Welfare (HEW).

Id. (citations omitted).

B. Medicaid and Federalism in the PPACA Litigation

If Congress were to federalize Medicaid, the Spending Clause clearly provides the enumerated power to do so, just as it does for Medicare.¹⁶⁰ But, this is not the hard question. The bigger issue is whether the Tenth Amendment restrictions will be applied to the spending power, and the Court now has a vehicle to revisit this question through Florida's challenge to PPACA's constitutionality, *Florida ex rel. Bondi v. United States Department of Health and Human Services*.¹⁶¹ This litigation is the biggest challenge to the most dramatic change to Medicaid since its inception, and yet it is, at heart, purely about economics—the philosophical change to Medicaid eligibility has not been opposed.

Many parties are challenging PPACA from a number of constitutional perspectives. Most of the litigation involves challenges to Section 1501, the minimum coverage provision that will facilitate universal insurance coverage, and the Court has granted certiorari regarding the constitutionality of this provision.¹⁶² It is clear that whatever the Commerce Clause and Necessary and Proper Clause outcome may be,¹⁶³ no federalism issue exists in the individual mandate. PPACA states that individuals who do not carry insurance by 2014 will be assessed a tax for each month they do not carry insurance unless certain exceptions apply.¹⁶⁴ This insurance coverage requirement affects the relationship between the federal government and individuals, but it does not implicate the states.¹⁶⁵ The Court's federalism doctrine, though sometimes claiming to protect individual

¹⁶⁰ U.S. CONST. art. I, § 8, cl. 1.

¹⁶¹ *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011).

¹⁶² Kaiser Health News keeps a helpful "scoreboard" regarding this litigation. See Bara Vaida & Karl Eisenhower, *Scoreboard: Tracking Health Law Court Challenges*, KAISER HEALTH NEWS (Sept. 13, 2011), <http://www.kaiserhealthnews.org/Stories/2011/March/02/health-reform-law-court-case-status.aspx>. The ACA Litigation Blog is also quite useful. See Brad Joondeph, *ACA LITIGATION BLOG* (Sept. 9, 2011, 1:13 PM), <http://acalitigationblog.blogspot.com/>.

¹⁶³ Professor Hall provides a nice Commerce Clause/Necessary and Proper Clause analysis. See Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825 (2011) (detailing the constitutionality of PPACA's minimum coverage requirement).

¹⁶⁴ PPACA § 1501 (2010).

¹⁶⁵ Professor Barnett argues that the language "the people" in the Tenth Amendment protects individuals. See Randy E. Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional*, 5 N.Y.U. J.L. & LIBERTY 581, 627 (2010), available at <http://ssrn.com/abstract=1680392> ("[T]he text of the Tenth Amendment recognizes popular as well as state sovereignty."). This argument is quite novel, however, because "the people" has only been read to protect the people collectively, not individual rights. *Id.* at 623.

liberty by limiting governmental function, is not typically a doctrine by which individuals are protected directly. Admittedly, Justice Kennedy's opinion in *Bond* calls this assertion into question, as he repeatedly asserted that federalism protects not just governmental sovereignty but also the people being governed.¹⁶⁶

As this Article goes to press, the Supreme Court has granted certiorari on the petitions that arose out of the Eleventh Circuit litigation while holding the remaining petitions that represent the multi-circuit split that exists regarding the constitutionality of PPACA.¹⁶⁷ The Sixth Circuit issued a decision that upheld a facial challenge to the constitutionality of Section 1501, but that litigation does not contain a challenge to the Medicaid expansion.¹⁶⁸ Additionally, the Fourth Circuit dismissed a challenge to Section 1501 for lack of standing based upon the Anti-Injunction Act, but that case also did not address the Medicaid expansion.¹⁶⁹ Other circuits have weighed in, but only the Florida-led litigation, in which the Eleventh Circuit declared Section 1501 unconstitutional but severable, asserts that PPACA exceeds Congress's power under the Spending Clause by creating coercive conditions on Medicaid funding.¹⁷⁰ It seems strange to say "only" given that this litigation now involves more than half of the states, yet none of the other major challenges to PPACA include this question.¹⁷¹

The claim that the Medicaid expansion is unconstitutional has been sustained as the litigation progresses and is one of the questions presented in Florida's petition for certiorari, providing a vehicle for

166 See *Bond v. United States*, No. 09-1227, slip op. at 9 (U.S. June 16, 2011) ("Federalism secures the freedom of the individual").

167 See Joondeph, *supra* note 162.

168 See *Thomas More Law Ctr. v. Obama*, 651 F.3d 529 545 (6th Cir. 2011) (finding the PPACA's minimum coverage provision to be a "valid exercise of legislative power by Congress under the Commerce Clause").

169 *Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253 (4th Cir. 2011).

170 *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683, at *3-7 (N.D. Fla. Jan. 31, 2011). The Tenth Amendment challenge was not briefed and thus not addressed by the decision, *id.* at *7 n.5, though notably the claim was not dismissed in the initial Motion to Dismiss of October 14, 2010. See *Florida ex rel. McCollum v. U.S. Dep't of Health & Human Serv.*, 716 F. Supp. 2d 1120, 1156-60 (N.D. Fla. 2010) (dismissing a handful of the claims in the Florida litigation).

171 I say major because the Lieutenant Governor of Missouri's complaint included a charge that the Medicaid expansion was, essentially, impermissible commandeering under *Printz*, but the complaint was dismissed for lack of standing. See Complaint at 26, *Kinder v. Geithner*, No. 1:10 CV 101 RWS (E.D. Mo. July 7, 2010); see also *Kinder v. Geithner*, No. 1:10 CV 101 RWS, 18-19 (E.D. Mo., Apr. 26, 2011) (dismissing Count IV). An appeal was heard before the Eighth Circuit on October 20, 2011. 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>.

the Supreme Court to decide longstanding questions regarding limits on the power to spend.¹⁷² At the district court level, Florida basically argued that the Medicaid expansion would cost too much and be too different from Medicaid pre-PPACA but that the states could not leave the amended program because they rely too heavily on it financially. Thus, according to Florida, the law constitutes impermissible coercion under the test for conditions on spending articulated in *South Dakota v. Dole*.¹⁷³ The coercion theory was issued as the fifth, unenumerated element of the conditional spending test in *Dole*, which stated that the federal government may place conditions on its spending so long as: the spending is for the general welfare; any conditions on the spending are clear and unambiguous; the conditions are germane to the purpose for which the government is spending; and the conditions are not themselves unconstitutional.¹⁷⁴ Finally, the Court stated: “Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’”¹⁷⁵ The Supreme Court has not broached the coercion idea in subsequent spending cases, and the theory largely has been unsuccessful in lower federal courts.¹⁷⁶

The states urged only that the coercion element is violated; they did not allege infringement of the other four elements of the *Dole* test.¹⁷⁷ Heretofore, the clear statement rule (the second element, demanding that conditions on funds be unambiguous) has been the most widely litigated and successful challenge to federal spending, but the coercion theory has been part of spending and federalism case law since 1937.¹⁷⁸

172 Petition for Writ of Certiorari at i, 1–2, *Florida v. U.S. Dep’t of Health & Human Servs.*, No. 11-398 (U.S. Sept. 27, 2011) (urging the Court to determine whether the fifth *Dole* element—coercion—applies to the Medicaid expansion or is effectively “no longer appl[icable]”).

