

Spring 2012

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Recommended Citation

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MEDICAID GOVERNANCE IN THE WAKE
OF *NATIONAL FEDERATION OF
INDEPENDENT BUSINESS V. SEBELIUS*:
FINDING FEDERALISM'S MIDDLE
PATHWAY, FROM ADMINISTRATIVE LAW
TO STATE COMPACTS

JOHN D. BLUM* AND GAYLAND O. HETHCOAT II**

I. INTRODUCTION

“Keep your government hands off my Medicare” is a phrase that echoed through the summer of 2009 in town-hall meetings in which public outrage over health reform was the news of the day.¹ Interestingly enough, there were no signs imploring politicians not to legislate away the other major public health insurance program: Medicaid. As the story of health reform unfolds, however, it is this program that lies at the epicenter of controversy over health reform.² The dispute over Medicaid is not driven by passions of the citizenry about loss of benefits but by a fight within the halls of government concerning the dramatic expansion and restructuring of the program contained in the Affordable Care Act (ACA),³ the reform legislation that Congress passed in 2010. The challenge to the Medicaid expansion rests on the oddities of public health insurance governance and raises disputes about federalism, a somewhat perennial battleground of American jurisprudence, which, not surprisingly, has followed us into the twenty-first century.⁴

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1. Paul Krugman, *Why Americans Hate Single-Payer Insurance*, N.Y. TIMES, July 28, 2009, <http://krugman.blogs.nytimes.com/2009/07/28/why-americans-hate-single-payer-insurance/>.

2. Benjamin D. Sommers & Arnold M. Epstein, *Medicaid Expansion—The Soft Underbelly of Health Reform?*, 363 NEW ENG. J. MED. 2085, 2085-2087 (2010).

3. Pub. L. No. 111-148, §§ 2001-2955, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

4. *See generally* ERWIN CHERMERINSKY, *ENHANCING GOVERNMENT: FEDERALISM FOR THE 21ST CENTURY* (2008).

The Medicaid claim heard by the U.S. Supreme Court arose in the mire of details and complexities in the pages of the ACA legislation, as well as those in the even more voluminous accompanying regulations. Clearly, disputes over laws as complex as ACA are to be expected, but they generally unfold as a type of legal trench warfare sparked by regulatory matters of implementation. The legal battles over ACA, however, go well beyond administrative law details and reach core aspects of the law's insurance reform scheme.⁵ Nagging doubts about the constitutionality of the ACA insurance expansion have moved from the margins to the mainstream, fueled by emotions and politics, reflective of the passionate seniors at the town halls in 2009, but also driven by sophisticated legal considerations.⁶ The details of the constitutional challenges to ACA were layered and nuanced, and the merits of the issues that the courts have heard have passed from being casually marginalized in legal circles to sparking serious angst about how public health insurance reform can proceed, in light of the majority ruling in *National Federation of Independent Business v. Sebelius*.⁷

As ACA has moved beyond the realms of statutory and administrative law and into the arena of federal litigation, the merits of the legal challenges coalesced around two primary issues: the constitutionality of the minimum essential coverage provision, or the "individual mandate" to acquire health insurance, under the Commerce Clause,⁸ and the expansion of Medicaid under the General Welfare Clause.⁹ Both of the challenges touched on the core elements of the health reform initiative, which are essential to the architecture of universal coverage. Undoubtedly, the individual mandate has received broader consideration, as it has been the focal point of contention in the federal cases leading up to the Supreme Court's review, and ultimately the Court ruling that the mandate stands as a valid exercise of federal taxing power.¹⁰ Although the jurisprudential intricacies must be

5. Kevin Arts & Bill Erwin, *Legal Challenges to Health Reform*, ALLIANCE FOR HEALTH REFORM (May 18, 2010), http://www.allhealth.org/publications/Uninsured/Legal_Challenges_to_New_Health_Reform_Law_97.pdf.

6. *Id.*; see also Ian Urbina, *Beyond Beltway, Health Reform Turns Hostile*, N.Y. TIMES, Aug. 7, 2009, http://www.nytimes.com/2009/08/08/us/politics/08townhall.html?_r=1.

7. *National Federation of Independent Business v. Sebelius*, No.11-393, slip. op (U.S. June 28, 2012). For historic reference, see Stephanie Stapleton, *Back-Up Plans for the Individual Mandate?*, KAISER HEALTH NEWS (Sept. 6, 2011), <http://www.kaiserhealthnews.org/stories/2011/september/06/individual-mandate-round-robin.aspx> (providing differing opinions).

8. U.S. CONST. art. I, § 8, cl. 3.

9. U.S. CONST. art. I, § 8, cl. 1.

10. Betsy Goldman, *Justice Kennedy and Obamacare: In Which Direction Will He Swing?*, BLOOMBERG LAW REPS., Jan. 25, 2012.

distinguished in considering the merits of these issues, there are overarching connections between them, namely the legal propriety of the exercise of federal power in the area of health insurance generally. This underlying constitutional theme is embedded in the question of whether Congress can exert its powers to force individual and state actors alike to comply with requirements that expand health insurance coverage to thirty-two million citizens, moving close to the elusive goal of universal coverage—the bedrock of ACA, and the determining factor of the success of the historic legislation.

This Article evolves from one side of the ACA Supreme Court case, *National Federation of Independent Business v. Sebelius*, namely the challenge mounted by several states concerning their obligation to expand Medicaid coverage by raising eligibility standards to 133 percent of the federal poverty level (FPL), which is arguably the most significant element of ACA.¹¹ Here, the Supreme Court finding of merit in the state argument of coercion was even more stunning than its upholding of the mandate on taxing power grounds.¹² The inquiry in this Article touches on details of the Medicaid “coercion” claim considered by the Court as a backdrop to a broader discussion concerning federalism and the future of state regulation in health care—a matter shaped not only by law, but variables not easily controlled by law or Washington, in particular the economic realities faced by state government. It is difficult to write about the long term impacts of a Court ruling when the ink has barely dried: as confronting the black and white of the actual ruling will be a process that will likely unfold over several years. While no doubt, the decision in *National Federation* and its unfolding details will inevitably reinforce the grand caveat that no one, lawyer and layperson alike, should neither second guess the U.S. Supreme Court nor draw hasty conclusions about how Court jurisprudence will impact machinations of government policy. It is not, the intent of this Article to offer a lengthy analysis of the Medicaid aspects of the *National Federation* case. Rather, this Article builds on the opinion as a springboard for a consideration of the federalism issue, one that proposes fundamental reforms to the current structures of health governance in the contexts of Medicaid and federal-state relations in this sector more broadly. While it may be startling to

11. For an excellent overview of the Medicaid expansion in ACA, see Renee M. Landers & Patrick A. Leeman, *Medicaid Expansion Under the 2010 Health Care Reform Legislation: The Continuing Evolution of Medicaid's Central Role in American Health Care*, 7 NAELA J. 143 (2011). See also Chris Edwards, *Medicaid Reforms, Downsizing the Federal Government*, CATO INST. (Sept. 2010), <http://www.downsizinggovernment.org/hss/medicaid-reforms> (discussing the costs that will take place in the coming years).

12. *National Federation*, No.11-393, slip. op at 45-57.

constitutional scholars that the coercion claim in *National Federation* succeeded, the long-term challenge for ACA is the emerging need to restructure the federal-state relationship to meet the legislative goals of expanding health insurance to the poor.¹³

This Article is composed of four parts. The first part explores health reform from a broad perspective, considering the array of goals and key elements in ACA, which, when pieced together, aspire for universal coverage. The second part discusses the status of Medicaid, a program that lies at the middle of the federalism debate, and whose future will determine the success or failure of ACA. The third part reflects on the legal argument that the Medicaid expansion in ACA violates Congress's constitutional tax-and-spend power, which is noteworthy not only for its legal basis but also its potential to usher in a broader exploration of the duality of health governance. The fourth part proposes how Medicaid reform can move forward, beyond the parameters of combative federalism and the confines of the present constitutional ruling over Medicaid, positing considerations to better balance public health governance, and with luck goes beyond the mere proverbial shifting of deck chairs.

II. HEALTH REFORM OBSERVATIONS: THE BACKDROP

ACA charts an ambitious course in federal health policy, building on the many facets of public health insurance that have emerged over the past seventy-five years.¹⁴ Although the ten titles that make up ACA cut across a wide variety of issues and programs, the core of this effort is to address the problem of the uninsured through an individual mandate, a series of coverage reforms, and notably a major expansion of the Medicaid program.¹⁵ Since its enactment two years ago, ACA has had a significant effect not only on health law and regulation, but also on the marketplace of health delivery.¹⁶ In particular, the impacts of ACA are evident in both the hospital industry and the practice of medicine.¹⁷

13. Jonathan Cohn, *New Republic: The Undermined Medicaid Expansion?*, NATIONAL PUBLIC RADIO (July 2, 2012), <http://www.npr.org/2012/07/02/156105350/new-republic-the-undermined-medicaid-expansion>.

14. JOHN E. MCDONOUGH, *INSIDE NATIONAL HEALTH REFORM* 1-100 (2011).

15. *Id.* at 101-55.

16. Jon Stewart, *Experts Say Health Reform Has Its Own Momentum, Observations*, KAISER PERMANENTE INST. FOR HEALTH POL'Y (Apr. 13, 2011), http://www.kpinstituteforhealthpolicy.org/kpihp/frmContent.aspx?CMS_Entry_Id=319&Content_Type=H.

