2002

The "New Federalism" Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health

Dayna Bowen Matthew

*University of Kentucky*

Follow this and additional works at: [https://uknowledge.uky.edu/klj](https://uknowledge.uky.edu/klj)

Part of the [Health Law and Policy Commons](https://uknowledge.uky.edu/klj)

Right click to open a feedback form in a new tab to let us know how this document benefits you.

**Recommended Citation**


Available at: [https://uknowledge.uky.edu/klj/vol90/iss4/10](https://uknowledge.uky.edu/klj/vol90/iss4/10)

This Article is brought to you for free and open access by the Law Journals at UKnowledge. It has been accepted for inclusion in Kentucky Law Journal by an authorized editor of UKnowledge. For more information, please contact UKnowledge@lsv.uky.edu.
The "New Federalism" Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health

BY DAYNA BOWEN MATTHEW*

I. INTRODUCTION

Since its inception in 1965, the Medicaid program has been at the center of a pendulous dance between the federal and states' governments that jointly control its funding and administration. Strong federal oversight and policy control marked the Medicaid program initially. However, from its inception the Medicaid program allowed states considerable flexibility through various waiver programs.¹ From 1981 to roughly 1990, the states increasingly gained the power to exercise discretion in administering Medicaid to their neediest citizens.² In 1990, the


² Originally enacted in 1980, the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2650 [hereinafter ORA 1980], set the standard for reimbursement of nursing and intermediate care facilities and then in 1981 the
federal judiciary stepped in to quell excesses and abusive administrative practices by the states. In 1993, President Clinton began responding to states’ call for independence and relief from Federal Medicaid oversight, urging the Department of Health and Human Services to streamline the process for states to obtain § 1115 waivers. By 1995 the process for relaxing federal restrictions had so developed that states met few barriers as they began contracting with managed care providers to reduce the cost of their Medicaid Programs. The result was an unprecedented and rapid transition from traditional to managed care based delivery systems serving the Medicaid populations. By 1998, more that fifty-three percent of all Medicaid beneficiaries nation-wide were enrolled in managed care health plans. In 1997, Congress enacted the Balanced Budget Act of 1997 ("BBA") which returned considerable power to states to manage their respective health care “safety nets” using federal Medicaid dollars. The BBA allowed states wishing to institute mandatory managed care enrollment for Medicaid beneficiaries to do so automatically without seeking Federal waivers. Also, the BBA gave states increased latitude in

Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173, 95 Stat. 808 [hereinafter OBRA 1981], extended the reimbursement to hospitals. The Boren Amendment requires reimbursement according to rates that a “State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to . . . services of adequate quality.” 42 U.S.C. § 1396a(a)(13)(A) (1994). Later, the Boren Amendment’s reimbursement standard was applied to payments made to intermediate care facilities for the mentally retarded. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4211(h)(2)(A), 101 Stat. 1330-205 [hereinafter OBRA 1987].

3 See Wilder v. Va. Hosp. Ass’n, 496 U.S. 498 (1990) (The Court recognized health providers had a privately enforceable right to enforce the Boren Amendment in an action against state governments pursuant to 42 U.S.C. § 1983 by holding that “[t]here can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment.”). Id. at 510.

4 Two types of Medicaid waivers allowed states to bypass the federal Medicaid restrictions during the early 1990s in order to enroll their citizens in managed care programs. By 1998, thirty-five states operated mandatory managed care enrollment using section 1915(b) “Freedom of Choice” waivers while another seventeen states operated Section 1115 Research and Demonstration projects.

establishing most providers' reimbursement rates. The pace of the federalism dance music continues to quicken.

On January 19, 2001, the eve of its departure from Washington, D.C., the Clinton Administration promulgated a series of Medicaid regulations that ostensibly granted states greater flexibility in managing their Medicaid programs, but also significantly strengthened federal requirements for states enrolling Medicaid beneficiaries in managed care and prepaid health plans. One month later, the new Bush Administration froze the stronger federal regulations enacted by its predecessors and in another six months once again returned increased authority and discretion in the administration of the Medicaid program to the states.

In August 2001, the Bush Administration announced it would amend the Medicaid Managed Care and State Children's Health Insurance Program ("SCHIP") regulations promulgated in January 2001. The Clinton-era Medicaid regulations, now repealed, had as their stated objective "to allow for greater flexibility for State agencies to participate in Medicaid managed care programs and provide greater beneficiary protections and quality assurance standards." At the same time, the Clinton rule

---

6 Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4712, 111 Stat. 509 (1997). (The Balanced Budget Act of 1997 ("BBA") repealed the Boren Amendment, and thus the statutory language that entitled providers to a legally enforceable interest in reasonable reimbursement rates. In its place, the BBA enacted a provision controlling only the rate setting process used by the states, not the reimbursement rates themselves. The BBA does, however, require states to ensure medical care accessibility and it exempts disproportionate share hospitals ("DSH") those that serve a disproportionate share of Medicaid beneficiaries—from the more relaxed BBA rate regulations. The BBA also provided that "a state may require an individual who is eligible for medical assistance . . . to enroll with a managed care entity as a condition of receiving such assistance." See 42 U.S.C. § 1396u-z (1998); see also Managed Care Provisions, 63 Fed. Reg. 52,022 (1998).


8 Id. at 6397 ("Summary of the Final Rule"); see also Joel M. Hamme, The Second Clinton Administration: The Future of Long-Term Care Reimbursement Under the Medicaid Program, 3 HEALTH L. PRAC. GUIDE § 33:8 (2001) (observing that the BBA Medicaid reform "halts and reverses the trend toward federalization of the Medicaid program."). Passed in 1997 under the Clinton Administration, the Medicaid reforms contained in the BBA were projected to save the program $14.6 billion over the five years following the changes. These reforms included repeal of the Boren Amendment, thus allowing states increased flexibility in setting rates for certain institutional providers, and the relaxation of the waiver process for states
proclaimed it "was developed with a clear emphasis on consumer protections." The Clinton regulations included implementing a grievance and appeal procedure for Medicaid managed care and prepaid health plan enrollees; setting disclosure requirements to inform enrollees of their choices in their own language; requiring ongoing quality assessment by state agencies of their Medicaid managed care programs to ensure they met access of care standards, continuity of care and grievance procedure standards; and expanding guaranteed eligibility standards.10

Tommy G. Thompson, Department of Health and Human Services ("DHHS") Secretary, announced a new interim rule on August 17, 2001.11 Explaining that the Clinton Administration rules "went far beyond what Congress intended . . . and its excessive mandates actually threatened beneficiaries' access to care under Medicaid,"12 Thompson said the Bush proposal revises the grievance and appeals process, information disclosure requirements and screening and assessment deadlines set by the Clinton regulations.13

According to consumer advocates, the new Bush Administration rules will weaken patient protections and favor state governments and managed care organizations.14 The Administration, on the other hand, describes these changes as measures that afford states more "flexibility" in managing their wishing to implement managed care systems for Medicaid recipients. At the same time, the BBA implemented the State Children’s Health Insurance Plan ("SCHIP") to provide health insurance to poor and nearly poor children at an estimated cost of $24 million between 1998-2002. Id.

9 See Final Rule (with Comment Period), supra note 7, at 6229.
10 Id. at 6397-6402.
12 Combs, supra note 11.
13 See id. The Bush Administration’s "new" proposed rule, with the exception of sections described in the text, largely re-issues the Clinton final rule, but allows time for comment:

Alternatives Considered

We considered allowing the January 19, 2001 final rule with comment to become effective as published, after the two 60-day delays in effective date for Department review. However, the serious concerns raised by some key stakeholders, especially regarding changes made to the final rule that had not been included in the proposed rule, led us to decide to develop a new proposed rule.

14 See Combs, supra note 11.
Medicaid programs and expanding Medicaid coverage. The revised rules were announced soon after Thompson attended a February 2001 meeting of the National Governors Association ("NGA") at which the Governors proposed "radical" changes in Medicaid. At that same NGA meeting, Thompson pledged to "completely refocus the relationship between the states and the federal government." Thus, the new Medicaid rules implement changes that are intended to shift the balance of power away from the federal government, towards state government and individuals. This article examines the likely public health impact that increased state control over Medicaid administration will have on poor, elderly and disabled Americans covered by the Medicaid program.