173 *Bondi*, 2011 WL 285683 at *3.

174 *South Dakota v. Dole*, 483 U.S. 203, 207–08 (1987). The second element of this test was modified by *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006). See Huberfeld, *Clear Notice*, *supra* note 146, at 445–46, 469–72 (tracing and explaining the evolution of the clear notice standard in *Arlington*).

175 *Dole*, 483 U.S. at 211.

176 See, e.g., Response/Reply Brief for Appellants at 51–52, *Florida v. U.S. Dep’t of Health & Human Servs.*, Nos. 11-11021 & 11-11067 (11th Cir. Aug. 12, 2011) (summarizing the status of the coercion theory in lower federal courts).

177 *Bondi*, 2011 WL 285683 at *3. The states added a more complete analysis of the *Dole* test late in the litigation, but Judge Vinson rejected their cursory analysis. *Id.*

178 See *Steward Machine Co. v. Davis*, 301 U.S. 548, 591–92 (1937) (finding that Title IX of the Social Security Act of 1935 was not coercive, and thus not invalid).

Judge Vinson's opinion at the district court level rejected the coercion claim.¹⁷⁹ Judge Vinson noted that the state plaintiffs asserted that they were forced to spend huge amounts of money in the Medicaid program but that they "effectively have no choice other than to participate in the program."¹⁸⁰ But, as the judge noted, other non-litigant states, as well as the defendants, claimed the Medicaid expansion would save states' money in the long run.¹⁸¹ The judge found the factual issues to be too prominent for summary judgment, but then, paradoxically, he ruled as a matter of law that the coercion claim should be dismissed.¹⁸² Judge Vinson explored other federal courts' treatment of coercion and concluded that coercion is a non-justiciable issue, presumably as a political question, though it was not specifically stated.¹⁸³

The Eleventh Circuit upheld the district court's dismissal of the Medicaid claim.¹⁸⁴ In a relatively small portion of the 200-plus page opinion, Judges Dubina and Hull noted that Florida had refined its arguments at the appellate level, claiming that it was not just the size of the federal funding but also the nature of the condition attached to the federal funding that could constitute coercion.¹⁸⁵ The judges phlegmatically traced the roots of the coercion theory and found it to be justiciable, despite the difficulty of finding a judicial standard for coercion.¹⁸⁶

An intriguing aspect of this history and exploration was the judges' conclusion that *Dole* must mean that the Tenth Amendment limits the spending power. The court wrote:

[W]e find it a reasonable conclusion that *Dole* instructs that the Tenth Amendment places certain limitations on congressional spending; namely, that Congress cannot place restrictions so burdensome and threaten the loss of funds so great and important to the state's integral function as a state—funds that the state has come to rely on heavily as part of its everyday service to its citizens—as to compel the state to participate in the

179 *Bondi*, 2011 WL 285683 at *5–6. This was a bit surprising, given that Judge Vinson seemed to be a sympathetic ear (he held the individual mandate to be an unconstitutional exercise of Commerce Clause authority and a federalism problem). *Id.* at *33.

180 *Id.* at *4.

181 *Id.*

182 *Id.*

183 *Id.* at *4–5.

184 *Florida v. U.S. Dep't of Health & Human Servs.*, Nos. 11-11021 & 11-11067, slip op. at 206 (11th Cir. Aug. 12, 2011).

185 *Id.* at 56 n.63. See Opening/Response Brief of Appellee/Cross-Appellant States at 51–52 *Florida*, Nos. 11-11021 & 11-11067 (arguing that post-*Dole* decisions "correctly recognize that the coercion doctrine focuses on both the size of the federal inducement and the relationship between the condition and the inducement").

186 *Florida*, Nos. 11-11021 & 11-11067, slip op. at 60–63.

“optional” legislation. This is the point where “pressure turns into compulsion.”¹⁸⁷

This passage is notable given that the Court in *Dole* specifically stated that the Tenth Amendment does not limit the power to spend,¹⁸⁸ and *New York* reiterated the analysis only five years after *Dole*.¹⁸⁹ On the other hand, if coercion has any meaning, it must be that it is a problem of dual sovereignty, which is rooted in the Tenth Amendment.¹⁹⁰

Ultimately, the Eleventh Circuit upheld the grant of summary judgment regarding the Medicaid expansion not because the theory of coercion is non-justiciable but because the court concluded that coercion is not present.¹⁹¹ The court presented four reasons for this conclusion, namely, that the states knew upon entering Medicaid that the federal government could alter the program at will; the federal government bears the vast majority of the costs of the Medicaid expansion; states have years of notice and therefore have time to drop out or raise more money as they need; and states that are noncompliant may only be penalized rather than dropped from Medicaid totally.¹⁹²

The coercion issue will now be heard by the Supreme Court. The petition for certiorari filed by Florida and the other states in the Ele-

187 *Id.* at 64 (internal quotation marks omitted).

188 *South Dakota v. Dole*, 483 U.S. 203, 210 (1987). The Court wrote: “We have also held that a perceived Tenth Amendment limitation on congressional regulation of state affairs did not concomitantly limit the range of conditions legitimately placed on federal grants.” *Id.* (referring to *Oklahoma v. Civil Serv. Comm’n*, 330 U.S. 127, 143–44 (1947)).

189 *New York v. United States*, 505 U.S. 144, 173 (1992) (“The Act’s first set of incentives, in which Congress has conditioned grants to the States upon the States’ attainment of a series of milestones, is thus well within the authority of Congress under the Commerce and Spending Clauses. Because the first set of incentives is supported by affirmative constitutional grants of power to Congress, it is not inconsistent with the Tenth Amendment.”).

190 If coercion is a problem of dual sovereignty, it seems the Court’s decisions indicate one of two things: Either it is not proper for Congress to make an offer because the offer is not a suitable exercise of federal power and thus inherently infringes states’ autonomy, see Thomas R. McCoy & Barry Friedman, *Conditional Spending: Federalism’s Trojan Horse*, 1988 SUP. CT. REV. 85, 97, 102–03 (1988) (noting that the test in *National League of Cities* was unworkable and should be replaced by the question of “whether the enactment was a proper subject of federal regulation”), or Congress has constitutional authority, but state compliance is a foregone conclusion because the state will lose too much if it rejects the federal offer. The *Dole* test, which looks for excessive financial inducement, implies that the latter is correct. See *Dole*, 483 U.S. at 211 (explaining that depending on its severity, a financial inducement can become compulsive).