17. *Id.* See generally THE PHYSICIANS FOUND., *HEALTH REFORM AND THE DECLINE OF PHYSICIAN PRIVATE PRACTICE* (2010), <http://www.merritthawkins.com/uploadedFiles/>

On its face, ACA is not a grand vision of health care. Rather, the legislation constitutes a series of initiatives, or smaller visions, which collectively facilitate a new, albeit expanded, network of insurance coverage. The policy objectives of ACA are best captured by the operating plans of the law's chief bureaucratic agent, the Department of Health and Human Services (DHHS). In the agency's 2010-2015 strategic plan, DHHS Secretary Kathleen Sebelius identified fixing the nation's broken health insurance system as the agency's primary health goal, clearly mirroring what can be extrapolated from ACA as its most basic purpose.¹⁸ To this end, the agency enumerated six objectives, all of which emerge from the pages of ACA and could, in fact, be labeled as a restatement of the legislation's core objectives. These objectives are (1) making coverage more secure for those who have health insurance and extending it to the uninsured, (2) improving health care quality and patient safety, (3) strengthening primary and preventive care, (4) reducing health care costs, (5) better serving vulnerable populations, and (6) adopting "meaningful use" of health information technologies (IT).¹⁹ While development of health IT is more fully articulated in the Hi-Tech Act provisions of the American Recovery and Reinvestment Act, it is a vital element in the architecture of reform efforts, and must be seen as a critical component of public and private health insurance reform.²⁰ In a broader sense, the objectives can be seen together as an affirmation of the governmental commitment to a public health insurance system. And that commitment—a type of social contract—becomes far more critical to ACA's success than implementation of any one set of details.

But details do matter, and in ACA's case, they are abundant and complex, unfolding in a massive piece of legislation that must be assessed in reference to an array of prior laws, and the broad federal and state structures developed for health care and insurance alike. ACA's primary features can be viewed as a series of measures that roll out a string of regulations, which lead to the end point of coverage expansion and along the way create a floor

MerrittHawkins/Pdf/mhafoundationwhitepapcondens.pdf.

18. See U.S. DEPT OF HEALTH & HUMAN SERVS., STRATEGIC PLAN FISCAL YEARS 2010-2015 (2012), http://www.hhs.gov/secretary/about/stratplan_fy2010-15.pdf (explaining that the federal Departments of Treasury and Labor, as well as state departments of health and insurance play Key roles in ACA).

19. *Id.* at 16. See also Letter from Cindy Mann, Dir., Center for Medicaid and State Operations, Dep't of Health & Human Servs., to State Health Officials and State Medicaid Dirs. (April 9, 2010), available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10005.PDF> (detailing individual coverage options under Medicaid made possible by the ACA).

20. See 42 U.S.C.S. § 17935 (2012).

for system reform. The most direct way to achieve a general understanding of ACA is to chart the legislation over its ten titles. For purposes of this Article, the key sections of expansion fall into two titles. Title I contains the temporary reforms that immediately addressed access and funding needs of targeted groups, such as young adults and early retirees.²¹ But the heart of Title I lies in four key reforms: (1) an individual insurance mandate; (2) a guaranteed issue requirement, which bans the use of preexisting condition exclusions in health insurance policies; (3) premium and cost-sharing subsidies for low-income people; and (4) state-based insurance purchasing collectives, known as exchanges. It is estimated that Title I expansions will result in health insurance coverage for half of the uninsured population.²² Title II—the heart of this Article—mandates an expansion of the state Medicaid programs to poor people with less than an income set at 133 percent of the federal poverty level.¹⁹ The Title II expansion is dramatic in that it extends Medicaid to uncovered individuals typically not covered by the program, in particular poor, childless adults. This portion of ACA accounts for the expansion of health insurance to as many as twenty million people.²³

21. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1101-1105, 124 Stat. 119 (2010).

22. Patient Protection and Affordable Care Act, Title II, Pub. L. No. 111-148 (2010).

23. See Roni Caryn Rabin, *With Expanded Coverage for the Poor, Fears of a Big Headache*, N.Y. TIMES Apr. 26, 2010, <http://www.nytimes.com/2010/04/27/health/27landscape.html> (discussing concerns over Title II). As to the other titles in ACA, Title III deals with Medicare, mandating major cuts in the program over ten years; the creation of a cost review panel, the Independent Payment Advisory Board; and increased drug payments for seniors, thereby shrinking the Medicare Part D donut hole. Patient Protection and Affordable Care Act, Title III, Pub. L. No. 111-148 (2010). In addition, Title III allows Medicare enrollees to obtain coverage for preventive services without co-pays or deductibles. *Id.* Public health is the centerpiece of Title IV, which creates a \$15 billion fund to spur investments in a range of population health initiatives. Patient Protection and Affordable Care Act, Title IV, Pub. L. No. 111-148 (2010). Title V is directed toward the health care workforce, with a focus on the expansion of primary care providers. Patient Protection and Affordable Care Act, Title V, Pub. L. No. 111-148 (2010). Title V expands enrollment in the National Health Service Corps program, which provides debt relief to medical students, and increases funding for community health centers. *Id.* Title VI focuses primarily on efforts to expand Medicare and Medicaid fraud and abuse controls. Patient Protection and Affordable Care Act, Title VI, Pub. L. No. 111-148 (2010). Title VII expands the authority of the Food and Drug Administration to enable the agency to more effectively regulate the manufacture, marketing, and sale of biosimilar products. Patient Protection and Affordable Care Act, Title VII, Pub. L. No. 111-148 (2010). Title VIII, a long-term care insurance program (the Community Living Assistance Services and Supports), has been the first portion of ACA to be scrapped, as the Obama Administration could not guarantee that premium support would be adequate for the seventy-five-year

Beyond discernment of the broad objectives in health reform and key factors in ACA's titles, another perspective on the law can be garnered, in even broader terms, as it relates to health insurance. That is, ACA fails to contain a distinct vision of health and lacks a single, integrated national health insurance plan. In fact, the law is a rejection of the long-standing effort on the part of some in the health policy community to create a uniform, single-payer system, as well as a new public option plan for the uninsured.²⁴ Nevertheless, the law endeavors toward the goal of offering most Americans primary and acute-care health care coverage by maintaining existing coverage and building new avenues for coverage, which, with the exception of the health insurance exchanges, rest on existing coverage platforms. Thus, ACA is an elaborate webbing of public and private health insurance, a scheme in four parts, tying together coverage based on Medicare, Medicaid, employer-sponsored health insurance, and expanded private-sector small and individual market insurance offerings. To achieve dramatic expansion of health insurance, however, ACA does more than construct a benign floor; it also makes significant changes in the structure, processes, and administration of insurance, and in so doing, markedly expands the scope of federal oversight in an area traditionally left to the states. Of particular note, the law expands the administrative simplification regulations under the Health Insurance Portability and Accountability Act of 1996, mandating new operating rules to create uniformity in medical information reporting and electronic transfer of data to health insurers—an unheralded, but critical infrastructure reform.²⁵

time period required in the law. Patient Protection and Affordable Care Act, Title VIII, Pub. L. No. 111-148 (2010). Title IX contains the revenue portions of ACA, which include Medicare taxes on high-income earners, as well as assessments and taxes on drug, medical device, and health insurance companies, and special taxes on high-cost health insurance plans and tanning beds. Patient Protection and Affordable Care Act, Title IX, Pub. L. No. 111-148 (2010). Title X is largely a procedural title making changes and amendments to the law, but is primarily noteworthy for its reauthorization of the Indian Health Care Improvement Act. Patient Protection and Affordable Care Act, Title X, Pub. L. No. 111-148 (2010).

24. See Jason Linkins, *The Beginning of the End for the Public Option*, HUFFINGTON POST (Nov. 29, 2009), http://www.huffingtonpost.com/2009/09/29/the-beginning-of-the-end_n_303612.html (discussing the public option); see also Ben Smith, *Obama Rejects Single Payer*, POLITICO (June 15, 2009), http://www.politico.com/blogs/bensmith/0609/Obama_rejects_single_payer.html (citing Obama's plan for a middle ground between private and government funded care).

25. Patient Protection and Affordable Care Act, Title I, Pub. L. No. 111-148, § 1104 (2010); *Affordable Care Act cuts red tape, saves \$12 billion*, U.S. DEPT OF HEALTH & HUM. SERVICES (June 30, 2011), <http://www.hhs.gov/news/press/2011pres/06/20110630a.html>.

Shortly after the President signed ACA, the Obama Administration set off a vigorous regulatory timeline, which resulted in rapid implementation of key sections of the law.²⁶ From the regulations on a tanning-bed tax, to more recent regulations on accountable care organizations (ACO), health insurance plan information requirements, and value-based purchasing, a new landscape of rules has developed, which must be accommodated by virtually all components of the health care sector.²⁷ This regulatory activity—spearheaded by three agencies, the Departments of Health and Human Services, Labor, and Treasury—is unprecedented for its volume and complexities, as regulators must meet ACA's new legislative directives that expand federal programs in ways that both harmonize with and build off existing statutes. In addition to the federal activity, states have been extensively engaged in ACA-related health reform in both their roles as regulator and regulatee. Many states are creating health insurance exchanges, and virtually all are engaged in insurance reforms, Medicaid analyses and revisions, and major statutory compliance revisions.²⁸ But, however voluminous and complex ACA regulatory design and compliance may be, such processes are the stock and trade of modern governments; of all the variables that will determine ACA's success or failure, regulatory accommodation is one that can be addressed, not easily, but nevertheless, within the parameters of established administrative laws and related bureaucratic processes.