Part II begins with a brief historical summary of Medicaid's swings between federal and state control. Part III places Medicaid cases and regulation within the larger context of the new federalism, focusing first on the judicial strand of the doctrine as it applies to Medicaid administration and performance, and then on the legislative strand. Part IV examines what we already know about Medicaid enrollment trends and accessibility disparities among the states. This section develops the first thesis of this Article: The empirically predictable effect of increasing states' control over Medicaid will be decreased access to healthcare for the poor, young and disabled, in some states, and thus inevitably disproportionate harm to the

---

15 See, e.g., American Political Network, 6 AM. HEALTH LINE No. 9 (Aug. 6, 2001) ("The Bush administration this weekend announced a 'fundamental change' in Medicaid and the State Children's Health Insurance Program that would give states more flexibility in 'ensuring that their programs broaden coverage for low-income Americans.'"). See also Joanne Silberner, Analysis: White House Plan to Expand Health-Care Coverage to the Poor Without Spending More Money, NPR: MORNING EDITION, Aug. 29, 2001, 2001 WL 9328664 ("The administration's new policy, announced earlier this month, will allow states more flexibility in how they spend Medicaid funds.").


17 Id. Thompson further added:

First of all, many of you have some concerns about a number of regulations that were issued in the final days of the previous administration, most notably those on Medicaid Managed Care and the State Children's Health Insurance Program. We have heard your concerns, and today I am announcing that we are delaying the effective dates for both regulations for 60 days. During that time, we will consult with you, advocacy groups and health plans, and if changes need to be made, we will make them.

Id.
public health of those states' Medicaid populations. Part V reviews the Constitutional and historical definitions of federal and state public health powers and concludes with the Article's second thesis: Where the access to publically financed healthcare for America's poor, disabled, elderly and minority citizens is at issue, the federal government's Constitutional obligation may be to limit rather than to facilitate flexibility and autonomy of state governments administering the Medicaid program. A brief conclusion follows in Part VI.

II. MEDICAID AND THE "NEW" LEGISLATIVE\textsuperscript{18} FEDERALISM

The Medicaid program provides the nation's "safety-net" for poor and medically vulnerable individuals by forging a partnership between the federal and state governments to administer a means-tested, health insurance entitlement program to the needy. Begun in 1965 as a virtual afterthought\textsuperscript{19} to the Social Security Act's Medicare program,\textsuperscript{20} Medicaid\textsuperscript{21} was enacted as a part of President Lyndon Johnson's "Great Society" legislation\textsuperscript{22} to provide access to healthcare for America's poor, disabled and elderly.\textsuperscript{23} It was envisioned that by providing public health insurance, this law would remove financial barries to mainstream healthcare and thus

\textsuperscript{18} The legislative strand of the new federalism refers to "a congressional about-face in rethinking the presumption that national problems require a solution initiated or controlled by the federal government." Jeffrey A. Modisett, Discovering the Impact of the "New Federalism" on State Policy Makers: A State Attorney General's Perspective, 32 IND. L. REV. 141 (1998). A most recent and poignant example is, of course, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA"), Pub. L. No. 104-193, 110 Stat. 2105, which replaced the national welfare system with state block grant programs. Other examples, of course, are the legislative and regulatory Medicaid reforms summarized herein.

\textsuperscript{19} See Sara Rosenbaum & David Rousseau, Medicaid at Thirty-Five, 45 St. Louis U. L.J. 7, 8 (2001).


\textsuperscript{22} See BARRY R. FURROW ET AL., HEALTH LAW 562 (4th ed. 2001).

\textsuperscript{23} President Johnson stated in his first speech to Congress, "We are going to fight for medical care for the aged as long as we have breath in our bodies." Damon Henderson Taylor, Note, ERISA Preemption: Will the Elimination of the ERISA Preemption Clause Help or Harm America's Ability to Deal with its Pending Health Care Crisis?, 14 J.L. & HEALTH 133, 144 (1999-2000).
ensure access to better quality healthcare for the targeted groups. Initially, although Medicaid services were reimbursed jointly by the state and federal governments, the federal government exercised substantial control over states' administration of the program. In order to qualify to receive federal matching funds, states had to submit a "plan for medical assistance" which the DHHS Secretary had to approve. Each state's plan had to outline the proposal for providing medical care to its needy residents. The plan had to satisfy all the federal requirements and rules promulgated by DHHS in the process. Because of the size of its financial investment in state Medicaid programs, the federal government still oversees implementation and the overarching federal controls are still in place though the rigor with which many are enforced is greatly relaxed, especially in light of the federal waiver initiatives aggressively employed by the states.

Each plan must still satisfy federal criteria. Moreover, the federal government's general revenue finances the states' administration of the program, currently at over $100 billion annually, providing between fifty percent and nearly eighty percent of states' Medicaid budgets. The federal government, therefore, controls the program's purse-strings and states remain dependent upon this partnership with the national government to avoid astronomical increases in the numbers of uninsureds among their citizenry. However, over the past twenty years, states have gradually been given increasing flexibility to design and manage their own Medicaid programs. The federal government sets the mandatory and optional

24 Jon R. Gabel & Thomas H. Rice, Reducing Public Expenditures for Physician Services: The Price of Paying Less, 9 J. HEALTH POL. POL'Y & L. 595, 597 (1985). But see John V. Jacobi, Missions and Markets in Health Care: Protecting Essential Community Provides For the Poor, 75 WASH. U. L.Q. 1431, 1437 (1997) (arguing that both the mainstreaming and egalitarian goals of the original framers of Medicaid program have been compromised by subsequent amendments to the statute Jacobi concludes the original vision was vague).
26 Id.
27 See infra notes 38-48 and accompanying text for a discussion of these waiver initiatives. See also 103d Cong., 1st Sess., Medicaid Source Book at 371 "Alternate Delivery Option and Waiver Programs" (1993).
28 MEDICAID CHARTBOOK 2000, supra note 5, at 31. In 1998, the last year for which reliable figures have been complied, federal Medicaid outlays totaled $101.2 billion. Combined federal and state Medicaid spending equaled $175.1 billion. Id. See also Rosenbaum & Rousseau, supra note 19, at 16.
29 See Rosenbaum & Rosseau, supra note 19, at 14 (without Medicaid, the number of uninsured persons would likely rise to near seventy million).
30 Under the Medicaid program, there has always been some degree of state flexibility: "Each state establishes its own eligibility standards, benefits package,
eligibility criteria for program participants by establishing the eligibility categories. However, the states set the income thresholds for these categories, and the resource requirements for their eligible populations. Under federal law, a rigidly defined mandatory benefits package must be available to Medicaid enrollees. States, however, may choose to offer coverage for a long list of optional additional benefits and services. Federal standards test whether the services offered in a state’s benefit package are reasonable. On the other hand, states have the freedom to set standards to qualify participating health care providers and to set providers’ reimbursement levels though federal law controls reimbursements to some institutional providers such as disproportionate share hospitals (“DSH”). Federal law also controls the distribution of Medicaid providers to ensure access to targeted geographical areas. In short, because federal Medicaid reimbursements were (and still are) a significant portion of state budgets,

31 The Medicaid Source Book requires all states to cover pregnant women, children under age nineteen, those who meet the welfare program Aid to Families with Dependent Children (“AFDC”) criteria and certain disabled Supplemental Security Insurance (“SSI”) recipients. Beyond these categories, the federal government defines several optional groups states may chose to cover such as elderly and “medically needy” families who meet all but the income criteria for SSI. See Rosenbaum & Rousseau, supra note 19, at 18-19; see also Furrow et al., supra note 22, at 606; 42 C.F.R. § 435.4 (2001).