191 *Florida*, Nos. 11-11021 & 11-11067, slip op. at 63–64. This seems like a factual analysis, not a decision as a matter of law, but Judge Marcus concurred in this conclusion. *Id.* at 208 (Marcus, J., concurring and dissenting) (dissenting regarding the constitutionality of the minimum coverage provision but concurring in standing, constitutionality of the Medicaid expansion, and taxing power).

192 *Id.* at 64–67.

venth Circuit places the Medicaid expansion issue as the first question presented in their petition. Specifically, they have asked the Court to determine whether Congress

exceed[s] its enumerated powers and violate[s] basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress's spending power . . . in *Dole* . . . no longer apply?¹⁹³

Thus, the states are directly posing the question that prior decisions have only hinted at: is the Tenth Amendment a limit on Congress's spending power, or is it not? If it is, then innumerable spending programs will be affected. If not, then the fifth unenumerated element from *Dole* should be explicitly overruled. Given the few hints the Roberts Court has provided regarding its interpretation of the Spending Clause and the Tenth Amendment as a protector of federalism, it is possible this Court would read the Tenth Amendment to be a judicially enforceable limit on spending.

States demonstrated long ago they could not support impoverished patients or the healthcare providers who treat them without significant federal assistance; this is the reason we have a Medicaid program but also part of the reason states claim they cannot leave the program. States argue that the problem with Medicaid expansion is that they have become locked in to the program and cannot reject any new conditions on the federal spending.¹⁹⁴ An aspect of their complaint is that states are locked in politically, as few politicians would have the courage to drop federal Medicaid dollars and face the wrath of healthcare providers (the voices of the poor are not nearly as loud, though they too would protest). The states are also locked in monetarily because the federal match makes it very hard for states to cut Medicaid dollars without losing substantially more than the actual dollar amount cut from their budget.¹⁹⁵ If a state has a 50% match, then that state loses one federal dollar for every dollar it cuts from its

193 Petition for Writ of Certiorari, *supra* note 172, at i.

194 See Blumstein & Sloan, *supra* note 9, at 133 ("Once adopted, a cooperative federalism program such as Medicaid has a political 'lock-in' effect—the matching formula that makes program enhancements so appealing also makes cutbacks very unappealing."); see also David Freeman Engstrom, *Drawing Lines Between Chevron and Pennhurst: A Functional Analysis of the Spending Power, Federalism, and the Administrative State*, 82 TEX. L. REV. 1197, 1242–44 (2004) (expressing concern about lock-in and proposing that clear statement rules could prevent administrative attempts to ratchet-up federal requirements in spending programs).

195 See Blumstein & Sloan, *supra* note 9, at 142 (describing the disproportionately large loss of federal funding for every dollar of reduction in state contributions to Medicaid).

budget, for a net cut of two dollars.¹⁹⁶ If a state has a 75% match, then that state loses three federal dollars for every dollar it cuts, making it much harder for poorer states to trim their Medicaid programs because the total loss is four dollars for a one dollar budget cut.¹⁹⁷ It is on this basis that states claim to be “coerced” in the Medicaid program. Legal scholars have puzzled through the idea of coercion in federal spending programs and have questioned whether coercion should be justiciable, but no one theory has predominated.¹⁹⁸ While coercion may be one way to describe the situation, it seems like the states suffer from their own path dependence in Medicaid (“we desire to be partners and to have more autonomy because we have always asked for these things”).

On the face of it, the *Dole* test indicates that this kind of financial pressure would be impermissible coercion. It is not problematic for the federal government to spend for the general welfare through Medicaid; the condition is perfectly clear; it is germane to the purpose of increasing medical access for the poor; and it is not based on unconstitutional conditions (unless the Court were to start using the Tenth Amendment to limit the spending power). Unlike South Dakota (which would have lost 5% of federal funds), states could lose all Medicaid funding if they rejected the expansion, which they could not do without major financial repercussions reverberating through the healthcare systems in the state.¹⁹⁹ While the states’ second largest

196 In 2010, thirty-five states had an FMAP between 50% and 75%. Henry J. Kaiser Family Found., *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, STATEHEALTHFACTS.ORG, <http://statehealthfacts.org/comparemaptable.jsp?ind=184&cat=4&sub=47&yr=1&typ=2> (last visited Oct. 23, 2011).

197 Fifteen states and the District of Columbia had an FMAP above 75% in 2010. *Id.* Although 75% is typically the upper limit, special funding for the states has brought the FMAP as high as nearly 85% in the Great Recession years. *See supra* notes 77–81 and accompanying text.

198 *See, e.g.*, Lynn A. Baker & Mitchell N. Berman, *Getting off the Dole: Why the Court Should Abandon Its Spending Doctrine, and How a Too-Clever Congress Could Provoke It to Do So*, 78 IND. L.J. 459, 517–20 (2003) (criticizing the coercion theory of unconstitutionality as too difficult for courts to enforce because it is unclear how a constitutional doctrine should differ from common law concepts of coercion); *cf.* McCoy & Friedman, *supra* note 190, at 118–19 (explaining that *Dole* mischaracterized the coercion test for congressional spending, which, properly understood, should be an inquiry into whether the federal government is using the taxing or spending power to create a result that Congress could not command directly).

199 *See* Huberfeld, *Clear Notice*, *supra* note 146, at 488 (noting that foregoing federal Medicaid funds would be “an unsatisfactory response given how many citizens rely on Medicaid and how long states have relied on federal spending to provide health insurance and services to the poor”).

budgetary commitment is Medicaid,²⁰⁰ states would say they do not *choose* to make Medicaid a commitment of that size.²⁰¹

On the other hand, the Medicaid expansion is primarily funded by the federal government. Some states claim the PPACA expansion will actually save them money because it will help to alleviate other burdens such as uncompensated care in hospitals.²⁰² These states do not feel coerced, they feel assisted. The factual differences of opinion make summary judgment inappropriate for resolving the issue. They also make it possible for the Court to decide a smaller question—the constitutionality of this Medicaid expansion provision under existing doctrine—rather than the larger issue of federalism as it relates to the spending power.

Even if the states were successful in their coercion argument, the end result is not obvious. The states do not automatically win by devolution; *New York* tells us that the federal government can take over the program completely, which would actually be a win for the states monetarily (and for Medicaid enrollees who are not subject to the economic vagaries of the states).²⁰³ This seems to be where dual sovereignty and cooperative federalism collide in Medicaid.