The question of whether ACA can successfully build a national floor for health insurance goes well beyond concerns over bureaucratic responses and capacities, and implicates greater considerations about the federal role in shaping macro and micro policies in the areas of health care delivery and insurance generally. The law deals with many of the major variables, such as cost, quality, and human resource development, which will

26. See *Implementation Timeline*, KAISER FAMILY FOUNDATION, <http://healthreform.kff.org/timeline.aspx> (last visited Mar. 3, 2012) (outlining the ACA timeline).

27. See *Indoor Tanning Services*, 75 Fed. Reg. 33,683 (June 15, 2010) (establishing a tanning-bed tax); *Medicare Shared Savings Program*, 76 Fed. Reg. 67, 802 (Nov. 2, 2011) (establishing the Medicare Shared Savings Program for accountable care organizations); *Summary of Benefits and Coverage and Uniform Glossary*, 77 Fed. Reg. 8668 (Feb. 14, 2012) (summarizing benefits and coverage).

28. Rachel Morgan, *The 2011 State Legislators' Check List for Health Reform Implementation*, NAT'L CONFERENCE OF STATE LEGISLATURES (February 2011), http://www.ncsl.org/documents/health/State_Legislators_Checkdec20.pdf. See Michael Cooper, *Many Governors Are Still Unsure About Medicaid Expansion*, N.Y. TIMES, July 14, 2012, http://www.nytimes.com/2012/07/15/us/governors-face-hard-choices-over-medicaid-expansion.html?_r=1&ref=nationalgovernorsassociation.

influence the course of health reform. In building its web of coverage, ACA lays the foundation for key system redesigns through a variety of initiatives to promote innovation in the delivery of care and the practice of medicine. Initiatives such as the Medicare Shared Savings Program for physicians in ACOs and the expansion of value-based purchasing for hospitals are directed to long-term systemic changes, which encapsulate the core feature of so much of government health policy, namely improving quality through leverage of reimbursement systems.²⁹ Although each of these areas presents massive and complex challenges, these challenges remain within the purview and influence of government health regulators and Congress.

Other, larger variables affecting ACA, such as economics, federal budget realities, politics, and the march of science and technology, extend beyond the capacity of any law; they are wild cards that may skew the plans of health reformers and play havoc with the future prospects of government health policy. From its inception to the present, ACA has been molded and implemented in the cross currents of these variables. Although fiscal externalities in health policy are hard to gauge, they nevertheless can be anticipated to some extent and, as is evident in ACA's history, have been and will continue to be fundamental considerations in legislative deliberations. What is curious about ACA, however, is that the one externality that has somewhat blindsided the process of reform has been the law itself. Legal challenges to legislation of every sort are not unusual, and it is certainly evident in review of ACA that there was a strong awareness that the individual mandate could become a point of contention.³⁰ There is not, however, comparable evidence that a challenge concerning the law's Medicaid expansion was a serious threat to legislative implementation. On the implementation side, there are many challenging issues surrounding the ACA Medicaid expansion, but the constitutionality of this expansion was an unpredictable variable of health reform that only the most ardent of state rights' advocates would have predicted, and arguably added to state challenges primarily for the sake of standing.

29. Paul B. Ginsburg & Chapin White, *Health Care's Role in Deficit Reduction—Guiding Principles*, 366 NEW ENG. J. MED. 1559, 1559-61 (2011).

30. See Jennifer Staman & Cynthia Brougher, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, CONG. RESEARCH SERV. (July 24, 2009), http://www.gwumc.edu/sphhs/departments/healthpolicy/healthreform/CRS%20Report_Constitutionality.pdf; David B. Rivkin Jr. & Lee A. Casey, *Mandatory Insurance is Unconstitutional*, WALL ST. J. (Sept. 18, 2009), <http://online.wsj.com/article/SB10001424052970204518504574416623109362480.html>.

III. MEDICAID: OBSERVATIONS ON THE CONTEXT OF FEDERALISM

Medicaid grew out of the Johnson Administration's War on Poverty and reflects a fundamental concern about the health and wellbeing of the disadvantaged.³¹ It is rooted in the Social Security Act and designed to follow the format of other welfare programs. That is, it is voluntary, jointly administered by the states and federal government, financed out of matching general revenue funds, and based on an eligibility means test.³² The core of Medicaid was to provide medical assistance to two primary populations: families enrolled in the Aid to Families with Dependent Children program and individuals participating in the federally assisted cash welfare program for the blind, aged, and disabled. For state governments, the cooperative federalism approach underlying Medicaid has created a challenging balance of flexibility and control. On one hand, the Medicaid statute conditions the receipt of federal matching funds on federal approval of a state operating plan, as well as subsequent amendments to such a plan, which must meet requirements for program structure, operations, and benefits.³³ But, on the other hand, the statute grants states flexibility to individually tailor their Medicaid programs through the addition of optional benefits, resulting in significant variations in plans across the country, reflected in eligibility, the scope and nature of services, and provider reimbursement rates.

Although the history of Medicaid does not parallel the constant reinvention of Medicare, it is nevertheless characterized by ongoing and regular changes in structure and benefits. Without accounting for the ACA expansion, Medicaid is already the nation's largest public health insurer, enrolling a population exceeding fifty-five million, with a combined federal-state cost of

31. Frank Fossett & Frank J. Thompson, *Administrative Responsiveness to the Disadvantaged: The Case of Children's Health Insurance*, 16 J. PUB. ADMIN. RES. & THEORY 370 (2006), available at http://www.rockinst.org/pdf/health_care/administrative_responsiveness_to_the_disadvantaged_the_case_of_childrens_health_insurance.pdf. 2005-09-15-

32. Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 856-57 (1990). See generally John K. Iglehart, *Expanding Eligibility, Cutting Costs—A Medicaid Update*, 366 N. ENG. J. MED. 105, 105-07 (2012); *Report to the Congress on Medicaid and CHIP*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N 26-45, (2011), available at http://healthreformgps.org/wp-content/uploads/MACPAC_March2011_web.pdf.

33. 42 U.S.C.S. 1396(a) (2012); *Report to the Congress on Medicaid and CHIP*, supra note 32. See generally *Policy Basics: Introduction to Medicaid*, CTR. ON BUDGET & POLICY PRIORITIES (Dec. 17, 2008), <http://www.cbpp.org/cms/index.cfm?fa=view&id=2223> (providing a basic introduction to the Medicaid program).

\$400 billion.³⁴ In its 2011 report, the Medicaid and CHIP Payment and Access Commission, a body that advises Congress on Medicaid policy, detailed twenty-five changes in the federal Medicaid law in coverage and eligibility since its passage in 1965. These changes include the 1972 coverage extension of individuals covered under the then-new Supplement Security Income (SSI) program, and new mandates and optional categories for pregnant women and children based on higher FPL guidelines in the 1980s.³⁵ More recent major changes have occurred as a result of new eligibility guidelines in federal welfare reform legislation: Temporary Assistance for Needy Families, and the Children's Health Insurance Program (CHIP) in 1997 and its 2009 reauthorization.³⁶ Not only have Medicaid benefits been markedly expanded over time, but noticeable changes in the nature and structure of care have occurred, and continue to occur. These changes emphasize shifting enrollees from fee-for-service settings to managed care and primary care case management, and from long-term care facilities to community-based non-institutional care arrangements.³⁷ The current picture of the program, at best, is a mixed one, as the fifty-six different plans under the Medicaid umbrella are essential to provide safety-net services to a growing number and type of enrollees, yet they are plagued with problems of cost and quality, manifest in low provider payment and in states' ongoing struggles to expand long-term care needs.³⁸ The troubled yin and yang of federal Medicaid financing, underpinned by the open nature of the federal medical assistance program (FMAP)—the so-called matching rate—has created a dizzying array of programmatic changes, and a persistent dissonance between expansion of efforts and control of expenditures occurring in the face of unemployment, recession, and the complexities of cost containment driven by swelling numbers of the aged and disabled.³⁹

ACA represents the largest expansion of Medicaid since its inception in 1965 and accounts for forty-five percent of the overall

34. *Report to the Congress on Medicaid and CHIP*, *supra* note 32.

35. *Id.*

36. *Id.* at 117-122.

37. Iglehart, *supra* note 32.

38. *Report to the Congress on Medicaid and CHIP*, *supra* note 32, at 13; Iglehart, *supra* note 32.

39. *Report to the Congress on Medicaid and CHIP*, *supra* note 32; *see also* Iglehart, *supra* note 32 (discussing Medicaid costs and recent Supreme Court rulings); *see also* Vernon K. Smith et al., *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, KAISER COMM'N ON MEDICAID & THE UNINSURED (2011), <http://www.kff.org/medicaid/upload/8248.pdf> (noting Medicaid costs and the impact of the recession on state funding).

costs of health reform.⁴⁰ The law expands Medicaid coverage in 2014 by creating a new eligibility category for nearly all individuals under age sixty-five and, with a special deduction equal to five percent of the FPL, in essence raises eligibility levels to 138 percent of the FPL.⁴¹ New categories of eligible enrollees will qualify for the program based on a calculation of an individual's modified adjusted gross income removed from traditional asset or resource tests.⁴² The expansion, while primarily directed to adults without dependent children, will also impact poor parents, as well as children with family incomes up to 133 percent of the FPL.⁴³ States do not need to provide newly-enrolled adults standard comprehensive Medicaid benefits, but rather must offer essential health benefits, which include ten core features, such as hospitalization, prescription drugs, and preventive services, as well as benchmarks for plans to guarantee uniformity of offerings for new enrollees. Over the next ten years, ninety-three percent of the costs for the ACA Medicaid expansion will be borne by the federal government, with varying state FMAP payments.⁴⁴ Then, in 2020, the federal share will drop to ninety percent for all Medicaid programs.⁴⁵ Until health exchanges begin operation in 2014, states must follow maintenance-of-effort standards, which prevent them from altering program eligibility criteria that were in place at the time of ACA's passage.⁴⁶ Other key ACA Medicaid changes include increasing rebates for prescription drugs, streamlining enrollment via state-administered websites, and mandating states to increase outreach to, and enrollment of, underserved and vulnerable populations.⁴⁷

40. Landers & Leeman, *supra* note 11, at 145.

41. Pam Silberman, *Eligibility and Enrollment: Medicaid Workgroup*, N.C. INST. OF MED. (Apr. 13, 2011), <http://www.nciom.org/wp-content/uploads/2010/12/eligibility-enrollment.pdf>.