33 Initially, federal regulations controlled Medicaid rate-setting retrospectively, requiring states to reimburse hospitals at the same rate as Medicare program, and physicians at their “usual and customary” rates. Inflationary pressure and the introduction in 1983 of the Prospective Payment System changed these expensive reimbursement policies, but the federal government retained control over Medicaid rate setting, as well as the authority to set broad eligibility requirements and to define the basket of health care goods and services covered by the states. See generally Clark C. Havighurst et al., Health Care Law and Policy 228-34 (2d ed. 1998).


the federal government has been the "more equal" member of the federal/state partnership that administers Medicaid to the nation's needy.\footnote{See MEDICAID CHARTBOOK 2000, supra note 5, at 10.} Yet, over the past twenty years, legislative reforms and case law have gradually shifted the balance of control towards the states. In 1967, the Medicaid Act was amended to require all states to provide early and periodic screening, diagnostic, and treatment for Medicaid beneficiaries under age twenty-one. This represented expanded federal influence over the program. However, in 1972 states gained increased authority to link Medicaid eligibility to the federal Supplemental Security Income ("SSI") program. Again, however, federal standards controlled the reform.\footnote{Notably, the seeds for states' flexibility within the federally controlled framework of Medicaid were down long before the new federalism. For example, Section 1115 Waivers were enacted as part of the original Medicaid statute, though states did not aggressively avail themselves of this flexibility until recently.}

The Omnibus Reconciliation Act of 1980 ("ORA 1980") marked the first significant relaxation in federal control over states' administration of the Medicaid program. In ORA 1980, Congress enacted the "Boren Amendment" which gave states the flexibility to set the rates at which hospitals, nursing and intermediate care facilities were reimbursed for medical services. The Boren Amendment required that the rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards."\footnote{ORA 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2650.} The following year, Congress passed the Omnibus Budget Reconciliation Act of 1981 ("OBRA 1981") containing important Medicaid reforms.\footnote{OBRA 1981, Pub. L. No. 97-35, § 2173, 95 Stat. 808. Later, the amendment was further extended to facilities for the mentally handicapped. See OBRA 1987, Pub. L. No. 100-203, § 4211(h)(2)(A), 101 Stat. 1330-205.} OBRA 1981 introduced "Freedom of Choice" Waivers (§ 1915b)\footnote{OBRA also enacted Section 1915c Waivers to protect community based care providers. See MEDICAID CHARTBOOK 2000, supra note 5, at 10.} by which states wishing to enroll Medicaid recipients in managed care organizations, could receive federal permission to selectively contract with providers willing to offer discount capitalization rates through a competitive bidding process in exchange for a guaranteed enrollment of Medicaid recipients.\footnote{For a full discussion of Medicaid waivers, see, for example, Elizabeth Andersen, Administering Health Care: Lessons from the Health Care Financing Administration's Waiver Policy-Making, 10 J.L. & POL. 215 (1994).}
In fact, the Medicaid waiver statutes represent a premier example of the legislative federalism, by which statutory enactments and regulatory revisions have gradually increased states’ discretion to circumvent the federal oversight that originally characterized this program. States that obtain waivers from the Secretary of DHHS are able to revise their Medicaid programs in ways that do not comply with federal guidelines and law. The grant of these waivers receive little judicial scrutiny.\(^{42}\) Moreover, beginning in 1993, the Executive Branch has encouraged DHHS to grant these waivers to the states in order to grant increasing flexibility to the state governments in administering their Medicaid Programs. The Section 1115 Research and Demonstration Projects waivers, and the Section 1915(b) Freedom of Choice waivers are the primary vehicles by which states obtained federal authority to rapidly expand their managed care contracts within the Medicaid program.\(^{43}\)

More recently, the Bush Administration has also made active use of waivers to, in the words of the President, “empower states to propose reforms tailored to the needs of their citizens.”\(^{44}\) The Bush initiative, called the “Health Insurance Flexibility and Accrutable Initiative” further releases states from federal Medicaid rules, allowing them to revise federally outlined benefit packages and eligibility rules. Moreover, the Bush Administration is expanding flexibility for the states through use of the Section 1915(c) immunity-based waivers;\(^{45}\) and other specialized waivers as well.\(^{46}\) The danger of these legislative shifts away from Federal oversight toward state independence lies not only in the fact that centralized uniformity of quality and eligibility standards may be sacrificed,\(^{47}\) but also that, unlike traditionally provided Medicaid benefits, Medicaid beneficiaries provided by states in these waiver programs create

\(^{42}\) Rosenberg & Zaring, supra note 1, at 548-49.

\(^{43}\) Managed care enrollment rose dramatically during the period from 1993 to 1999, due to states’ obtaining waivers from the federal government. See James W. Fossett & Frank J. Thompson, Back-off Not Backlash in Medicaid Managed Care, 24 J. HEALTH POL’Y & L. 1159, 1161 (Oct. 1999).


\(^{45}\) See Medicaid: Self-Directed Care a Standard Option in States’ Community-Based Waivers, Health Care Daily Rep. (BNA) (May 13, 2002).


\(^{47}\) See Rosenberg & Zaring, supra note 1, at 554.
no legally enforceable right to the benefits they provide to Medicaid recipients.\textsuperscript{48}

In 1990, the United States Supreme Court, in \textit{Wilder v. Virginia Hospital Ass'n},\textsuperscript{49} affirmed that under the Boren Amendment, institutional providers had a private cause of action under 42 U.S.C. § 1983, which permitted them to challenge unreasonably low Medicaid reimbursements from the states. The \textit{Wilder} Court construed the Boren Amendment to create a cause of action for providers as the intended beneficiaries of that statute.\textsuperscript{50} For a period, this Supreme Court case and its progeny reinstated federal oversight to judicially scrutinize the level of states' Medicaid reimbursements. As the expense of the increasing burden of covering Medicaid costs grew, states began to "clamor" for the right to run their own programs.\textsuperscript{51}

In 1996 and 1997, Congress enacted two sweeping pieces of legislation in an effort to address health care cost inflation, the first of which increased federal control over their Medicaid programs, while the second increased states' flexibility. First, in 1996, Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA"),\textsuperscript{52} providing substantial financial resources to the Health Care Financing Agency ("HCFA"), the Inspector General, and the Department of Justice to enhance their efforts to reduce the estimated ten percent of total Medicare and Medicaid costs wasted on fraudulent and abusive claims.\textsuperscript{53} This statute effectively added a layer of federal oversight to the Medicaid program.

\textsuperscript{48} See Westside Mothers v. Haveman, ___ F.3d ___, 2002 WL 987291 (6th Cir. 2002) (holding Medicaid Act creates privately enforceable right against state officials). The effect of the legislative trend toward increased state control resulted, almost immediately, in decreased access to care for Medicaid patients. As one commentator has put it, states "took advantage of their new freedom to underpay . . . [providers so that] many physicians became unwilling to accept [Medicaid] patients [and] many physicians became unwilling to accept such patients, and concern grew about their access to care." HAVIGHURST ET AL., supra note 33 (with discussion re \textit{Wilder}). Ironically, the Congress responded to this concern by enacting the 1997 Balanced Budget Amendment which replaced the Boren Amendment with a significantly weaker provision from a reimbursement rate perspective. See 42 U.S.C. § 1396a(a)(30)(A) (2001).


\textsuperscript{50} Id. at 509-10.

\textsuperscript{51} See Hamme, supra note 8.


\textsuperscript{53} See H.R. 104-496, 104th Cong. (1996), reprinted in 5 U.S.C.C.A.N. 1865, 1869. HIPAA established the "National Health Care Fraud and Abuse Control
The next year, Congress passed the BBA, which introduced a variety of managed care options for Medicare and Medicaid beneficiaries; granted the states increased flexibility in administering Medicaid programs; and implemented deep cuts in Medicare reimbursements generally, and to rural health clinics specifically. Moreover, the BBA repealed the Boren Amendment, replacing it with a more general provision that each state “provide for a public process” to determine rates of reimbursement for hospitals and nursing facilities. This more relaxed provision, requiring adherence to a procedure rather than the Boren Amendment’s reasonableness standard, favored the states by reducing the likelihood that providers and beneficiaries could raise successful challenges to states’ reimbursement rates.

The shift between federal and state control of Medicaid is as old as the program itself. Most recently, the new federalism has been manifested in the states’ transition to managed care plans; the Clinton and Bush Administrations’ use of generous waiver standards, and finally the regulatory tug-of-war over implementation of the BBA. In January 2001, the Clinton Administration instituted a series of regulations, ostensibly to implement the BBA’s requirements but essentially attempting to exert increased federal control over the quality and cost of states’ Medicaid plans. A short eight months later, in August 2001, the Bush Administration

Program.” The stated purpose of the program is to “coordinate Federal, State and local law enforcement to combat health care plan fraud.” Id. at 1866. In order to accomplish this purpose, HIPAA created a national fraud data bank and established guidelines for the government to periodically publish fraud advisory opinions, special fraud alerts, guidelines and interpretive opinions. Moreover, HIPAA granted the government broader investigatory and audit authority and an expanded range of intermediate sanctions and monetary penalties for a wide variety of providers and situations. Overall, the effect of HIPAA was to broaden and coordinate the federal government’s ability to reduce the amount of the public fisc wasted on paying for medical fraud.