The question is why the states continue to jointly operate Medicaid. After all, the states have demanded at times that Medicaid become a federalized program, but that is not the current trend; in-

²⁰⁰ See Donald J. Boyd, *Health Care Within the Larger State Budget*, in *FEDERALISM AND HEALTH POLICY*, *supra* note 14, at 59, 59–60 (“[S]tate governments spend more of their own funds on health care than on any other function except elementary and secondary education.”).

²⁰¹ A recent article quoted Governor Barbour of Mississippi as stating, “‘We shouldn’t have to kowtow and kiss the ring’ to make changes that will work for Mississippi residents.” Mary Agnes Carey, *Miss. Gov. Barbour: ‘We Shouldn’t Have To Kowtow’ to Feds on Medicaid Rules*, KAISER HEALTH NEWS (Mar. 1, 2011), <http://www.kaiserhealthnews.org/Stories/2011/March/01/barbour-block-grants-medicaid-short-take.aspx>. Ironically, Mississippi has the highest federal match for Medicaid in the country at 85%, *id.*, which means the state spends the least and has the most to lose.

²⁰² See Brief of the States of Oregon et al. at 18–19, as Amici Curiae in Support of Defendants-Appellants, Florida *ex rel.* McCollum v. U.S. Dep’t of Health & Human Servs., 716 F. Supp. 2d 1120 (N.D. Fla. 2010) (No. 3:10-cv-91 RV/EMT) (explaining the cost savings to be found in universal insurance coverage); Brief of Amici Curiae State Legislators in Support of Defendants-Appellants at 25–34, *McCollum*, 716 F. Supp. 2d 1120 (No. 3:10-cv-91 RV/EMT) (describing the financial benefits of PPACA to the states).

²⁰³ *New York v. United States*, 505 U.S. 144, 161 (1992) (explaining that if a state does not wish to submit to a regulatory program of federal and state cooperation, the federal government can bear the full burden of regulating that area); see also *Hodel v. Virginia Surface Mining & Reclamation Assn., Inc.*, 452 U.S. 264, 304–05 (1981) (upholding the constitutionality of a surface mining regulatory regime promulgated by Congress to be enforced by participating states or by the Secretary of the Interior and the federal government in non-participating states).

stead, many state governors would have the federal government provide more money with fewer controls in the form of “block grants” as an answer to their coercion complaints. Professors Feeley and Rubin have asserted that “states’ rights” is a cipher for disagreement with federal policy but not a true rationale for federalism.²⁰⁴ This interpretation applies well to the Medicaid context. Becoming a block grant program could relieve the states of some federal oversight and thus provide them with some ability to “experiment,” but the history of Medicaid tells many tales of state inability to manage and pay for welfare medicine.²⁰⁵ The states agreed to participate in Medicaid because they were eager for federal assistance. When the states have had room to “experiment,” they have often hewed to old-fashioned notions of the deserving poor to keep enrollment down, gamed the federal reimbursement system,²⁰⁶ and cut assistance whenever budgets are tight. In a severe economic downturn, the states need to trim their budgets for lack of tax revenue, but they have mandatory Medicaid enrollees swelling the budget at the same time, which generally leads the states to ask for additional federal funds.²⁰⁷ The states are entitled to the matching federal funds that the Medicaid Act promises if they comply with the terms of the law, but they are not entitled to higher federal funding with no responsibilities.

Surely this is not the experiment of the states that the Court (or anyone else) envisioned—state deviation based on budgetary shortfalls.²⁰⁸ This kind of variation is neither normatively useful nor posi-

204 See, e.g., FEELEY & RUBIN, *supra* note 16, at 74. Medicaid has shown itself to be an example of this kind of federalism: it is a program that could be decentralized, but that does not require geographic sub-units empowered to make independent policy decisions.

205 A modern example of welfare medicine, CHIP, shows that the states would be likely to overspend block grants significantly. See Kaiser Comm’n on Medicaid & the Uninsured, *A Decade of SCHIP Experience and Issues for Reauthorization*, THE HENRY J. KAISER FAMILY FOUND. 2–3 (Jan. 2007), <http://www.kff.org/medicaid/upload/7574.pdf> (explaining that despite state efforts to increase coverage, fiscal pressures and documentation requirements undermined that goal, necessitating an increase in federal funding for CHIP’s continued viability). CHIP was renewed with expanded federal funding because the states could not manage their CHIP budgets well. See Children’s Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 8.

206 Teresa A. Coughlin & Stephen Zuckerman, *States’ Strategies for Tapping Federal Revenues: Implications and Consequences of Medicaid Maximization*, in FEDERALISM AND HEALTH POLICY, *supra* note 14, at 145, 145 (describing policies developed by states to achieve a maximum return in federal funding for a minimum investment of state funds to finance Medicaid).

207 See, e.g., American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (extended by Pub. L. No. 111-226, 124 Stat. 2389 (2010)) (making supplemental appropriations for areas including state Medicaid funding).

208 See Henry Aaron, *Health Reform and Federalism: Henry Aaron’s View*, HEALTH AFF. BLOG (Mar. 11, 2011, 10:25 AM), <http://healthaffairs.org/blog/2011/03/11/health-reform-and-federalism-henry-aarons-view> (noting that, at the beginning of the recession in the

tive for the program, as it leads to wild fluctuations in access to and quality of care for Medicaid enrollees.²⁰⁹ State experimentation has resulted in some success in terms of such challenges as incorporating managed care into Medicaid to cover more enrollees, but it seems more and more that states seek to experiment so they can cut services or enrollment. This has no value for Medicaid enrollees, who seem to have gotten lost in the federal-state ideological battle over Medicaid.

IV. CHOOSING A DIFFERENT PATH—FEDERALIZE MEDICAID COMPLETELY

PPACA federalized Medicaid from both a philosophical and an economic perspective. Fully federalizing Medicaid would halt the contentious debate about states' rights in a national healthcare program. Federalization would create a more coherent, consistent, and equal program for the poor, who often experience uneven, substandard care by overworked and underpaid healthcare providers. Moreover, in many ways, Medicaid is largely already federalized considering the level of federal spending for all healthcare and the ways in which medical standards have steadily been nationalized. This part explores some reasons that federalizing Medicaid would be an improvement over the current structure, first by noting the ways in which Medicaid is already federalized, then by describing why federalization would be beneficial.

A. Steps Already Taken

1. Federal Funding

Most of the cost of Medicaid already is paid by the federal government, despite the cooperative federalism status of the program. The federal match varies from 50% to 75%, with an average of about 57%.²¹⁰ These percentages do not include the supermatch for

early 2000s, the states immediately stopped their experiments in health reform and started asking the federal government for funding).

209 See John Holahan, *Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?*, in *FEDERALISM AND HEALTH POLICY*, *supra* note 14, at 111, 136 (“[T]he existing federal-state financing structure has left the United States with serious inequities in regard to health care.”).