42. *Id.*; see also Carrie Au-Yeung and John Czajka, *Modified Adjusted Gross Income: Implications for Medicaid Eligibility Systems under the ACA*, STATE HEALTH ACCESS DATA ASSISTANCE CTR. (July 2011), http://www.shadac.org/files/shadac/publications/ACA%20Note_MAGI_FMAP.pdf.

43. Landers and Leeman, *supra* note 11.

44. January Angeles & Matt Broaddus, *Federal Government Will Pick Up Nearly All Costs of Health Reform's Medicaid Expansion*, CTR. ON BUDGET & POLY PRIORITIES (Mar. 28, 2012), <http://www.cbpp.org/cms/index.cfm?fa=view&id=3161>.

45. *Id.*

46. *Maintenance of Effort Requirements Under Health Reform*, FAMILIES USA (Mar. 2010), <http://www.familiesusa.org/assets/pdfs/health-reform/maintenance-of-effort.pdf>.

47. See S. FIN. COMM. & H. ENERGY & COMMERCE COMM., 112TH CONG., *MEDICAID EXPANSION IN THE NEW HEALTH LAW: COSTS TO THE STATES* (2011), available at <http://energycommerce.house.gov/media/file/PDFs/030111MedicaidReport.pdf>; Angeles and Broaddus; Silberman, *supra* note 41.

Even with massive amounts of new federal money, state governments are concerned about potential expansion in administrative costs, the financial implications of increases in enrollment from already qualified populations, and their overall ability to comply with maintenance-of-effort requirements in the face of a deep economic downturn.⁴⁸ State Medicaid programs were able to sustain their efforts through the worst part of the recession with the help of special stimulus funding, but as of 2011 that funding expired.⁴⁹ The Congressional Budget Office projects that an additional 25.6 million people will enroll in Medicaid in the next decade, increasing state administrative costs by \$12 billion, and that the new eligibility groups will cost the states a total of \$118 billion through 2023.⁵⁰ The pressures of expansion will be compounded by the fact that Medicaid financing will remain a perennial target for cost cutting at the federal level in the face of the seemingly intractable budget deficit and the burgeoning federal debt. In his 2013 federal budget proposal, President Obama calls for fifty-one billion dollars in Medicaid cuts over the next ten years, which conceivably could improve the overall functioning of the program, but would likely exact a price on state finances.⁵¹ Although Washington is holding the line on ensuring states' compliance with current Medicaid obligations, federal policy in this area has reflected, and continues to reflect, an awareness of the core role of states and a growing sensitivity to the fragility of state finances. Of late, the posture of the federal executive branch is one that, at least publically, has embraced individual state approaches to Medicaid and, within the boundaries of federal obligation, provides significant latitude to

48. S. FIN. COMM. & H. ENERGY & COMMERCE COMM., *supra* note 47.

49. Ron Shinkman, *States Pockets Empty as Medicaid Stimulus Winds Down*, FIERCE HEALTH FIN., (July 19, 2011), <http://www.fiercehealthfinance.com/story/medicaid-stimulus-winds-down-states-ask-now-what/2011-07-19>.

50. See generally CHRISTOPHER J. TRUFFER ET AL., DEP'T OF HEALTH & HUMAN SERVS., 2010 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID (2010), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2010.pdf> (outlining Medicaid trends, past and present, and discussing enrollment and expenditures).

51. To save costs, the President proposes blending the Medicaid and Children's Health Insurance Program match rates, reducing the number of provider taxes for which states can draw down matching dollars, reducing the disproportionate share funds for hospitals, and reducing fraud and abuse for durable medical equipment. Debra Miller, *The President's Health Budget: Federal Savings May Translate to Increased State Expenditure*, KNOWLEDGE CENTER, (Feb. 14, 2012, 11:10 AM), <http://knowledgecenter.csg.org/drupal/content/president%E2%80%99s-health-budget-federal-savings-may-translate-increased-state-expenditures-0>.

state reform proposals.⁵² The implications of *National Federation* for Medicaid expansion only serve to exacerbate the federal need to accommodate states, as the conditions of expansion must be carefully crafted with all fifty-six programs.

IV. COERCION: THE LEGAL CLAIM

Despite the federal government's attempts to conciliate the states, a number of state governments concluded that ACA stretched the program beyond the parameters of cooperative federalism. To these states, the costs and administrative burdens they would have to bear under the law transformed Medicaid into a far different arrangement from what they agreed to when they joined the program post-1965, constituting a type of breach of contract. These states claimed to effectively have no choice to take on these new responsibilities, moreover, because to decline them would trigger withdrawal of all federal Medicaid matching funds—a circumstance too daunting for any state to consider, particularly in the current economy. Thus, in either scenario, the states were allegedly forced to bankrupt their treasuries. Faced with such prospects, these states turned to federal court for redress. In that forum, they alleged that the federal government exploited its tax-and-spend power to “coerce” them to comply with an overreaching federal dictate, thereby violating the Constitution's structural safeguards to preserve a federalist system of governance—an argument surprisingly accepted by the Supreme Court majority in *National Federation*.⁵³

The high stakes of this claim were evident in the states' carefully tailored, albeit politically charged, litigation strategy. Florida, a large-population political bellwether that has confronted federal oversight of its Medicaid program in other contexts,⁵⁴ led

52. *Sebelius Outlines State Flexibility and Federal Support Available for Medicaid*, U.S. DEPT OF HEALTH & HUM. SERVICES (Feb. 3, 2011), <http://www.hhs.gov/news/press/2011pres/01/20110203c.html>.

53. *National Federation*, No.11-393, slip. op at 45-57.

54. As Florida litigated its challenge to ACA in court, the state in late 2011 asked the Centers for Medicare and Medicaid Services (CMS) to waive certain statutory requirements under the federal Medicaid law. Most ambitiously, the state proposed to shift nearly all its three million Medicaid beneficiaries onto privately-managed care plans. See Letter from Roberta K. Bradford, Deputy Sec'y for Medicaid, Fla. Agency for Health Care Admin., to Richard Jensen, Dir., Div. of State Demonstrations & Waivers, Ctrs. for Medicare & Medicaid Servs. (Aug. 1, 2011), available at http://ahca.myflorida.com/Medicaid/statewide_mc/fsdocs/Amendment_1_1115MedicaidReformWaiver_08012011.pdf (outlining the proposed shift from Medicaid to private managed care plans). Additionally, the state proposed to require beneficiaries to pay a \$10 monthly premium and a \$100 copayment for nonemergency use of the emergency room. See generally Letter from Roberta K. Bradford, Deputy Sec'y for Medicaid, Fla. Agency for Health Care Admin., to Richard Jensen, Dir., Div. of State Demonstrations & Waivers, Ctrs. for Medicare & Medicaid Servs.

the group of litigants. Together with thirteen other states—a number that grew to twenty-six state governors and attorneys general after the 2010 midterm election—then Florida Attorney General Bill McCollum filed suit in federal court only minutes after President Obama signed the law in 2010.⁵⁵ Any one of the various states could have been the setting for the challenge, but media reports speculated that the state officials opted for Florida to ensure appeal with the U.S. Court of Appeals for the Eleventh Circuit, which has garnered Supreme Court review (and reversal) in recent years in cases holding that Congress unconstitutionally exerted its Commerce Clause power.⁵⁶ To this supposed end,

(Aug. 1, 2011), http://ahca.myflorida.com/Medicaid/statewide_mc/fsdocs/Amendment_2_1115_Medicaid_Reform_Waiver_08012011.pdf; Letter from Roberta K. Bradford, Deputy Sec'y for Medicaid, Fla. Agency for Health Care Admin., to Richard Jensen, Dir., Div. of State Demonstrations & Waivers, Ctrs. for Medicare & Medicaid Servs. (Aug. 1, 2011), http://ahca.myflorida.com/Medicaid/statewide_mc/fsdocs/Amendment_3_1115_Medicaid_Reform_Waiver_08012011.pdf (explaining the increased costs for beneficiaries). CMS denied the latter two proposals, citing in part ACA's maintenance-of-effort requirements as barring the monthly premium. See Letter from Victoria Wachino, Dir., Div. of State Demonstrations & Waivers, Ctrs. for Medicare & Medicaid, to Justin M. Senior, Deputy Sec'y for Medicaid, Fla. Agency for Health Care Admin. (Feb. 9, 2012), http://ahca.myflorida.com/medicaid/statewide_mc/fsdocs/Final_signed_FL_amend_02-09-12.pdf (deciding against adopting a proposal that would include monthly premiums). As of this writing, CMS has yet to rule on the managed-care proposal, which some analysts suggest could restrict beneficiaries' access to care and yield minimal, if any, savings. See Christine Vestal, *Studies Point to Flaws in Florida's Medicaid Managed Care*, STATELINE (Dec. 14, 2011), <http://www.stateline.org/live/details/story?contentId=619038>. Though different in form, these proposals substantively derive from the same source as Florida's coercion claim: a desire to release the state from what it perceives to be a tremendous financial burden.