55 Id. §§ 4001-4006 (Medicare Part C called “Medicare + Choice”).
56 Id. §§ 4901-4923 (Title XI of the Social Security Act establishing the State Children’s Health Insurance Program).
57 COUNCIL ON GRADUATE MED. EDUC., TENTH REPORT: PHYSICIAN DISTRIBUTION AND HEALTH CARE CHALLENGES IN RURAL AND INNER-CITY AREAS, at 3 (1998).
59 It is unclear whether a cause of action under 42 U.S.C. § 1983 remains available to providers to challenge reimbursements under this new provision, as was available under the Wilder Court’s interpretation of the Boren Amendment.
announced the repeal of the Clinton regulations, swinging the Medicaid control pendulum back towards the states. The contours and tensions of balancing power between the federal and state governments under our Constitution is as old as the document itself. Today, this same debate is nowhere more alive and of more practical importance, than in the contest for control of the government's obligation, pursuant to the Medicaid Act of 1965, to provide health care to America's neediest.

III. MEDICAID AND THE "NEW" JUDICIAL FEDERALISM

The term “Federalism” describes the theory of relationship and allocation of power between the federal and state governments based on the premise that each “should be limited to [their] own sphere and, within that sphere, should be independent of the other.” The doctrine represents the tension between the federal government’s limited power, granted to it under the United States Constitution by the sovereign states, and the residual power of the several states, reserved to them by the Constitution’s Tenth Amendment. Issues of Federalism—the balance of power between the federal and state governments—have been the subject of American jurisprudence and politics since the nation’s inception. Moreover, Chief Justice John Marshall, in 1819, prophetically remarked that the central question of federalism is “perpetually arising, and will probably continue to arise, as long as our system shall exist.” As such, there really is nothing

60 One commentator observed that current debates and discussion of federalism principles in the Congress and in our courts are “reminiscent of the early debates between the Federalists and Anti-Federalists over ratification of the Constitution.” Leon Friedman et al., The New Federalism, 16 TOURO L. REV. 265 app. I, at 267 (2000).


62 Id. Hodge cites the debate between federalists and nationalists at the Constitutional Convention which resulted in the “compromise” doctrine of federalism. See id. at 314.

63 See McCulloch v. Maryland, 17 U.S. 316, 405 (1819) (“But the question respecting the extent of the powers actually granted, is perpetually arising, and will probably continue to arise, as long as our system shall exist. In discussing these questions, the conflicting powers of the general and State governments must be brought into view, and the supremacy of their respective laws, when they are in opposition, must be settled.”).
Yet, the term new federalism connotes what one commentator has called "two related strands" of judicial and legislative pronouncements that have shifted power from the federal government to the states.\(^6\)

The judicial strand of the new federalism, foreshadowed by Justice Powell's dissent in *Cannon v. University of Chicago*,\(^6\) is marked by the United States Supreme Court's decisions since the 1994-95 term, holding no fewer than twenty federal statutes unconstitutionally intruded upon states' authority.\(^6\) This trend has not been lost on the courts' construction of the Medicaid Act.

---

\(^{6}\) For an excellent survey of the origins, decline and resurgence of Federalism, both as a political and legal doctrine and application of this analysis specifically to the federal government's role in protecting public health, see generally Hodge, *supra* note 61.

\(^{65}\) See Modisett, *supra* note 18, at 141.

\(^{66}\) Cannon v. Univ. of Chicago, 441 U.S. 677, 730 (1969) (Powell, J., dissenting) (Justice Powell explained the fundamental constitutional flaw in the majority's decision to permit a woman denied admission to medical school which received federal funds under Title IX, to claim gender discrimination in a civil action against the medical schools by inferring a private cause of action under Title IX). After Justice Powell explained that by creating private remedies where Congress has not, he argued federal courts may not impermissibly "enlarge their jurisdiction" contrary to the constitutional limits of federal jurisdiction set out in Article III of the United States Constitution. *Id.* at 730-31. For other early examples of cases shaping the new federalism doctrine, see also California v. Sierra Club, 451 U.S. 287 (1981) (holding no private right of action implied on behalf of parties injured by violations of the Rivers and Harbors Appropriation Act); Touche Ross & Co. v. Redington, 442 U.S. 560 (1979) (declining to infer a private remedy for damages in securities cases under Section 17(a) of the 1934 Securities and Exchange Act); Regents of the Univ. of Cal. v. Bakke, 438 U.S. 265 (1978) (declining to create private actions under Title VI of Civil Rights Act of 1964). However, it should be noted that the Supreme Court's reluctance to imply private causes of action under federal statutes where Congress has been silent has not been uniform. Compare Maine v. Thiboutot, 448 U.S. 1 (1980) (holding that 42 U.S.C. § 1983 creates a private cause of action for violation of the federal AFDC statute) with Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n, 453 U.S. 1 (1981) (refusing to allow plaintiffs to invoke 42 U.S.C. § 1983 to create private remedy against state officials violating federal environmental statutes.).

\(^{67}\) See Friedman et al., *supra* note 60, at 265 ("Since the 1994-95 Supreme Court Term, the Court has held twenty separate federal laws unconstitutional."). *See*, e.g., Printz v. United States, 521 U.S. 898 (1997) (holding portions of the Brady Handgun Violence Prevention Act requiring state officers to conduct background checks on handgun purchasers violated the Tenth Amendment);
Even before repeal of the Boren Amendment, the new federalism limited the reach of the *Wilder* decision. In 1992, two years after that case was decided, the Supreme Court declined to follow *Wilder* in a case holding there was no private cause of action to enforce the Adoption Assistance and Child Welfare Act of 1980 under 42 U.S.C. § 1983. The Act at issue in that case was strikingly similar in structure to the Medicaid Act. It was a reimbursement program, jointly run by the states and the federal government, for which states had to submit an assistance plan in order to receive federal funds for providing foster care to needy families. Rejecting a private challenge to the state’s control of its foster care program, this case marked a judicial return of a degree of authority and autonomy to the states as against the federal government. Lower courts followed suit. In *Minnesota Developmental Achievement Center Ass’n v. Haas-Steffen*, the Eighth Circuit rejected a challenge to changes in Minnesota’s Medicaid reimbursement rates on the grounds that the Boren Amendment did not apply to developmental achievement centers. In *Rx Pharmacies Plus, Inc. v. Weil*, a Colorado District Court sided with the state which administered a managed care program for Medicaid recipients, and rejected challenges to Colorado’s plan brought by pharmacists and Medicaid recipients.

Although *Wilder* has never been expressly overruled, after repeal of the Boren Amendment, courts further limited the extent to which states’ administration of their Medicaid programs could be challenged under federal law. In *Florida Ass’n of Rehabilitation Facilities, Inc. v. Florida Dep’t of Health & Rehabilitative Services*, the Eleventh Circuit rejected a health provider’s challenge to a state’s Medicaid reimbursements for services provided after 1997 when the Boren Amendment was repealed. In...

---


70 *Minn. Dev. Achievement Ctr. Ass’n v. Haas-Steffen*, 20 F.3d 889 (8th Cir. 1994).

71 *Id.* at 892.


so doing, the Florida Ass'n Court summed up the effect that both the judicial and legislative strands of the new federalism have had on the Medicaid program’s balance of power between state and the federal governments, holding that "Congress’s repeal of the Amendment empowered states to replace their existing Boren-compliant rate plans with new rate plans not subject to challenge based on the reasonableness and adequacy requirements of the Boren Amendment."74

Where Medicaid reforms are concerned, it is important to recognize that the new federalism is not merely affecting a doctrinal shift or interesting historical trend. Rather, the new federalism has the potential to influence the health of the entire population of Medicaid enrollees.75 Moreover, Rosenbaum and Rousseau report that children, women and African Americans constitute the overwhelming majority of that population.76 The new federalism in Medicaid, therefore, is a significant public health issue that is affecting the most vulnerable populations in our nation.

A. The New Federalism and Public Health

James Hodge, Jr. explains the relationship between public health law and the new federalism as a "collision" between states' authority to "regulate matters affecting the health, safety, and general welfare of the public"—the states' police powers—and the federal government’s power to preempt state laws that intrude on areas of the federal government’s supreme lawmaking authority:77

When federalism concerns are more strongly emphasized, states have more ability to regulate matters of public health pursuant to their police powers. When federalism principles are weakened or ignored, states lose out to federal interventions over such traditional exercises.