210 See EVELYNE P. BAUMRUCKER, CONG. RESEARCH SERV., RL 32950, *MEDICAID: THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) 13–14* (2010) (listing the federal medical assistance percentages for each state in fiscal year 2011). This percentage will be higher when the Medicaid expansion is complete. See *id.* at 11.

PPACA's new Medicaid enrollees or such special state fiscal relief as that provided in the American Recovery and Reinvestment Act of 2009 (ARRA),²¹¹ which increased the FMAP for all states from a low of about 62% in thirteen states to a high of almost 85% for Mississippi.²¹² In addition to matching the states' expenditures for medical services, the federal government pays more than 50% of state administrative costs for Medicaid, as was described above.²¹³

Looking beyond Medicaid, the federal government currently pays for a substantial portion of the healthcare costs in the United States.²¹⁴ The indicators of the federal government's share of healthcare expenditures vary depending on the factors one considers, but the Centers for Medicare and Medicaid Services ("CMS") conveys measurements each year that are useful. CMS reports that national healthcare expenditures ("NHE") currently account for about 18% of the nation's gross domestic product.²¹⁵ While this percentage does not correlate directly to the federal government's payments for healthcare, it suggests the national status of the "medical industrial complex."²¹⁶ In direct payments for healthcare, federal dollars account for about 34% of NHE.²¹⁷ This accounts for Medicare, Medica-

211 See American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, 123 Stat. 115 (2009).

212 BAUMRUCKER, *supra* note 210, at 15–16 (charting the increased federal medical assistance percentages for states as a result of ARRA in fiscal year 2009); see also Henry J. Kaiser Family Found., *Federal Medical Assistance Percentage (FMAP) for Medicaid with American Recovery and Reinvestment Act (ARRA) Adjustments, FY2010*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparetable.jsp?ind=695&cat=4&sub=154&yr=133&typ=2> (last visited Oct. 23, 2011) (listing the post-ARRA federal medical assistance percentages for the states).

213 See *supra* notes 78–80 and accompanying text; see also APRIL GRADY, CONG. RESEARCH SERV., RS 22101, STATE MEDICAID PROGRAM ADMINISTRATION: A BRIEF OVERVIEW 2 (2008) (noting that the administrative match does not vary like the FMAP, and remains 50% with some exceptions for certain state activities that receive designated higher federal funding).

214 See Abigail R. Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 861–62 (2009) (explaining that, in addition to Medicaid, the federal government also contributes to payment for medical care in the United States through Medicare, CHIP, and targeted tax breaks, amounting in sum to about 40% of total national health expenditures).

215 *NHE Fact Sheet, National Health Expenditure Data*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp (last updated June 14, 2011).

216 See Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 963 (1980) (exploring the development of what the author calls the "new medical-industrial complex," an industry providing health-care services for profit, including the rise of proprietary hospitals and diagnostic laboratories, comprised of manufacturers of pharmaceuticals and medical equipment).

217 See *NHE Fact Sheet*, *supra* note 215 ("The federal government share of health care spending increased just over three percentage points in 2009 to 27 percent, while the shares of

id, CHIP, and military healthcare programs, but not the Federal Employees Health Benefits (“FEHB”) program.²¹⁸ FEHB appears to add about \$28 billion to the health expense tally.²¹⁹

Interestingly, the CMS numbers also show that the administrative cost of Medicaid (\$18.2 billion) is much higher than the administrative cost of Medicare (\$7 billion).²²⁰ Though CMS does not explain the disparity, at least one reason is apparent. The federal government’s payment for states’ administrative costs in addition to administering Medicaid at the federal level creates a double executive structure that is inherently inefficient. The higher federal matching for utilization review, immigration documentation checks, MFCUs, and other items creates additional double expenses.²²¹ The issue of administrative costs will be discussed further below.

The CMS report on NHE does not report other kinds of federal healthcare expenditures. Indirect payments would include such costs as the tax subsidies that incentivize employers to provide health insurance as an employment benefit. The 2010 estimate of lost income taxes from individuals’ exemption for employers’ contributions to health insurance is reported to account for about \$105.7 billion.²²² When added to direct expenditures, this brings the federal government’s share of NHE to almost 40%. And numerous such subsidies exist, such as the tax-exempt status of hospitals and the resulting tax-free bonds they can procure for development, which accounted for

spending by households (28 percent), private businesses (21 percent) and state and local government (16 percent) fell by about 1 percentage point each.”); Medicare, Medicaid, CHIP, Department of Defense, and Department of Veterans’ Affairs expenditures totaled \$839.3 billion in 2009. *Table 3: National Health Expenditures, Levels and Average Annual Growth from Previous Year Shown by Source of Funds, Selected Calendar Years 1960–2009*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, available at <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>. This is about 34% of NHE, which was about \$2.4 trillion total. *Id.*

218 *Id.*

219 OFFICE OF PERS. MGMT., CONGRESSIONAL BUDGET JUSTIFICATION: PERFORMANCE BUDGET 21 (2010) (estimating that in FY 2010, the federal government would contribute about 70% of premium costs in FEHB, about \$28 billion). When FEHB is added to the sum of federal contributions to healthcare, the federal government pays about 36% of NHE.

220 *Table 4: National Health Expenditures, by Source of Funds and Type of Expenditure: Calendar Years 2003–2009*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, available at <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

221 See GRADY, *supra* note 213, at 2–3 (listing various administrative functions with federal matches higher than 50%).

222 JOINT COMM. ON TAXATION, ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2010–2014, at 47 (2011), available at <http://www.jct.gov/publications.html?func=startdown&id=3717> (charting the calculated magnitude of the exclusion from income tax of employer contributions for health care, health insurance premiums, and long-term care insurance premiums).

about \$500 million dollars in 2010.²²³ The list of such exclusions, deductions, and other special tax treatments is reported every four years to the House of Representatives, and it is considerable.²²⁴ In 2002, Woolander and Himmelstein estimated that the federally financed share of health spending was 40%; they reached this number by accounting for the indirect spending through tax redistribution (such as that detailed in this paragraph), which they described as “tax financed” health spending.²²⁵ This percentage would likely be higher today due to increased use of such tax-free vehicles as flexible spending accounts.

The numbers show that the federal government is already responsible for a large portion of health spending. Though the states were once the locus of medical regulatory and financial activity, that is no longer the case. The federal government and the states each play roles in American healthcare, but the federal role grows by the year. Medicaid seems to be an area where the states cling to their historic welfare medicine role, yet they have not been able to afford that task for decades upon decades.

2. *Medical Standards*

The practice of medicine is increasingly nationalized, but Medicaid enrollees live in a world subject to local rules by virtue of variations in state policy.²²⁶ Medicaid should reflect the ever more national nature of the practice of medicine, which can be seen through a few examples of the move from local practice standards to national standards of care.²²⁷

First, people who obtain a medical doctor degree and who want to practice medicine in this country must pass the U.S. Medical Licens-

223 *Id.* at 48.