55. Complaint, *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256 (N.D. Fla. 2011) (No. 3:10-cv-91-RV/EMT), 2010 WL 1038209 [hereinafter *Florida*]. Virginia filed its own federal lawsuit challenging ACA on the day that the President signed the law. Complaint for Declaratory and Injunctive Relief, *Virginia ex rel. Cuccinelli v. Sebelius*, 702 F. Supp. 2d 598 (E.D. Va. 2010) (No. 3:10CV188-HEH), 2010 WL 3875236 [hereinafter *Virginia*]. Several months later, Oklahoma filed a similar lawsuit. Complaint for Declaratory and Injunctive Relief, *Oklahoma ex rel. Pruitt v. Sebelius*, No. 6:11-CV-30-RAW (E.D. Okla. Jan. 21, 2011) [hereinafter *Oklahoma*]. Unlike the Florida lawsuit, both the Virginia and Oklahoma lawsuits challenge only the individual mandate. See generally *Virginia, supra*, at ¶¶ 17-20; *Oklahoma, supra*, at ¶¶ 16-21. All the lawsuits, however, seek to invalidate ACA in full on the ground that the allegedly unconstitutional mandate is not severable from the legislation. Notwithstanding these efforts, other states have proffered their support for the law in amici briefs in the courts. See, e.g., Brief of the States of Oregon et al. as Amici Curiae in Support of Respondents, *Florida v. Dep't of Health & Human Servs.*, 132 S. Ct. 604 (2012) (No. 11-400), 2012 WL 588460 (addressing the Medicaid challenge).

56. Kevin Sack, *Florida Suit Poses a Challenge to Health Care Law*, N.Y.

McCollum elected against suing in Tallahassee, the location of the attorney general's office; instead, he sued more than 200 miles away in Pensacola, promising that the presiding judge at the small court there would be a Republican appointee.⁵⁷ On the merits, the states attacked the constitutionality of ACA's Medicaid expansion and also the individual mandate,⁵⁸ which clashed with laws that some of the states passed to relinquish their citizens' obligation to acquire health insurance under ACA.⁵⁹ Later, the states amended their complaint to include two individuals and a trade association,⁶⁰ who seemed better able to satisfy the jurisdictional requirements to challenge the mandate. Thus amended, the suit presented a quantity and diversity of plaintiffs and claims unseen in the multiple other ACA lawsuits then emerging, making it the most formidable vehicle to test the legislation before the Supreme Court.

Nevertheless, the strategic planning did not remove the legal obstacles to succeeding on the coercion claim in the lower courts. The claim traces to a single sentence from *South Dakota v. Dole*,⁶¹ a 1987 case in which the Supreme Court speculated 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.'"⁶² In making this observation, the Court relied on *Steward Machine Co. v. Davis*, a 1937 case in which the Court

TIMES (May 10, 2010), <http://www.nytimes.com/2010/05/11/health/policy/11lawsuit.html?pagewanted=1&emc=eta>.

57. *Id.*; Tom McLaughlin, *Why Challenge Health Care Reform in Pensacola?*, NW. FLA. DAILY NEWS (Mar. 24, 2010), <http://www.nwfdailynews.com/news/pensacola-27292-mccollum-health.html>.

58. Florida, *supra* note 55, at ¶¶ 54-67.

59. See generally Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2011-2012*, NAT'L CONF. OF ST. LEGISLATURES, <http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-aca.aspx> (last updated Apr. 5, 2012) (discussing state proposals). Framing the individual mandate as an affront to federalism, both Virginia and Oklahoma premise their challenges on the mandate's conflict with laws in these states exempting their citizens from any obligation to procure health insurance. In the Virginia case, however, the Fourth Circuit held that this conflict failed to impose a sufficient injury on the state so as to provide it with Article III standing to challenge the federal requirement. *Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253, 270-72 (4th Cir. 2011), *petition for cert. filed*, No. 11-420 (U.S. Sept. 30, 2011); *cf.* *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1243-44 (11th Cir. 2011) (declining to determine whether the state plaintiffs in the Florida lawsuit had standing to challenge the individual mandate because private plaintiffs in the case had standing to challenge the provision).

60. Amended Complaint at ¶¶ 26-28, *Florida ex rel. Bondi*, 780 F. Supp. 2d 1256 (No. 3:10-cv-91-RV/EMT).

61. *South Dakota v. Dole*, 483 U.S. 203 (1987).

62. *Id.* at 211 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

“assume[d] that [the] concept [of coercion] can ever be applied with fitness to the relations between state and nation.”⁶³ Just as the Court concluded in *Steward Machine Co.* that Congress did not use a tax credit for employers to coercively induce the states to establish unemployment compensation schemes, the Court concluded in *Dole* that Congress did not use highway appropriations to coercively induce the states to raise their alcohol drinking age to twenty-one.⁶⁴ Since *Dole*, moreover, no court has found coercive use of Congress’s tax-and-spend authority. Almost all the courts that have considered the question indeed have held that *Dole’s* “coercion test” is not much of a test at all, reasoning that it implicates questions of economics, policy, and politics far beyond the judiciary’s competence to answer.⁶⁵ Some of these cases specifically involved federal reforms of Medicaid. In *California v. United States*,⁶⁶ for example, the Ninth Circuit Court of Appeals held that the federal government’s conditioning Medicaid funds on California’s agreeing to provide emergency medical services to undocumented immigrants presented the State with “hard political choices,” not coercion.⁶⁷

The failure of the states in *Florida v. Department of Health & Human Services*⁶⁸ to successfully allege coercion before the single federal court to invalidate all of ACA as tainted by the unconstitutionality of the individual mandate attests to the states’ difficult legal position. After allowing their coercion claim to survive a motion to dismiss,⁶⁹ the district court held on motions for summary judgment that it was “simply impossible to resolve this factual dispute now as both sides’ financial data are based on economic assumptions, estimates, and projections many years out.”⁷⁰ Ultimately, however, because the court ruled that the individual mandate was unconstitutional and not severable from ACA, thus necessitating invalidation of all the legislation,⁷¹ the

63. *Steward Mach. Co.*, 301 U.S. at 590.

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

65. See, e.g., *Kansas v. United States*, 214 F.3d 1196, 1201-02 (10th Cir. 2000) (“[T]he cursory statements in *Steward Machine* and *Dole* mark the extent of the Supreme Court’s discussion of a coercion theory. The Court has never employed the theory to invalidate a funding condition, and federal courts have been similarly reluctant to use it.”) (footnote omitted); *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989) (describing the coercion theory as “highly suspect as a method for resolving disputes between federal and state governments”).

66. *California v. United States*, 104 F.3d 1086 (9th Cir. 1997).

67. *Id.* at 1092 (quoting *Skinner*, 884 F.2d at 448).

68. *Florida ex rel. McCollum v. U.S. Dep’t of Health & Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010).

69. *Id.* at 1156-60.

70. *Florida ex rel. Bondi v. U.S. Dep’t of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1267 (N.D. Fla. 2011).

71. *Id.* at 1299-1305; cf. *Florida ex rel. Bondi v. U.S. Dep’t of Health &*

states prevailed, at least as a practical matter, on their coercion claim.

The reprieve, however, was short lived. On appeal, the Eleventh Circuit affirmed the district court on the coercion claim and reversed on the severability of the individual mandate, thereby leaving the Medicaid expansion intact.⁷² To this end, the court chastised its sister circuits for rejecting *Dole's* coercion test, deeming it “an amorphous . . . [doctrine], honest in theory but complicated in application.”⁷³ Still, the court concluded the Medicaid expansion was not unduly coercive.⁷⁴ The court cited four reasons for support: (1) Congress gave Medicaid-participating states statutory notice that it reserved the right to change the program, and over the years it exercised that right, requiring participant states to comply with the changes or lose all or part of their funding; (2) the federal government will bear nearly all of the costs of the expansion; (3) because the expansion will not go into effect until 2014, the states will have had nearly four years of notice from the President signing ACA to decide whether to continue to participate; and (4) the states have independent taxing and spending powers, which they could use to create and fund their own programs if they did not like Congress’s conditions on Medicaid.⁷⁵ In addition, the court disputed the states’ contention that their failure to participate in the expansion would trigger loss of all their federal Medicaid funding because federal law provides DHHS with discretion over the amount of funding to withhold from a noncompliant state.⁷⁶ Therefore, the court summarized, “the Medicaid-participating states have a real choice—not just in theory but in fact—to participate in the Act’s Medicaid expansion.”⁷⁷

Thus unanimously rejected by both the district court and Eleventh Circuit, the states’ coercion claim seemed unlikely to attract the Supreme Court’s attention. Yet, in one of the most surprising developments in the ACA litigation, the Court granted

Human Servs., 780 F. Supp. 2d 1307, 1317-20 (N.D. Fla. 2011) (staying the court’s declaratory order on the constitutionality of ACA pending appeal).