Thus, federalism preserves the police powers of the states and acts as a barrier to federal legislative intervention in matters within the scope of

74 Id. at 1217.
76 See Rosenbaum & Rousseau, supra note 19, at 28-29.
77 Hodge, supra note 61, at 315.
those powers. It simultaneously restricts the federal government’s ability to regulate in the interests of public health since such regulation has traditionally been the responsibility of state governments. Hanging in the balance of these observations are the very goals of public health which rely on the role federalism plays. 78

Medicaid reform defies the straight-forward, cause and effect relationship between strong enforcement of federalism principles and increased public health intervention that Hodge describes. Implied in Hodge’s equation is the conclusion that “weakened or ignored” federalism may cause a loss not only to the states themselves but also to the overall goals of public health. While there may be public health laws for which this relationship is true, in Medicaid it is not necessarily the case. As discussed in Part IV of this Article, in many states Medicaid suffers as a public health tool when federalism principles are over-enforced to allow the states to exceed what is traditionally a realm of federal regulation and responsibility. 79

Eleanor D. Kinney, noting the woeful lack of coordination between the executive branch and the DHHS agency to which that branch has delegated administrative authority over the Medicaid program, the declining percentage of the poor covered by Medicaid, and wide disparities in the states’ Medicaid programs due to the structure of the Medicaid program, raises this issue by asking, “Are all states committed and capable of executing the responsibility of financing health care for the poor even with substantial federal assistance, and are resulting disparities in the treatment of protected groups by states tolerable?”79 The next section of this article suggests an empirical analysis to begin to answer these two questions which are fundamental to evaluating the impact of new federalism on Medicaid reform.

IV. EMPIRICAL EVIDENCE OF THE PUBLIC HEALTH IMPACT OF INCREASED STATE CONTROL OVER MEDICAID

The effect of the new federalism on Medicaid may be measured empirically. For example, researchers have documented the fact that disparity among the states’ Medicaid coverage and expenditures increases

78 Id. at 318.
79 See discussion infra Part IV.
as federal oversight of the program decreases. More recently, the steady decline in Medicaid enrollment due to federal welfare reform enacted in 1996 has been explored in the literature. Using these two bodies of research, this section of the article explores the following working hypothesis: First, wide disparities already exist among the various states’ Medicaid programs. Second, applying the new federalism to Medicaid will lead to a decline in federal oversight of the various states’ Medicaid programs. Declining federal influence will lead to an increase in the number of uninsured people because some states will exercise their new discretionary authority to shrink their Medicaid enrollments. Third, this decreased access to healthcare will in turn lead to widening disparities in the health status of Medicaid eligible populations. In short, the new federalism will have an adverse impact on the public health of Medicaid’s target populations.

A. Disparities in State Medicaid Programs

Proving the first proposition of the working hypothesis is the easiest. Differences in state program size, benefits, expenditures, and eligibility criteria are reported annually and commented upon regularly. For example, under federal law, the HCFA must report its Medicaid expenditures quarterly. Table 1 below selects enrollment and expenditure

---

81 See, e.g., Jerry Cromwell et al., Center for Health Economics Research, Defederalizing Medicaid: Fair to the Poor, Fair to Taxpayers?, 12 J. HEALTH POL. POL’Y & L. 1 (1987).


83 "The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) is the accounting statement which States, in accordance with 42 CFR 430.30(c), must submit each quarter under title XIX of the Social Security Act (the Act)." HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., QUARTERLY MEDICAID STATEMENT OF EXPENDITURES
information from these publically available sources to highlight the disparities in Medicaid programs for selected states.

**TABLE 1**
Disparities in State Medicaid Enrollment and Selected State Expenditures Statistics

<table>
<thead>
<tr>
<th>State</th>
<th>Total Enrollees</th>
<th>Total Medicaid Expenditures</th>
<th>Average Pmt Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>3,500,292</td>
<td>$27,539,936,152</td>
<td>$8,356</td>
</tr>
<tr>
<td>Texas</td>
<td>2,680,583</td>
<td>10,272,990,995</td>
<td>3,800</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>538,229</td>
<td>2,830,114,783</td>
<td>5,436</td>
</tr>
<tr>
<td>Mississippi</td>
<td>526,604</td>
<td>1,748,939,562</td>
<td>3,222</td>
</tr>
<tr>
<td>Kentucky</td>
<td>653,553</td>
<td>2,696,929,368</td>
<td>3,883</td>
</tr>
<tr>
<td>Alabama</td>
<td>649,302</td>
<td>2,386,960,623</td>
<td>3,782</td>
</tr>
</tbody>
</table>

Table 1 demonstrates that although New York and Texas, the second and third largest Medicaid programs (after California, by number of enrollees) serve close to the same number of Medicaid beneficiaries, Texas spends roughly half of what New York does in payments to enrollees. Similarly, although Wisconsin and Mississippi have almost an identical number of people enrolled in Medicaid, their respective expenditures per person are quite different. Also, Kentucky's spending is comparable to Alabama's and to Texas' though the size of these respective programs measured both in expenditures and number of enrollees is quite different.

For the Medical Assistance Program CMS-64, at http://www.hcfa.gov/medicaid/ofs-64.htm.


85 Both the U.S. government and numerous commentators collect the data from which similar comparisons may be made. See, e.g., Kinney, supra note 80, at 857, for similar comparisons from earlier years' data.
B. Decreased Federal Oversight Will Lead to Decreased Medicaid Enrollment

It is also clear that as the federal government relaxes its role, some states will exercise their newly granted flexibility to create policies that will reduce coverage to different segments of the Medicaid population. Other states will use increased autonomy and flexibility to expand access to health care for working poor and near poor citizens within their borders. The result will be increasingly disparate Medicaid coverage for similarly situated populations in the various states. Recent studies presented to members of Congress confirm this conclusion.

In May 2000, the United States House of Representative’s House Ways and Means Committee released a report evaluating health coverage for families leaving welfare. Included in that report was a pilot study of twenty-one states, examining the changes in Medicaid enrollment between the period from June 1997 to June 1999. Overall, the entire sample experienced a dramatic decline in Medicaid enrollment from 1997 through December 1998. That decline began to reverse in June 1999. Of note, however, is the lack of uniformity in the extent of the decline amongst the twenty-one states, and the disparate impact of the enrollment reversal. From June 1997 through June 1998, only three of the sample states—Arkansas, Massachusetts, and Oklahoma—experienced an increase in Medicaid enrollments. The sharpest declines during that period were in Indiana, Kansas and Texas. Figure 1 graphically illustrates the changes in Medicaid

---

86 Oregon and Tennessee, for example, are two states whose Medicaid reforms, made pursuant to Section 1115 waivers have expanded access to low income individuals previously ineligible to receive Medicaid, while simultaneously reducing overall program costs, without any apparently detrimental affect on the quality of health care beneficiaries received. See James F. Blumstein & Frank A. Sloan, Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and Paradigm, 53 VAND. L. REV. 125, 136 (2000); Rosenberg & Zaring, supra note 1, at 552 (describing Oregon, Hawaii, and South Carolina successes in Medicaid reform).


88 Id. The twenty-one states included in the study, listed alphabetically, were Arizona, California, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, and Wisconsin.
enrollments for the twenty-one states studied during the first year following the enactment of the PRWORA.

**FIGURE 1**

Medicaid Enrollment
% Changes June 1997 - June 1998

By the following year, however, several states had improved the percentage changes in their enrollments, but some by more than others. The House Report highlighted state policies in Indiana, Massachusetts and Oklahoma that experienced particularly dramatic reversals in declining enrollments from the previous year. These states’ success at increasing Medicaid enrollments from June 1998 to June 1999 testifies to comprehensive, targeted outreach programs that simplified the Medicaid application process, advertised its availability in a non-stigmatized way, and aggressively sought to expand Medicaid coverage to uninsured populations. Figure 2 summarizes Medicaid enrollments for the same twenty-one states during the second year of the study.