224 *See id.* at 47–49 (providing data on various health-related exclusions, deductions, and other special tax treatments).

225 Steffie Woolhandler & David U. Himmelstein, *Paying for National Health Insurance—And Not Getting It*, 21 HEALTH AFF. 88, 91–92 (2002) (noting that if state and local tax-financed health spending are included, the government pays for 59.8% of healthcare expenditures, which counters the public perception that our healthcare system is private in nature).

226 *See* Holahan, *supra* note 209, at 136 (“[T]he existing federal-state financing structure has left the United States with serious inequities in regard to health care.”).

227 *See generally* Moncrieff, *supra* note 214 (arguing for federal malpractice reform proposals to address the increasing extent to which the federal government shoulders malpractice policy costs externalized by the states).

ing Examination (“USMLE”).²²⁸ This standardized exam is administered by the National Board of Medical Examiners, a body comprised of physicians from across the country, and the exam is created and graded by a nation-wide body of physicians.²²⁹ Every state requires the USMLE as a condition of licensure, and states may vary in other licensure requirements,²³⁰ but the USMLE reflects the idea that medicine has become a science with uniform, national standards.²³¹ In addition to the USMLE, consider the ease with which doctors trained in Massachusetts, Connecticut, or Maryland will practice in Kansas, Montana, or California. Doctors are not trained within a state to practice only within that state’s borders. Granted, many doctors practice medicine within only one state, but even that is changing with the rise of telemedicine as a method to reach medically underserved areas and to spread the expertise of certain specialists.²³²

Second, national medical standards have been recognized in medical malpractice litigation. This is not a perfect proxy for the nationalization of medical treatment, but it is a serviceable microcosm that has existed for decades. For the first part of the 1900’s, medical liability litigation relied on local medical standards, as physicians argued that the practice of medicine was an art as well as a science that varied by physician, by local practice standards, and by resources. Medical

228 See *About USMLE*, U.S. MED. LICENSING EXAMINATION, <http://www.usmle.org/about/> (last visited Oct. 23, 2011) (explaining how the USMLE acts as a common evaluation system for applicants to the state medical boards by assessing “a physician’s ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care”).

229 See *2011 USMLE Bulletin—Overview*, UNITED STATES MED. LICENSING EXAMINATION, <http://www.usmle.org/bulletin/overview> (last visited Oct. 23, 2011) (providing general background information on the USMLE, its purposes, and its development).

230 *Medical Licensure, Becoming a Physician*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/education-careers/becoming-physician/medical-licensure.shtml> (last visited Oct. 23, 2011) (noting that, despite some variation in state licensing requirements, all states require proof of successfully completing all stages of the USMLE, or its equivalent for individuals licensed before the USMLE was implemented in 1994). One could argue that state licensure requirements and oversight of state medical boards militate toward state dominance of the practice of medicine, but the historic role of the states seems to be diminishing in light of such trends as nationalized standards.

231 This is unlike the case for lawyers, though the legal profession is trying to nationalize its licensing process through a Uniform Bar Examination. See, e.g., *Uniform Bar Examination: Jurisdiction News*, NAT’L CONFERENCE OF BAR EXAMINERS (Mar. 2011), <http://www.ncbex.org/single-news-item/article/58/27/> (listing uniform bar examination jurisdictions).

232 See, e.g., Heather L. Daly, *Telemedicine: The Invisible Legal Barriers to the Health Care of the Future*, 9 ANNALS HEALTH L. 73, 79–80 (2000) (describing the benefits of telemedicine, including increased ability to reach remote areas and wider access to medical specialists).

malpractice standards were governed by “locality” rules until about 1967, when courts started to recognize that doctors were held to national practice standards with variation for resources and hardships imposed by locale.²³³ Granted, the locality rule is more about testifying in medical malpractice cases than it is about actually setting national standards, and tort law is state law, but it also speaks to the essentially uniform training that physicians receive and the nationalization of standards of care through medical education and certification processes.

Third, the Emergency Medical Treatment and Labor Act (“EMTALA”) has strengthened the trend toward understanding the practice of medicine as national in scope rather than a local, varied “art.”²³⁴ EMTALA requires hospitals that have emergency departments and that accept Medicare as reimbursement for their services to screen and stabilize every patient who presents an emergency medical condition regardless of the person’s ability to pay.²³⁵ Patients who believe that EMTALA has been violated in their treatment (or lack thereof) can sue the hospital that allegedly wronged them in federal court. This litigation has produced a consensus that screening is sufficient so long as the hospital follows its own screening procedures, but treatment is subject to national standards of care.²³⁶ EMTALA too points toward recognition that patients should receive a certain scientific, nationally recognized standard of care.²³⁷

Why, then, is it acceptable for poor patients to receive highly varied forms of care in different states depending on that state’s Medicaid policy? Patients who are able to pay for their care would not to-

233 See, e.g., *Pederson v. Dumouchel*, 431 P.2d 973, 977–98 (Wash. 1967) (rejecting the locality rule for malpractice liability in favor of a rule defining the standard of care as that expected of the average practitioner in the relevant field, acting in the same or similar circumstances).

234 See Emergency Medical Treatment and Labor Act (“EMTALA”), 42 U.S.C. § 1395dd (2006) (describing national requirements for examination and treatment of emergency medical conditions).

235 *Id.*; see also *EMTALA Overview*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/EMTALA/> (last updated June 15, 2011) (giving an overview of the requirements imposed by EMTALA on Medicare-participating hospitals that offer emergency services).

236 See, e.g., *Baber v. Hosp. Corp. of America*, 977 F.2d 872, 880 (4th Cir. 1992) (listing various other jurisdictions agreeing with the court’s conclusion that screening should comport with the screening that hospital would have given to any patient, whether private pay, public pay, or indigent).

237 42 U.S.C. § 1395dd (“[T]he hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department . . .”).

lerate being subject to state ‘experimentation’ with their medicine;²³⁸ it seems absurd that patients should be subjects of the laboratory of the states because of their poverty. This variation speaks volumes about the devalued status of the health of the poor. One of the arguments for keeping states in the Medicaid program is that studies show medical practices vary across the country. But, importantly, these studies do not show that practices vary by state, just that variations exist.²³⁹ The assumption that the states are an effective organizational principle for delivery of healthcare is too simple; after all, a diabetic’s need for a kidney transplant does not change when she crosses the line between Arizona and New Mexico, but only one state covers the procedure in its Medicaid program.