72. Florida *ex rel.* Att’y Gen. v. U.S. Dep’t of Health & Human Servs., 648 F.3d 1235, 1328 (11th Cir. 2011).

73. *Id.* at 1266.

74. *Id.* at 1262.

75. *Id.* at 1267-68.

76. *Id.* at 1268 (citing 42 U.S.C. § 1396c (2006)).

77. *Id.* Justice Ginsburg in her dissent in *National Federation* adopts many of the arguments noted in the lower courts, seeing the ACA as an extension of Medicaid paid for by the federal government, as well as an extension that does not alter the considerable autonomy states enjoy in running their respective programs. *National Federation*, No.11-393, slip. op at 45-57 (Ginsburg, J., dissenting in part).

certiorari on the issue.⁷⁸ Why exactly is unclear, compared with the Court's much-expected decision to take on the question of the individual mandate's constitutionality, which contrastingly spurred disagreement on substantive and procedural grounds among the courts.⁷⁹ Whatever the reason, the states' task of convincing the Court to rule favorably for them on their coercion claim appeared steep.⁸⁰ Unlike its Commerce Clause jurisprudence, the Court has not significantly developed the theory of coercive federal spending since *Dole*, thus putting the impetus on the Court to craft and apply a constitutional principle that strikes at the heart of federalism. As commentator Brad Joondeph opines, moreover, the Court's responsibility to exercise "superintendence and rationalization of constitutional doctrine . . . generally leads the justices to eschew arguments or legal theories that seriously disrupt or complicate judge-made constitutional law."⁸¹ Consequently, it seemed that however sympathetic the Court might have been to the states' position, the Court would hesitate to invalidate the ACA Medicaid expansion, lest it render "a holding [that] would be far-reaching and doctrinally destabilizing."⁸²

The Court, however, once again proved that how it rules on the law is not based on the weight of speculation but rather its independent reading of the law. In *National Federation*, the Court found limits on congressional spending power rooted in the thin line of jurisprudence spawned by *Stewart Machine*.⁸³ The Court recognized the legitimacy of Congress's conditioning federal funds to the states—a typical practice—but found merit in the argument that there is a limitation on such power. The majority, quoting

78. *Florida v. Dep't of Health & Human Servs.*, 132 S. Ct. 604 (2011); N.C. Aizenman, *Supreme Court's Planned Review of Health-Care Law Shocks Medicaid Advocates*, WASH. POST, Nov. 16, 2011, http://www.washingtonpost.com/national/health-science/court-review-of-medicaid-expansion-could-have-massive-consequences/2011/11/15/gIQA1LwkSN_story.html.

79. *Compare Seven-Sky v. Holder*, 661 F.3d 1, 19-20 (D.C. Cir. 2011) (holding the individual mandate constitutional), *and Thomas More Law Ctr. v. Obama*, 651 F.3d 529, 544-45 (6th Cir. 2011) (same), *with Florida ex rel. Att'y Gen.*, 648 F.3d at 1328 (holding the individual mandate unconstitutional), *and Liberty Univ., Inc. v. Geithner*, No. 10-2347, 2011 WL 3962915, at *14 (4th Cir. Sept. 8, 2011) (holding that the Anti-Injunction Act precludes a pre-enforcement challenge to the individual mandate).

80. See Laura Hermer, *The States' Challenge to the Affordable Care Act's Medicaid Expansion*, 33 WHITTIER L. REV. 1, 5 (2011) (noting every federal appellate court has rejected a claim of coercion by the states).

81. Bradley W. Joondeph, *Federalism and Health Care Reform: Understanding the States' Challenge to the Patient Protection and Affordable Care Act*, 41 PUBLIUS 447, 449 (2011).

82. *Id.*

83. *National Federation*, No.11-393, slip. op at 49.

from *Stewart Machine*, concluded that the Medicaid expansion in ACA reconfigured the terms of the federal-state agreement, and was such a fundamental change as to constitute a breach of contract, and a gross infringement on state sovereignty. Chief Justice Roberts's opinion was colored by two realities: the provision of one hundred percent federal matching funds for the ACA Medicaid expansion and the Medicaid law's grant of authority to the Secretary of DHHS to withdraw all Medicaid funds for the failure of a state to expand its Medicaid program under the terms of ACA. Roberts characterized these elements—federal funding and the mounding potential loss of all Medicaid—as coercion, a type of “economic dragooning” that leaves the states with no choice but to accept the ACA expansion.⁸⁴ Secondly, the Court concluded that the ACA Medicaid expansion was so extensive as not to go beyond prior changes of degree and constitute a change in kind, reaching beyond the program's role of treating the neediest to establishing Medicaid as a building block of a national health insurance plan. The Court ruled that it is unconstitutionally coercive for the Secretary of DHHS to use her discretion to withhold all Medicaid funds for a state's refusal to expand its Medicaid program under the terms of the ACA.⁸⁵ The Court held that the coercive nature of the ACA Medicaid expansion could be mitigated by invoking the severability clause of the Medicaid law, allowing only the mandatory expansion to be struck and preserving the ACA Medicaid expansion as a matter of state discretion.⁸⁶

V. FEDERALISM AND BEYOND

In a sense, the dispute over Medicaid and federalism raised in *National Federation* is tangential to governance in that it does little or nothing to address the operational realities that the two levels of government, federal and state, face namely meeting the complex needs of current enrollees and more broadly the health needs of growing poor uninsured populations. This is not to suggest that the ruling in *National Federation* concerning the states' role in ACA's Medicaid expansion is not programmatically

84. *Id.* at 45-59.

85. *Id.* at 56. Under 42 U.S.C. § 1396(c), the Secretary of DHHS has the power to cut off all Medicaid funding for the failure of a state to amend its Medicaid plan to include the ACA program expansion.

86. *Id.* The Court used 42 U.S.C. § 1303 of the Medicaid law, a severability provision to allow, the unconstitutional extension of § 1396(c) to be struck without striking § 1396(c)'s application to existing Medicaid programs. The Court reading of ACA in the Medicaid context was such that a state's refusal to expand its Medicaid programs under the health reform bill put a state in the position of losing all its federal Medicaid funding. This finding was characterized by Chief Justice Roberts as “a gun to the head”. *Id.* at 51.

significant. Certainly, it is helpful to have a confirmation of the need to preserve dual sovereignty via the coercion doctrine and concepts of contract, but the Court refused to set boundaries for federalism in a way that will clarify the legislative parameters of Congress, or spark changes in federal-state governance.⁸⁷ Medicaid has existed for nearly fifty years, and the cries of states have resonated throughout this period, well before ACA's expansion and the current controversy.⁸⁸ Although fundamental, it should continue to be stressed, as the courts have noted over the years,⁸⁹ that Medicaid is a voluntary program. Like other social security-based programs, no state is forced to participate and accept federal dollars; however, once a state does participate, it must comply with federal law and face the reality of preemption.⁹⁰ Undoubtedly as demonstrated by *National Federation*, states have real, genuine concerns that must be recognized in dealing with the Medicaid expansion, but they are adept at navigating the regulatory and political shoals of the program, and have simultaneously sought increased funding while struggling to be free from Washington's regulatory handcuffs.⁹¹ Although perhaps overly glib, it does not seem unreasonable to characterize the overriding state position on Medicaid as "give us the money and leave us alone," with the federal corollary to state complaints being an exasperated "are you serious?"⁹²

Prior to turning to considerations of federalism, four observations emerge, which are external to constitutional law considerations visited in *National Federation*, but central to Medicaid's future. First, Medicaid as we know it cannot function without involvement of both federal and state levels of

87. *Id.* at 55.

88. *See generally*, JONATHAN ENGEL, POOR PEOPLE'S MEDICINE, MEDICAID AND AMERICAN CHARITY CARE SINCE 1965 (2006); *see also* LAURA KATZ OLSEN, THE POLITICS OF MEDICAID (2010) (discussing the political debates surrounding Medicaid).

89. The point has been widely recognized in the federal courts that Medicaid imposes obligations on the states, but is at its core a voluntary program. For an example, *see Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 503 (1990).

90. Bradley J. Sayles, *Preemption or Bust: A Review of the Recent Trends in Medicaid Preemption Cases*, 27 J. CONTEMP. HEALTH L. & POL'Y 120, 137-38 (2010).

91. *See, e.g.*, *Creating a Climate for Innovation*, NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS (Nov. 9, 2011), <http://medicaiddirectors.org/node/192>.

92. Eric Zimmerman, *Pelosi to Reporter, 'Are You Serious?'*, THE HILL (Oct. 23, 2009, 2:14 PM), <http://thehill.com/blogs/blog-briefing-room/news/64547-pelosi-to-reporter-are-you-serious> (reporting U.S. House Speaker Nancy Pelosi's three-word response to a question about whether there is sufficient congressional power to enact the individual health insurance mandate).

government.⁹³ States may be able to structure more narrowly tailored programs, such as programs for the elderly and disabled, but independent of federal dollars, they cannot afford the array of services and beneficiaries of even the leanest of current Medicaid programs, much less the ACA expansion.⁹⁴ In turn, however, states are viewed as sovereigns or delegated units of government. They play roles in Medicaid from eligibility determination to licensure, to care for the aged and disabled, which is either simply inefficient to federalize or—as seen with the demise of the Community Living Assistance Services and Support Act, the long-term care provision of ACA—may be simply beyond the capabilities of federal policymakers to address. Second, if Medicaid is to become a solid base on which to rest a significant portion of the nation's health care insurance, uniform standards for general operations, IT, quality-of-care evaluation, and claims reporting, among other measures, must be implemented for both program integrity and cost containment. Uniformity, moreover, can best be achieved on the national level. Third, although Medicaid has emerged as the nation's largest health program, Medicare is the engine of change in health policy and, despite its troubles, is the stronger of the two giants. It may be more realistic to expand elements of the Medicare program, in particular those concerning individuals dually eligible for both Medicare and Medicaid, the most costly population in public insurance.⁹⁵ Fourth, in order to achieve meaningful improvements in health delivery, flexibility and power sharing will be critical to encourage innovation and find anecdotal solutions that best fit local needs, as such cooperative federalism becomes essential.