---

89 See House Report, supra note 87, at 65. Rounded to the nearest whole number, the percentage enrollment changes for the first period from June 1997 to June 1998 were as follows:

<table>
<thead>
<tr>
<th>AZ</th>
<th>CA</th>
<th>FL</th>
<th>GA</th>
<th>IL</th>
<th>IN</th>
<th>IA</th>
<th>KA</th>
<th>MA</th>
<th>MI</th>
<th>NJ</th>
<th>NM</th>
<th>NY</th>
<th>NC</th>
<th>OH</th>
<th>OK</th>
<th>PA</th>
<th>TN</th>
<th>TX</th>
<th>UT</th>
<th>WI</th>
<th>ALI</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>-4</td>
<td>-3</td>
<td>-2</td>
<td>-5</td>
<td>-9</td>
<td>-4</td>
<td>-8</td>
<td>23</td>
<td>-1</td>
<td>-3</td>
<td>-1</td>
<td>-4</td>
<td>-2</td>
<td>4</td>
<td>-10</td>
<td>-3</td>
<td>-5</td>
<td>-7</td>
<td>-1</td>
<td>-5</td>
<td>-3</td>
</tr>
</tbody>
</table>

90 Id.
91 Id.
This evidence demonstrates that the new federalism approach to Medicaid will likely exacerbate already existing disparities among the states, notwithstanding the fact that the Medicaid program's shared federal and state partnership has always historically resulted in a network of fifty distinct welfare plans, governed and administered by the separate states. Certainly, there may be other explanations for these changes in enrollment. For example, the employment market in a given state or the state of the overall economy may affect enrollment. However, the temporal proximity between PRWORA's enactment and the declining enrollments strongly suggest a causal link between the two events. Other research strengthens this evidence of causality.

Joel Ferber and Theresa Steed, for example, describe the empirical evidence that Medicaid enrollments have declined sharply since 1996. Ferber and Steed explain the declines are due in large part to welfare reform legislation which transformed the sixty-five year old federally run national welfare program (Aid to Families with Dependent Children...
Congress enacted the PRWORA to give states discretion over the cash assistance benefits provided to needy families, for the express purpose of moving families off welfare, and into the workforce. However, since the old federal welfare system premised Medicaid eligibility upon enrollees' ability to meet AFDC standards, Congress specifically enacted “de-linking” provisions that would allow families removed from welfare eligibility to continue to receive Medicaid health insurance for which they were eligible, independent of their welfare status. Despite PRWORA's “de-linking” provisions, Ferber and Steed have compiled research and studies that document not only the decline in Medicaid coverage due to welfare reform, but also the fact that families that lose Medicaid coverage as they enter the workforce, largely end up in jobs that do not provide employer-sponsored health insurance. Moreover, there appears to be no commensurate rise in companion health insurance programs such as the S-CHIP Program for children or the Transitional Medical Assistance (“TMA”) program for individuals just entering the workforce. Therefore, these Medicaid-eligible families appear to be leaving the Medicaid program only to swell the ranks of the uninsured.

Ferber and Steed go on to describe evidence that several states have exercised their new found legislative flexibility to implement practices and policies that contribute to, if not encourage, a decline in Medicaid coverage. They report that twenty-three states offer “diversion grants” as an alternative to receiving cash assistance under the Temporary Aid to Needy Families (“TANF”) program. Since beneficiaries must apply for TANF and Medicaid via a joint application in many states, the diversion grants not only distract enrollees from going on welfare, but also from participating in states' Medicaid as well. Other state practices range from automatic computer termination, to deliberately improper denials of coverage. Although Ferber and Steed conclude by suggesting several

---

94 Id.
95 Id.
96 Id. at 155-57.
97 Id. at 157, 168-71.
98 Id. at 161-62.
99 Id. at 162-63.
100 Id.
101 Id. at 163-70. Reporting "systematic and unlawful terminations of Medicaid coverage" in Missouri; "front end diversions" in New York (see Reynolds v. Giuliani, 35 F. Supp. 2d 351 (S.D.N.Y. 1999)) (challenging New York's decision to change public assistance centers to employment centers, thus erecting a barrier
remedies to the reverse the Medicaid enrollment decline, the problem itself is an instructive example of the impact of the new federalism on Medicaid access for the poor and disabled.

The decline in Medicaid enrollment due to increased state control over welfare is not only a matter of policy interest, but it is also a matter of public health concern. The objective of enacting the Medicaid Act was to provide access to health care for America's poor and disabled, thereby improving the health of these populations. To the extent that changes in policy, practices and control of the Medicaid program reduce access to coverage, these policies and practices reduce the quality of health for Medicaid eligible populations.

C. Declining Medicaid Enrollment Will Adversely Influence Public Health

The salient question, of course, is to what extent do these disparities affect individuals' access to health care, and, in turn, their health, in the various states. The House Report presents the results of a telling survey that demonstrates the effects of losing Medicaid coverage on access to healthcare. The study compares responses to sample questions about healthcare access, given by people who experienced continuous Medicaid coverage during the relevant period from 1995 to 1997, with answers to the same questions from people who lost Medicaid coverage and became uninsured after 1995. The four questions required both groups to report whether they (1) had "No Usual Source of Care"; (2) were "Very Dissatisfied" with Health Care"; (3) had experienced "Barriers to Care"; and perhaps most importantly, (4) had experienced "No Physician Visit In

to obtaining Medicaid and other support); and more subtle practices discouraging Medicaid applicants in other states such as North Carolina and Pennsylvania.

Notably, some states have aggressively changed their administrative policies to address and reverse the decline in Medicaid enrollment at the state level. See, e.g., Florida, Indiana, and Oklahoma results as reported in House Report, supra note 87, at 4. It is of interest, however, to note the extent to which the proposed solutions to the states' inability to properly implement de-linking provisions are distinctly federal in nature. Not only Ferber and Steed, but researchers, as well as legislators have shown that the steps states must take to reverse the decline in Medicaid enrollment must be overseen by the federal government. See, e.g., id. at 32-36 (statement of Marilyn Ellwood, Senior Fellow, Mathematica Policy Research, Inc.). See also id. at 11 (statement of Hon. Fortney Pete Stark, Member, House Subcomm. on Human Res. of the Comm. on Ways and Means).
Figure 3 compares the responses of the people who had lost Medicaid coverage, with the responses from people who retained continuous Medicaid coverage.

**FIGURE 3**

**Effect of Losing Medicaid Coverage**


Medicaid Participants/Medicaid Ex-Participants

These responses confirm that individuals who lost their Medicaid coverage between 1995 and 1997 experienced decreased access to health care. Thus, it is fair to conclude from the empirical evidence that increasing states’ flexibility and control over Medicaid will decrease access to health care for some citizens who would otherwise eligible for Medicaid coverage.

This empirical evidence raises a substantial public health concern. The population at risk is readily identifiable: It is comprised of the 41.4 million people enrolled in the Medicaid program as of Fiscal Year 1998. These include 18.9 million children, 7.9 million adults, 6.6 million blind or disabled Americans, and 3.9 adults over the age of sixty-five. Some commentators have identified the significant role Medicaid plays in protecting public health. Jane Perkins, for example, counts the 1993

---

103 *House Report, supra* note 87, at 47.

104 *See id.* The survey responses tabulated were comparisons of Medicaid insured versus uninsured respondents. For each question, the uninsured responses are shown first, and then the Medicaid insured respondents’ answers are shown.

105 *See MEDICAID CHARTBOOK 2000, supra* note 5, at 12. “The federal fiscal year is from Oct. 1 to Sept. 30 of the following year.” *Id.*
Amendment to the Medicaid statute that enacted the Vaccine for Children program a public health success attributable to the Medicaid program. John Blum acknowledged the public health origins of the Medicaid program itself. However, the data reviewed herein suggests another insight: whether the federal government or the states control Medicaid eligibility will have a direct impact on the access Medicaid beneficiaries will have to health care in the various states. Hence, the absence of federally controlled uniformity may adversely affect the health of some Medicaid dependent populations who must then rely on their state governments to administer the nation's health care safety net. The final section of this Article therefore turns to consider what are the parameters of the federal government's constitutional duty to protect the health of the vulnerable populations.