B. Reasons to Forge a New Path

Medicaid has long been the second largest portion of state budgets (education is first).²⁴⁰ States often expand Medicaid when the economy is strong, adding benefits, adding categories of eligible enrollees, adding to existing benefits, and advertising the availability of Medicaid coverage.²⁴¹ But when recessions hit, states struggle to fund their Medicaid programs at the very moment that the enrollment swells due to job losses.²⁴² When hard times hit, states then attempt to remove the expansion populations from their Medicaid rolls, which is part of the reason PPACA contained a “maintenance of

238 Some exceptions may exist—for instance, surrogacy laws, medical marijuana, and physician assisted death—but these are not elements of basic care that are subject to varying state policy. Interestingly, these state-based variations appear to benefit wealthier patients who can obtain access to both the exotic medical care and the lobbyists needed to create special state laws.

239 See Marilyn Moon, *Making Medicaid a National Program: Medicare as a Model*, in *FEDERALISM AND HEALTH POLICY*, *supra* note 14, at 325, 332–34 (arguing that variation in states’ respective Medicaid programs is in part a result of their willingness or hesitance to experiment with innovation).

240 Boyd, *supra* note 200, at 59 (“[S]tate governments spend more of their own funds on health care than any other function except elementary and secondary education; when federal funding is included, states spend more on health care than on any other function, including education.”).

241 *See id.* at 60 (explaining that fiscal windfalls during the 1990s allowed states to easily fund Medicaid and other health care programs).

242 *See generally* Kaiser Comm’n on Medicaid & the Uninsured, *Key Questions About Medicaid and Its Role in State/Federal Budgets and Health Reform*, THE HENRY J. KAISER FAMILY FOUND. 2–3 (Jan. 2011), <http://www.kff.org/medicaid/upload/8139.pdf> (“Medicaid costs are driven largely by increases in enrollment. . . . This is especially true during economic downturns, when unemployment rises and incomes fall, increasing the number of low-income people eligible for Medicaid.”).

effort” provision.²⁴³ So, states often seek additional funding from the federal government, and without these additional funds, many states would be unable to pay for their Medicaid programs.²⁴⁴

States seem to be aware of this economic quagmire and to resent it. On the one hand, they ask for additional funding for Medicaid, knowing that the program is necessary. On the other hand, they ask for more freedom in Medicaid, understanding that more federal funding generally leads to greater federal control of the program. This schizophrenic behavior is on display in the briefs states have submitted in their challenges to PPACA. Some states argue that the PPACA expansion of Medicaid is indispensable to cut their costs for the uninsured in the healthcare system. Others argue that PPACA is coercive under the *Dole* test because it is too expensive, even though the federal government totally funds the enrollment increase initially and then provides a supermatch.²⁴⁵

Federalizing Medicaid would end the economic fluctuations that have a direct effect on Medicaid enrollees’ health. Enrollees rely on the Medicaid program for access to healthcare more than others in the population due to their poverty.²⁴⁶ If a state cuts its Medicaid budget and chooses not to cover certain services in the pursuit of maintaining fiscal integrity, Medicaid patients do not receive needed care. For example, Arizona made national headlines when it cut transplant services from its Medicaid program late in 2010, a decision that was clearly fiscal (it also cut basic services such as annual physicals).²⁴⁷ It appears that at least one Medicaid enrollee has now died due to this change in the Arizona program.²⁴⁸ Other states have responded to the recession by cutting provider payments, which are already quite low, and by cutting prescription drugs and other “option-

243 PPACA § 2001(b).

244 The renewal of the ARRA funding for Medicaid is a microcosm of this phenomenon.

245 See, e.g., Memorandum in Support of Plaintiff’s Motion for Summary Judgment, *Florida ex rel. Bondi v. U.S. Dep’t of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT (N.D. Fla. Jan. 31, 2011), 2011 WL 285683 (arguing that the PPACA is unlawfully coercive of the states under *Dole* and imposes “billions of dollars of unaffordable new costs”).

246 See Finkelstein et al., *supra* note 7, at 29 (finding that low-income individuals afforded health care coverage through the Oregon state health care lottery program reaped benefits not experienced by their uninsured counterparts).

247 See Kevin Sack, *Arizona Medicaid Cuts Seen as a Sign of the Times*, N.Y. TIMES, Dec. 4, 2010, <http://www.nytimes.com/2010/12/05/us/05transplant.html?ref=arizona> (“The cuts in transplant coverage . . . are testament to both the severity of fiscal pressures on the states and the particular bloodlessness of budget-cutting in Arizona.”).

248 Mary K. Reinhart, *2nd Person Denied Arizona Transplant Coverage Dies*, ARIZ. REPUBLIC, Jan. 5, 2011, <http://www.azcentral.com/news/articles/2011/01/05/20110105arizona-second-patient-denied-coverage-dies.html>.

al” Medicaid benefits.²⁴⁹ Medicaid enrollees are statistically in fragile health, more likely to suffer from chronic conditions and disabling conditions, and less likely to receive high-level care due to provider reluctance to participate in a low-paying program. It is disingenuous to call cutting benefits for budgetary savings a form of state experimentation.

States have argued that they merely provide health insurance to Medicaid enrollees, detaching themselves from responsibility for the actual care provided, especially when very low provider reimbursement has led to sub-standard care. Some federal courts bought this argument, despite the language in the Medicaid Act indicating that the program is intended to provide care, not just payment services. PPACA declares that Medicaid provides medical care to its enrollees, rather than merely being a payor for their services.²⁵⁰ Theoretically, this should make budget cuts harder. If states only act as insurers, then the leeway that the Medicaid Act provides them in making reasonable payments would allow states to pay even lower rates than they already do with little accountability for the lack of providers willing to participate in the program. But if Medicaid is designed to provide care, then the reasonable payment requirement means that states have to pay enough for medical care to actually be delivered to Medicaid enrollees. This should mean that states will reimburse providers enough that they will willingly participate in Medicaid and not leave the program.

In a post-recession economy, this is unlikely to be the case. States are cutting payments and services because they cannot cut eligibility (a requirement of the ARRA and other additional funding that the states have received during the recession). Interestingly, state flexibility in provider payment is an issue that the Supreme Court will hear this term.²⁵¹ As ominous as these financial decisions are, pointing fingers is not fruitful, as states often must maintain balanced budgets pursuant to provisions in state constitutions (a requirement

249 See Sack, *supra* note 247. Arizona was the only state to cut transplant benefits, and its savings for doing so seems small compared to the size of the state budget deficit: \$1.4 million in savings for a \$2.6 billion deficit. *Id.*

250 PPACA § 2304. This responds to federal court decisions that had held that Medicaid was simply a payor. See, e.g., *Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1215 (10th Cir. 2007) (holding that the state of Oklahoma was only required to pay for statutorily outlined services, not to provide those services), *cert. denied*, 552 U.S. 813 (2007).

251 *Indep. Living Ctr. of S. Cal. Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009), *cert. granted*, 131 S. Ct. 992 (Jan. 18, 2011) (No. 09-958). The case was heard October 3, 2011, the first day of oral arguments for the October 2011 term.

that does not exist in the U.S. Constitution), and so states make hard choices in fulfilling their state constitutional responsibilities. This revolves to the problem of political and financial lock-in. But it seems that we have tested all of the cooperative federalism incarnations for Medicaid.