It is an open question whether the constitutional machinations about federalism have any direct relation to broader Medicaid health policy considerations. It does seem reasonable, however, to argue that a reconceptualization of intergovernmental health relations is a necessary step in making ACA and its

93. See Hermer, *supra* note 80, at 9 (stating federal government matches state Medicaid funds by fifty percent or greater).

94. See *id.* (noting the federal Medicaid money is an enormous source of funds for the states). For a more recent reaction of state concerns over the potential economic issues raised by the Medicaid ACA expansion see Lloyd Dunkelberger, *Scott Says Florida Can't Afford to Expand Medicaid*, HERALD TRIBUNE (June 29, 2012), <http://politics.heraldtribune.com/2012/06/29/scott-says-florida-cant-afford-to-expand-medicaid/>.

95. Under section 2602 of ACA, there are several efforts directed toward better harmonization of care for dual eligibles. See *About the Medicare-Medicaid Coordination Office*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/> (last updated June 13, 2012, 10:27 AM) (listing eight goals of the Medicare-Medicaid Coordination Office to simplify and improve care to dual-eligible individuals).

progeny more viable. There are positive aspects that can be drawn from the current constitutional probing of Medicaid and federalism, particularly as *National Federation* has invigorated the doctrine of state sovereignty in a way that promotes cooperative federalism by strengthening the need for forging better partnership models. Paradoxically, federalism is both abstract and fundamental; in the annals of American law, it is anything but an obscure vestige of civics and constitutional law, but is an area ripe with case law and discourse in which notable trends can be identified in how federal courts have viewed the roles of the two arenas of government.⁹⁶ Several key frequently intersecting variables emerge in federalism, including the power of the three branches of the federal government to exert control over states generally, within which there are frequent questions about federal law supremacy, the power of Congress to regulate via the General Welfare and Commerce Clauses, and limitations on federal power under the Fourteenth Amendment. On the state side, federalism issues often involve questions about individual and collective state sovereignty, immunity from lawsuits, and the role of the Tenth Amendment in carving out a legal territory in which states can govern.⁹⁷ Constitutional scholar Erwin Chemerinsky notes that it has only been since the mid-1990s that the Supreme Court has reconnected with an older, more conservative view of federalism, which questions unfettered congressional regulation in the name of interstate commerce and revisits the governance role of states under the Tenth Amendment.⁹⁸ Notable trends can be identified in how federal courts have viewed the roles of the two arenas of government: the notion of dual federalism, which serves to demarcate the particular roles of the federal and state governments; cooperative federalism, which is a type of partnership or contract model; and formalism, a more recent shift which refocuses on considerations of the propriety of spheres of power. There is also the middle ground of federalism struck by the Court in *Bond v. United States*, in which Justice Kennedy notes that federalism is about more than state sovereignty because it ultimately serves to protect the rights of citizens against government through the duality of governance.⁹⁹

As discussed, the states' Medicaid expansion challenge framed ACA as an unconstitutional extension of congressional spending power, a type of coercion that finds a home with a formalistic approach to federalism. Clearly, the idea that

96. See generally CHEMERINSKY, *supra* note 4 (providing an overview of federalism).

97. See generally *id.* at 1-14 (examining issues related to federalism from the states' perspective).

98. *Id.*

99. *Bond v. United States*, 131 S. Ct. 2355, 2364 (2011).

Washington has commandeered state treasuries and moved Medicaid into the realm of an adhesion contract is hardly the stuff of cooperative governance; rather, it reflects a type of legal turf war that is very much about scopes of power, and political and legal battles that have both vertical and horizontal dimensions. Despite the seeming legal hurdles, the Court in *National Federation* found a violation of state rights in part resting on a breach of contract emanating from cooperative federalism, but *National Federation* is ultimately grounded in a finding of unconstitutionality rooted in a formalistic view of scopes of power. While the federalism-related portion of *National Federation* is more definitive than the recent, prior ruling in *Douglas v. Independent Living Center of Southern California*, it is far more relevant from a doctrinal vantage point than from an applied one.¹⁰⁰ Arguably the Court's ruling may have significant implications for the future of Medicaid and more immediately calls into question the abilities of health reform to reach its goal of covering the majority of poor, uninsured Americans. But the success of future governmental health policy demands that federal and state government continue to work collaboratively and new template for this critical relationship lies beyond the scope of the *National Federation* case, or perhaps any Supreme Court opinion. What is being posited here is that other areas of law, beyond constitutional doctrine, will need to be invoked in new and creative ways to solidify the foundations of cooperative federalism.¹⁰¹

100. See *Douglas v. Indep. Living Ctrs. of S. Cal.*, 132 S. Ct. 1204, 1204 (2012) (examining a federalism issue recently brought before the court). The question in this case concerned whether Medicaid providers and recipients could rely on the Supremacy Clause to bring an argument under the federal Medicaid law. *Id.* at 1207. The consolidated cases concerned state obligations to have sufficient numbers of providers to meet the care and service requirements of Medicaid in lieu of a ten percent across-the-board cut in provider fees. *Id.* at 1209. It was the position of the providers and recipients that the federal law preempted California from reducing payments to providers, an argument accepted by the Ninth Circuit Court of Appeals. *Id.* at 1209-10. In a 5-4 decision, a majority of the Supreme Court vacated the Ninth Circuit opinion and remanded the case for further proceedings due to the fact that CMS approved the California Medicaid statutes during the proceedings. *Id.* at 1211. The Court remand raised the question of whether the dispute should be handled under the Administrative Procedures Act. The majority opinion in *Independent Living Centers* does offer private parties aggrieved by arbitrary cuts in spending some opportunity for airing their claims through administrative processes, thus finding a type of middle ground. *Id.* at 1210. The minority opinion in *Douglas* simply rejected the idea that private parties have a right to privately enforce the Supremacy Clause. *Id.* at 1211 (Roberts, C.J., dissenting).

101. CHEMERINSKY, *supra* note 4. Chemerinsky argues that federalism needs to be reconstituted, not as a doctrine of limitation, but rather as a functional analysis of the authority needed by respective levels of government to respond to social needs. *Id.* Chemerinsky argues for an expansive

It is far easier to make an argument that federalism should be reconfigured to achieve a more optimal balance between the federal and state governments in health care than to actually devise a working model to achieve these ends. Ideally, it would have been helpful for the Court to craft a more definitive litmus test for federalism based on an analysis of the propriety of Congress's actions under the General Welfare Clause. The federalism test under *Dole*, adopted in *National Federation*, is largely generic, requiring that the spending in question is for the general welfare; that the respective spending conditions are clear; that the conditions relate to the federal interest in projects of national scale; that the conditions themselves are constitutional; and, most importantly, that the spending does not have a coercive effect in forcing a state to accept federal funds.¹⁰² *National Federation* did not expand the conditions noted in *Dole*, but only serves to affirm the viability of the coercion doctrine. Ideally a reconstituted test ought to include considerations of financial viability, programmatic efficiency, mutuality, and transparency—all elements that normally fall outside the landscape of constitutional law and that are more typically visited in legislative and executive circles. The biggest leap on this list is economic consideration, but for purposes of maintaining relevancy in adjudicating governance issues, fiscal concerns so central to a program like Medicaid need to be directly addressed.

Expecting the Court to reconfigure federalism in a way that strikes a new, more secure balance between the states and federal government is a noble hope, but such a reconfiguration may take years to play out. In the interim, two possible avenues—neither of which is new, but both of which have languished on the back burners of jurisprudence—could be pursued to enhance intergovernmental relations on a practical level. The first is administrative law reform, with a particular emphasis on collaborative rulemaking. The second is a contract-based approach to Medicaid, which rests on the use of interstate compacts as specified in Article I, Section 10 of the Constitution.

Administrative agencies are far more engaged in the daily operations of Medicaid than either the judicial or the legislative branch, so they are a logical focal point on which to leverage key changes in federalism on an applied level. Under the well-established rule of *Chevron U.S.A., Inc. v. Natural Resources*

interpretation of congressional power, a more liberal access to courts, increased restriction of federal preemption, a rejection of ill-defined state sovereignty and the use of the Tenth Amendment to support constitutional claims. *Id.* The Court's position on federalism in *Bond v. United States* is strong affirmation of the doctrine but adds little in the way of practical direction.

102. *South Dakota v. Dole*, 483 U.S. 203, 207-08, 211 (1987).