V. A PROPOSAL TO SHIFT THE CONCERN OF NEW FEDERALISM FROM LIMITS ON FEDERAL POWER, TO CONSTITUTIONALLY DEFINING THE GOVERNMENT'S INHERENTLY FEDERAL ROLE

It has become axiomatic that "[i]n the context of public health, . . . the Constitution acts as both a fountain and a levee; it originates the flow of power—to preserve the public health, and it curbs that power." Thus, constitutional law scholars historically and contemporarily have been concerned with defining the limits and extent of the government's flow of power. The Medicaid program specifically raises questions with respect to the balance between federal and state power, much like the questions raised in every other context, examining both the fountain and levee functions of

107 See John Blum, Overcoming Managed Care Regulatory Chaos Through a Restructured Federalism, 11 HEALTH MATRIX 327, 329 (Summer 2001).
109 See Hodge, supra note 61, at 315-16 (quoting Alexander Hamilton's observations on the limits of national government and, also, concluding "[t]he meaning of federalism, after all, has been the primary political issue for most of American history").
the federal law. The first relevant question is "whether the Medicaid-eligible population is a community to whom the government owes any specific duty to protect their overall health?" This first question asks whether the flow of government power reaches the health issues of this particular population. If the answer is "yes," as I suggest, then the second question is "which government—federal or state—should be primarily responsible for preserving the health of this population?" This second question asks what is the shape of the Medicaid levee? To properly answer these questions, however, we must depart from the current approaches taken by the recent cases and commentary. The key to resolving the federalism issues raised by Medicaid reform does not derive merely from understanding the limits needed to curb the federal government's power, but rather requires a grasp of the doctrinal provisions of the Constitution that mandate the continued strong presence of federal authority vis a vis the sovereign states and private individuals in providing access to health care to the populations. Medicaid will continue to fulfill its public health purposes only to the extent that the new federalism supports a strong federal role in protecting poor, elderly and disabled citizens' health rather

111 This question is raised here in a specifically legal context. That is, I am not asking here whether this is a population that should be afforded government assistance from a medical or even public health perspective. The public health inquiry considers the nature of risk this population faces, the probability of the risks, and the seriousness of the disease processes to which the population is exposed to determine whether the public health risk mandates government or other intervention. See, e.g., EDWARD J. BURGER, JR., PROTECTING THE NATION'S HEALTH 53-56 (1976). Rather, the questions raised in this section concern the sources, content and limits of law that assign responsibility to the government to act on behalf of a population's health needs.

112 Professors James F. Blumstein and Frank A. Sloan have ably argued that cooperative federalism in Medicaid gives rise to political moral hazard, causing states to overspend on health care for the poor, because the pact of their spending is not fully borne by state governments themselves. Blumstein and Sloan further refer to a "lock in" effect that prevents states from reversing patterns of over spending once federal and state funds have been committed to expanded Medicaid programming. See Blumstein & Sloan, supra note 86, at 125. Absent from their discussion, however, is any objective measure of whether the amount spent on healthcare for the poor and near poor is, in fact, at an optimal level. It is entirely possible that states avoid another moral hazard—that of under spending on healthcare in favor of local projects fueled by private or special interests rather than society's most efficient level.
than encourages the central government to abdicate its role to the sovereign states.

A. Federal and State Governments Powers Under the Constitution

In his seminal book, *Public Health Law: Power, Duty, Restraint*, Lawrence O. Gostin sets forth the principles of democratic theory and constitutional law that support the conclusion that the basic obligation of an organized society is to protect and preserve the health of its citizens. Further, Gostin finds that the United States Constitution ascribes that role to the government. Beginning with the Preamble to the Constitution, Gostin points to the Framers’ stated objective to "promote the general welfare" and "common good" as the basis for finding constitutional authority for the government’s obligation to preserve public health. The Constitution provides authority for both the federal and state governments’ role in protecting public health.

The legislative authority for Congress to tax, spend and regulate commerce comprise the core of the Constitution’s grant of power to the federal government to protect public health. Gostin explains that Article I, Section 8 defines the “foremost” federal powers for public health purposes. The power to tax is important as a source of federal revenue, and the means of regulating risk behavior or creating incentives for private activities that enhance the public’s health. The spending power delegated to Congress, Gostin explains, authorizes direct financing to protect public health, safety and well being, and gives the federal government the authority to condition the use of federal funds upon conformance with federal health standards. The Commerce Clause, according to Gostin, provided much of the regulatory authority the federal government has relied upon since the New Deal era to address public health issues. But as early

---

**Notes:**

114 Id. at 5-22.
115 Id. at 6. Wendy Parmet further points to the presence of disease and public health needs prevalent during the “framing era,” to find historical support for the federal government’s obligation to provide for public health. "Despite the disagreement and uncertainty over the actual meaning of ‘the common good,’ it seems likely that the preservation of public health ... was one meaning that all would share.” See Parmet, supra note 110, at 6.
117 Id. at 38.
118 Id. at 40. Gostin also describes the changing Supreme Court view of Commerce Clause authority for such federal activities as food and drug safety, environmental restrictions and soil and water protection.
as 1798, Gostin records the numerous federal agencies that have served public health goals in order to describe a historical argument for the federal government's "presence" in public health regulation. Finally, the Necessary and Proper Clause grants Congress authority to enact any other laws required and "reasonably appropriate" to achieve the public health purposes that are consistent with its constitutional authority.

Despite the federal authority and exercises of power Gostin chronicles, public health functions have historically been the purview of state government. The states' public health authority emanates first from the Tenth Amendment which reserves all powers not delegated to the federal government, to the state government and to the people. Thus the "police power"—the broadest inherent authority of a government to regulate to preserve, protect and promote health safety, morals and general welfare—belongs first and foremost to state government. Hodge explains that police power is the core source of legal authority to perform public health functions, and are at the core of what defines state government. Finally, the states' parens patriae powers also provide a source for these

119 John Adams signed a bill that created the first United States Marine Hospital in 1798. Id. at 41.
120 Id. at 41. But cf. Hodge, supra note 61, at 330 (Prior to the New Deal era, federal "presence" in public health was nominal. Hodge also describes the Supreme Court's initial opposition, on federalism grounds, to increasing the federal government's public health role.). See, e.g., United States v. Butler, 297 U.S. 1, 77 (1936) (striking the Agricultural Adjustment Act of 1933 and decrying a "central government exercising uncontrolled police power in every state of the union, superseding all local control or regulation of the affairs or concerns of the states").
121 GOSTIN, supra note 113, at 35.
122 "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST. amend. X.
123 Hodge credits Chief Justice Marshall with an early use of the phrase, "police power" in Brown v. Maryland, 25 U.S. 419, 442 (1827) ("The power to direct the removal of gunpowder is a branch of the police power, which unquestionably remains, and ought to remain, with the states."); see Hodge, supra note 61, at 321 n.65.
124 See GOSTIN, supra note 113, at 48-50; see also Hodge, supra note 61, at 319-22 (explaining that since the states were sovereign before formation of the United States, the police power is reserved to them).
125 Innumerable examples abound in history and contemporary life, but a few include state initiated disease quarantines, inoculation programs, data collection, sanitation regulations, property closings, and educational campaigns. These are all exercises of the states' police power.
126 Hodge, supra note 61, at 323-24.
sovereign governments to protect the health, particularly of children and the mentally ill, or the community as its health is threatened by those who cannot care for themselves. The constitutional and historical authority for both state and federal government role in protecting public health is clear. It is also clear that providing access to health care under the Medicaid Act represents a legitimate exercise of federal spending and state police powers under the Constitution. Thus, the answer to the question of whether the constitutional flow of government power reaches the public health objectives of the Medicaid Act, is clearly "yes."

B. Balancing the Federal and State Government Powers

As the federal government began to assume a more visible presence in public health regulation and control, it fell to the United States Supreme Court to serve as the interpreter of the meaning of federalism in practice. The Court’s interpretations, in large part, have defined the swings between federal and state control of public health law cases. Beginning first from the strong federalist roots displayed in the Court’s earliest decisions, through the period immediately prior to the New Deal, the U.S. Supreme Court employed federalism doctrine to favor strong state governments. In 1933, the Court in United States v. Butler, struck down the Agricultural Adjustment Act passed that year, holding that it impermissibly intruded upon the police powers reserved to the states. While Butler does not concern a public health issue, it is exemplary of the strong federalist views the Court expressed on behalf of the states prior to the New Deal era.

127 The term "parens patriae" means "parent of the country." This term has been flexibly interpreted to grant states the authority to act on behalf of incompetent citizens (i.e., through guardianship) and to support the states’ standing to sue on behalf of community interests. See, e.g., Support Ministries for Persons with AIDS, Inc. v. Village of Waterford, New York, 799 F. Supp. 272 (N.D.N.Y. 1992) (holding that state officials had standing to sue under parens patriae capacity to protect the HIV-infected population).