In addition to facilitating equality, federalization would have great administrative benefits. It would be more efficient for Medicaid providers and enrollees to deal with one executive branch rather than two, to deal with one set of payment policies, and to have reimbursement based on policy considerations rather than state economic conditions.²⁵² The potential administrative and thus economic savings can be seen in the comparison of Medicare and Medicaid administrative expenses provided above; Medicaid's administrative costs are more than two and a half times Medicare's. Additionally, administrative processes such as the waiver process, which take time and money, would cease.

Federalization could also reduce total costs in a variety of ways, such as by eradicating state costs, reducing federal administrative costs, and ending state incentives to game the federal match in order to increase their federal funding.²⁵³ Section 1983 lawsuits against the states to enforce Medicaid entitlements would cease and also result in cost savings.²⁵⁴ Also, the two levels of fraud prosecution would no longer need to be maintained, though they already seem redundant when the federal government is so successful at ferreting out fraud in federal healthcare programs (and often takes over state investigations into fraud).²⁵⁵ As well, states' costs for covering the uninsured for hospitals will be reduced by creating national equality in Medicaid, which PPACA will partially achieve in its enrollee expansion.²⁵⁶ These

252 See Moon, *supra* note 239, at 330 (arguing that nationalization would simplify the program resulting in saved costs and equalization of enrollee care).

253 See Boyd, *supra* note 200, at 63 (“[S]tates have exploited a number of loopholes . . . to draw down additional federal funds while spending little, if any, of their own money. Thus, Medicaid is a source of revenue as well as an area of spending.”).

254 PPACA instructs the Government Accountability Office (“GAO”) to investigate Section 1983 causes of action against states for Medicaid failures. PPACA § 10201(j). See generally Huberfeld, *Bizarre Love Triangle*, *supra* note 14 (discussing the role of 42 U.S.C. § 1983 as a means to enforce federal statutory rights against the states within the Medicaid context).

255 See, e.g., News Release, U.S. Dep’t of Health & Human Servs., Health Care Fraud Prevention and Enforcement Efforts Recover Record \$4 Billion; New Affordable Care Act Tools Will Help Fight Fraud (Jan. 24, 2011), available at <http://www.hhs.gov/news/press/2011pres/01/20110124a.html> (announcing a record high recovery from individuals seeking to defraud the health care system, resulting in money saved for taxpayers).

256 See Memorandum from Richard S. Foster, *supra* note 104, at 12 (“The net impact of the Medicaid and CHIP provisions on State Medicaid costs is a reduction totaling \$33 billion through fiscal year 2019.”).

are just a few examples of the practical and economic efficiencies nationalization could achieve.

It seems like the traditional federalism rationales no longer apply in the case of Medicaid (if they ever did). Revisiting the *Gregory v. Ashcroft* four core values, we see that none of the values are a good fit, and the reasons for nationalizing are much stronger. To wit: First, “decentralized government that will be more sensitive to the diverse needs of a heterogeneous society” is not a strength in Medicaid, a healthcare program that is supposed to provide equal access to mainstream medicine. Mainstream medicine is largely nationalized, with variations existing for location, lack of resources, and lack of skill. But the states are very imprecise proxies for these issues (think of the difference between the metropolis of New York City and upstate, rural New York close to New Hampshire and Vermont—vastly different resources, populations, etc., but both within the same state).

Second, the “opportunity for citizen involvement in democratic processes” is not particularly meaningful with a population that is notoriously politically invisible. The poor who enroll in Medicaid are often de facto disenfranchised. If they were politically powerful, they might have achieved the nationalization that senior citizens demanded when Medicare was created. Instead, Medicaid has been on the “state program with federal oversight” path since 1965, and even earlier, because its participants are not able to influence political processes.²⁵⁷

Third, and perhaps most important, “innovation and experimentation in government” has resulted in wild inequality and little learning by example from state to state. Though some states, such as New York, Massachusetts, and Maine, have managed to successfully expand their programs through waivers, most states now use waivers to cut costs by cutting benefits. This phenomenon is especially true during an economic downturn and very poorly timed under those circumstances. The counter-cyclical spending that the federal government can provide has been used to stabilize Medicaid for years, and the states have yet to find their own way to pay for Medicaid. Nationalization could at least raise the minimum care for Medicaid enrollees. If states want to provide a kind of wraparound additional benefit, they could do so with their own funds. Federal incentives to the

²⁵⁷ Kate Pickert, *What if All 50 States Get Ben Nelson's Medicaid Deal?*, TIME, Jan. 15, 2010, <http://www.time.com/time/politics/article/0,8599,1954158,00.html>. (quoting Gail Wilensky, a health care economist, regarding the Medicaid expansion).

states to provide more should be avoided; that just reintroduces the cooperative federalism morass.

And fourth, instead of making “government more responsive by putting the States in competition for a mobile citizenry,” states seem to try to ensure that they provide fewer benefits than their neighbors in a race to the bottom. Recall that the original Medicaid coverage was designed to equalize not only access to medical care but also the care provided to the poor. Nationalizing Medicaid would facilitate “mobile citizenry” by ensuring the same medical benefits when a person crosses state lines.

V. CONCLUSION

PPACA began the task of federalizing Medicaid from both a philosophical and an economic perspective. Medicaid’s cooperative federalism structure was the product of history and path dependence, not a deliberate process by Congress. Though Medicaid will cover all poor, not just the deserving poor, if the Eleventh Circuit’s decision is not overturned, this is only a piece of the puzzle. The debate that exists regarding Medicaid and states’ rights draws the wrong conclusion. If the states are right that they are being coerced, the answer could be that the federal government should nationalize Medicaid rather than to continue to negotiate with the ungrateful states. Further, this debate is overly formalistic, as federalizing Medicaid would have numerous benefits that help us to see past this amendment to the program to the bigger picture benefits of breaking from this path.

Medicaid enrollees receive differing access to medical care depending on only their geography. State experimentation with healthcare was rejected for the elderly in 1965, and yet states’ rights burden Medicaid operations to this day. The only reason for the disparity between the programs is the lack of political will that has been Medicaid’s albatross, despite polls that show a majority of Americans support a strong Medicaid program.²⁵⁸ Medicaid’s cooperative federalism structure undermines a program that is a necessary safety net; that safety net would be much stronger if it were federalized.

²⁵⁸ See *Kaiser Health Tracking Poll*, THE HENRY J. KAISER FAMILY FOUND. 1 (May 2011), <http://www.kff.org/kaiserpolls/upload/8190-F.pdf>. (demonstrating that reducing Medicaid coverage, as well as blocking grants for Medicaid, is unpopular with the public, even in the face of economic crisis).