The expressions of the framers of the Constitution, the decisions of this court interpreting that instrument, and the writings of great commentators will be searched in vain for any suggestion that there exists in the clause under discussion [Art. I, Sec. 8] or elsewhere in the Constitution, the authority whereby every provision and every fair implication from that instrument may be subverted, the independence of the individual states obliterated, and the United States converted into a central government exercising uncontrolled police power in every state of the Union, superseding all local control or regulation of the affairs or concerns of the states.
The familiar line of cases that signaled a shift in the Court away from rigid, states' rights federalism, towards a willingness to liberally construe the federal government's powers to tax, spend and regulate commerce is summarized by Hodge and others elsewhere. However, it is worth mentioning here that if these cases generally represented the albeit temporary demise of the federalism doctrine, the death knell to old federalism jurisprudence was dealt in United States v. Darby.

In Darby, the Supreme Court upheld Congress' authority to regulate interstate commerce via the Fair Labor Standards Act and expressly held, "[i]t is no objection to the assertion of the power to regulate interstate commerce that its exercise is attended by the same incidents which attend the exercise of the police power of the states." This case ushered in a period of judicially recognized "national police powers" which served the federal exercise of public health authority well. During this period, the Congress enacted the Hill Burton Act. Hodge records the post-New Deal developments in federal public health law including the development of the Center for Disease Control, the National Institutes of Health, the Food and Drug Administration and the passage of Medicaid and Medicare legislation. Federal regulatory and legislative activity during the post-New Deal era was expansive. The Supreme Court initially supported the federal government's role but that support began to wane as the new federalism began to take shape. One commentator, seeing the different composition of the Court and cadre of public health law issues facing the federal courts has lamented, "[w]hile the existing allocation of powers between national and state governments seem[ed] well-suited to accomplishing these national public health objectives, there is just one problem. Federalism is back."

In public health law and other cases, however, the resurrection of traditional federalism principles began in 1976 when the Court in National League of Cities v. Usery struck down Congressional amendments to the Fair Labor Standards Act that intruded on traditional state police powers. Although that case was later overruled, it marked the beginning of a

---

130 See, e.g., Hodge, supra note 61, at 333-35.
131 United States v. Darby, 312 U.S. 100 (1941).
132 Id. at 114.
133 See generally Hodge, supra note 61, at 335-38.
134 Id. at 338-39 (emphasis omitted).
136 Garcia, 469 U.S. at 528.
coalition formed on the Court that eventually developed the judicial strand of the new federalism in the following decade. According to Gostin, Justice Rehnquist, author of the 1976 *National League of Cities* opinion, now leads a “reenergized majority on the Supreme Court... actively recentering the balance between national and state power.”

The first new federalism pronouncement in public health came in *New York v. United States*, in which the Supreme Court held the “take title” provision of the federal Low-Level Radioactive Waste Policy Amendments Act of 1985 (“LLRWPA”) violated the Tenth Amendment. Describing the arguments that the LLRWPA violated the Tenth Amendment and that it legislated outside the enumerated powers of Congress “mirror images” of one another, the *New York* Court held, “[w]hether one views the take title provision as lying outside Congress’ enumerated powers, or as infringing upon the core of state sovereignty reserved by the Tenth Amendment, the provision is inconsistent with the federal structure of our Government.”

The Supreme Court again faced a public health issue in 1997. In *Printz v. United States*, the Court reiterated federalism principles as the basis for striking down portions of the Brady Handgun Violence Prevention Act which commanded state officials conduct background checks. The *Printz* Court stated that:

> [i]t is incontestible that the Constitution established a system of ‘dual sovereignty.’ Although the States surrendered many of their powers to the new Federal Government, they retained ‘a residuary and inviolable sovereignty.’...

The Framers’ experience under the Articles of Confederation had persuaded them that using the States as the instruments of federal governance was both ineffectual and provocative of federal-state conflict. The great innovation of this design was that ‘our citizens would have two political capacities, one state and one federal, each protected from incursion by the other....'
Similar to the Supreme Court’s new federalism which focuses on the levee function of the Constitution, public health law scholarship has been primarily concerned with restricting the extent to which the federal government might overreach its authority. While the Court’s concern has been preventing federal power from infringing upon state sovereignty, modern public health law literature addresses the threat that the federal government might over-extend its power to interfere with individual personal rights. Indeed, according to Gostin, “[m]uch of the history of public health . . . involves earnest debate over the relationship between the power of government and the freedom of individuals.” In order to answer the second question posed at the beginning of this section—which government should be primarily responsible for Medicaid—I propose a departure from this debate. Medicaid policy must not neglect the Constitutional fountain of federal power. Medicaid will continue to provide a health care “safety net” to America’s most vulnerable citizens only if the inherently federal responsibility of administering that program remains under the federal government’s control. The next section summarizes the sources of law from which federal authority to control Medicaid flows.

C. The Inherently Federal Responsibility to Protect the Public Health of Medicaid-Eligible Population

This Article has concluded above that the government’s obligation to protect the public health is both constitutional and democratic. It is practical as well. Public health is essential for a political community, not just for the individuals in that community, but for the life of that community itself. The community’s ability to create and sustain an economy, social interaction, raise a defense, and perform any defining functions will be compromised without a way to ensure the health of its participants. However, where the health of the most needy and least productive members of the community are concerned, the practical motivations for the government’s public health mission begin to blur. It is

143 See GOSTIN, supra note 113, at 63-64, 86-87, for excellent and comprehensive summaries of the numerous specific contests between the government’s exercise of its public health authority and personal liberties. A few examples include, state vaccination programs versus religious freedom and individual autonomy; nuisance abatement versus freedom from taking and unrestricted property rights; mandatory testing, screening, data collection and disease reporting versus individual rights to privacy and freedom from unreasonable search and seizure.

144 Id. at 59.
here that the constitutional mandates become essential. The federal government’s obligation to the Medicaid population rests upon the source of the Medicaid entitlements, the Supreme Court’s interpretation of those rights, and the constitutional protections historically extended to the demographic groups that dominate the Medicaid-eligible population.

First, although there is no recognized right to health care generally, the Medicaid statute, enacted pursuant to the congressional power to tax, spend and regulate commerce, creates an expectation, indeed a recognized, enforceable right to receive the health care the government has funded. Applying the familiar elements of the implied remedy doctrine, the Medicaid statute’s federally defined eligibility standards identify the target population the statute is intended to specially benefit. Moreover, the statute is intended to provide health care access to these populations and fund this care. Finally, it is consistent with the traditionally dominant oversight the federal government has provided in Medicaid to conclude that the federal government has assumed a role neither historically nor feasibly filled by state government.

Further evidence of the constitutional justification for federal control over Medicaid lies in the judicial view of the demographic community the program serves. In equal protection jurisprudence, the Supreme Court has extended the highest degree of deference to legislative efforts to protect precisely the segments of the population who are overwhelmingly represented among Medicaid enrollees or Medicaid eligible populations. In 1997, over forty percent of all people with incomes below the federal poverty line were enrolled in Medicaid; over twenty percent of all African-Americans were enrolled in Medicaid; nine percent of all American women were enrollees; and the highest percentage of all enrollees were children under the age of nineteen. The compelling need to eliminate the disparity of health care access and health care outcomes for these populations rests in their dependence and vulnerability; the fact is that only the collective action of the national community will protect the public health of this population. James Blumstein has observed that the Supreme Court focuses on three factors to determine whether a federal “right” should be

---

148 See Rosenbaum & Rousseau, supra note 19, at 28-29.
recognized in a given area. Those factors are (1) the importance and constitutional connections of the interest at stake; (2) whether the state has monopolized access to the service in question; and (3) whether there has been an absolute deprivation of the service at issue. Medicaid's importance and constitutional connections are clear; the state's monopoly over access to health care for this population is evidenced by the absolute deprivation of health care that results when the federal government withdraws. Applying Blumstein's factors, we must conclude that the essential mission of public health—to promote the physical and mental health of populations—can only be fulfilled where the Medicaid eligible population is concerned, by the "broad exercise of federal powers in a centralized, national government."^150

VI. CONCLUSION

The federalism doctrine grounded in the Constitution establishes balance between federal and state power. Across history, that balance has never been static, but as with the government's obligation to protect the public health of the needy, the balance changes as the political and judicial environment shifts. However, in light of the empirically demonstrable disparity that results from increased state control of Medicaid, this program may implicate a uniquely federal concern. In fact, the newest concern of the new federalism may be to preserve the admittedly limited and delegated power of the federal government, so that the states' exercise of their Tenth Amendment police powers does not compromise equal access to federally funded healthcare for Medicaid beneficiaries who are predominately women, minorities, elderly, disabled and children.

---


^150 See Hodge, supra note 61, at 312.