Defense Council, Inc.,¹⁰³ federal agencies have wide discretion, bound typically by the restraints of procedural due process and separation of powers, which have clear federalism implications.¹⁰⁴ Legal scholar Gillian Metzger advocates for expanding the boundaries of federalism and administrative law beyond matters of preemption and regulatory procedure, to judicial review of whether an agency “overstepped its boundaries . . . by exercising broader authority than Congress delegated, violating statutory requirements, ignoring procedural mandates, or failing to adequately justify its decisions.”¹⁰⁵ Metzger identifies two models for protecting federalism within the rubric of administrative law, which could be applied generally to Medicaid. One model builds on traditional administrative law principles with a heightened sensitivity to state concerns. The other model expands judicial deference to states, providing a distinct and enhanced protection to state interests beyond the current administrative law framework. A greater recognition of state interests via administrative law could be advanced procedurally by congressional and administrative policies that develop more participatory mechanisms for states to be involved in collaborative rulemaking and policymaking in programs such as Medicaid, triggered by significant shared financing requirements. Of course, the issue is not just a matter of deciphering processes that agencies could use to better recognize state interests, but it is also a matter of strengthening administrative law to adequately safeguard against agency failings.

A more immediate source of guidance to buttress state interests in cooperative federalism can be drawn from Executive Order (EO) 13,132 and subsequent developments related to the order.¹⁰⁶ President Clinton issued the order in 1999, amending President Reagan’s EO 12,612. EO 13,132 requires executive branch agencies, and urges independent agencies, to respect principles of federalism.¹⁰⁷ To this end, the Clinton order, which is still in force today, requires agencies to have an accountable process to ensure meaningful and timely input by state and local officials in the development of regulatory policies that have federalism implications.¹⁰⁸ The order also requires notice and an opportunity for state and local governments to participate in

103. *Chevron, U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 865 (1984).

104. Gillian E. Metzger, *Administrative Law as the New Federalism*, 57 DUKE L.J. 2023, 2026 (2008).

105. *Id.* at 2054.

106. Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (1999).

107. *Id.*

108. *Id.*; Exec. Order No. 12,612, 52 Fed. Reg. 41,685 (1987) (President Reagan’s executive order).

related proceedings in the event an agency action may result in preemption of a state law through rulemaking or adjudication, in which case the agency must provide a federalism impact statement.¹⁰⁹ To implement EO 13,132, the Office of Information and Regulatory Affairs within the Office of Management and Budget developed procedural guidelines for agencies to follow in meeting the dictates of the order, which include having a designated federalism official within an agency.¹¹⁰ In 2009, President Obama articulated a policy on preemption that reinforced EO 13,132, requiring agencies to include preemption policies within codified regulation.¹¹¹ EO 13,132 thus provides an interesting avenue to recognize state interests and add a balance in a more practical and immediate way than may happen via the evolution of the Spending Clause doctrine in the courts. The reality, however, is that this executive mandate must be recognized by the courts and must additionally be consistently followed by federal agencies. But as legal scholar Catherine Sharkey and a subsequent study by the U.S. Administrative Conference point out, the track record of federal agencies' compliance is inconsistent and difficult to determine to date, cutting across administrations and political parties.¹¹²

109. Adoption of Recommendation 76 Fed. Reg. 81 (Jan. 3, 2011).

110. Memorandum from Jacob J. Lew, Dir., Office of Mgmt. and Budget, to the Heads of Exec. Dep'ts. & Agencies, & Indep. Regulatory Agencies, Guidance for implementing E.O. 13132, "Federalism" (Oct. 28, 1999), available at <http://www.whitehouse.gov/sites/default/files/omb/inforeg/m00-02.pdf>.

111. Memorandum from Barack Obama, President, to the Heads of Exec. Dep'ts & Agencies (May 20, 2009), available at <http://www.gpo.gov/fdsys/pkg/FR-2009-05-22/pdf/E9-12250.pdf#page=1>.

112. See Catherine M. Sharkey, *Federalism Accountability: "Agency-Forcing" Measures*, 58 DUKE L.J. 2125 (2009) (explaining that federal agencies need to abide by executive mandates to ensure activity and federal compliance); see also Adoption of Recommendation, 76 Fed. Reg. 81 (Admin. Conference of the U.S. Jan. 3, 2011); Am. Bar Ass'n H.D. Res. 117 (2010), <http://www.abanow.org/2010/07/am.2010-117> (urging Congress to clearly address preemption issues when it enacts legislation). The U.S. Administrative Conference has recommended that preemption analyses required by EO 13,132 be reinvigorated through the adoption of ten recommendations that are classified in three primary categories: (1) internal procedures for compliance with the preemption provisions of EO 13,132; (2) updated policies to ensure timely consultation with state and local interests concerning preemption; and (3) actions by the Office of Management and Budget and the Office of Information and Regulatory Affairs (OIRA) to improve the process. Adoption of Recommendation, 76 Fed. Reg. at 83. OIRA recently issued a memorandum calling for early engagement with state, local, and tribal agencies to identify opportunities for harmonized regulatory development. *Memorandum from Cass Sunstein, Adm'r, Office of Info. & Regulatory Affairs, to the Heads of Exec. Dep'ts & Agencies, Cumulative Effects of Regulations* (Mar. 20, 2012), available at <http://www.whitehouse.gov/sites/default/files/omb/assets/inforeg/cumulative-effects-guidance.pdf>.

In reference to Medicaid programs, a movement to shift federalism to the more practical realms of agency policy development and rulemaking would be helpful in mitigating the detrimental effects of federal law that sharply alter the course of the program in ways that unreasonably strain state capacities. A preemption issue concerning California's cutting of provider fees in apparent conflict with the Medicaid statute recently confronted the Supreme Court in *Douglas v. Independent Living Center of Southern California*. Such preemption matters are deeply rooted in the jurisprudence of this program, and certainly collaborative bureaucracy along the lines of EO 13,132 may mitigate future disputes. In order for intergovernmental cooperation to develop in a more meaningful way, two additional requirements should be considered. First, the process of assessment in a program such as Medicaid should not be limited to determination of federal actors alone; state regulators also must make good-faith efforts to regulate in ways that are not arbitrary and capricious, guided by the dictates of Medicaid law, respective state plan documents, and a keen appreciation of the parameters of programmatic efficacy under waiver processes. Second, shifting back to federal obligation, the collaborative administrative law initiatives—whether driven by reforms in this area of law generally or by specific initiative—should extend beyond matters that concern preemption and encourage collaboration in all areas that have major impacts on state and local operations. The Medicaid coercion claim in *National Federation* does not raise a Supremacy Clause preemption challenge per se, but in a practical sense it is about both the viability of states meeting new fiscal mandates and concern over programmatic control, which are somewhat analogous to a preemption issue. The point is, however, that when states have concerns about new federal mandates and oversight efforts—particularly ones like those in ACA, which have serious financial impacts—such concerns should trigger an EO 13,132 analysis, and federalism matters should be central to policymaking and rulemaking in such contexts, preemption aside.

In the debate over coercion and Medicaid, the states' argued in *National Federation* that the relationship between Washington and the states constitutes a contractual arrangement.¹¹³ This strong contract theory, accepted by the Court, contends that legislation enacted pursuant to the General Welfare Clause is contractual in nature.¹¹⁴ Thus, in the parlance of contracts, Medicaid participation is an agreement by participating states to

113. I. Glenn Cohen & James F. Blumstein, *The Constitutionality of the ACA's Medicaid-Expansion Mandate*, 366 N. ENG. J. MED. 103 (2012).

114. *National Federation*, No.11-393, slip. op at 46, 47; see also Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L.J. 345 (2008).

meet federally imposed conditions in return for federal funds. Taking the contract argument further, adherents of the contract analogy argued that the ACA Medicaid expansion is a unilateral revision of the agreement entered into by the states and is such a dramatic change that it constitutes a breach of the federal-state agreement. Although the equation of coercion to a breach is a noteworthy parallel to contract law, until *National Federation*, it did not appear to have garnered much support in the courts. Even if the Medicaid is a type of contract between federal and state government, at the end of the day it is a contract encased in the borders of federal law, and, as problematic as it may be, it is Congress that has the power to amend and revise federal law without state permission.

The notion that Medicaid is informed and shaped by contract as a lever to create intergovernmental balance and equitable administration nevertheless should not be casually discarded as judicial rhetoric. On the contrary, what needs to be identified is a vehicle that can transform the presumptive contract from a de facto agreement to an express agreement between the states and federal government. This template could set out key measures of dual responsibility, thereby directly addressing matters of federalism. One model that has garnered recent attention is a state compact, a type of contract that can be used to address common state issues or matters that have intergovernmental implications.¹¹⁵ Traditionally, states have employed compacts to settle land disputes, but in the twentieth century states have expanded such agreements to function as regulatory, administrative, and management tools.¹¹⁶ Typically, interstate compacts seek to establish an independent multistate government authority (a commission), to develop uniform guidelines and standards for members, to achieve economies of scale in reducing administrative costs, and to devise some type of dispute resolution mechanism.¹¹⁷ Based on Article I, Section 10, Clause 3 of the Constitution, a compact carries with it the force of law and obligates the parties to the agreement to meet its terms. A compact is both contractual and statutory in nature, in that its

115. See *The Health Care Compact*, NAT'L CTR. FOR INTERSTATE COMPACTS, <http://apps.csg.org/ncic/PDF/Health%20Care%20Compact.pdf> (last visited Apr. 12, 2012) (outlining the background of the health care compact). See generally Herbert J. Naujoks, *Compacts and Agreements Between States and Between States and a Foreign Power*, 36 MARQ. L. REV. 219 (1953) (discussing the Compact Clause in regard to controversies involving the Great Lakes states).

116. CAROLINE N. BROUN ET AL., *THE EVOLVING USE AND THE CHANGING ROLE OF INTERSTATE COMPACTS: A PRACTITIONER'S GUIDE* 9-12 (2006).

117. John J. Mountjoy, *Corrections and Parole Trends in 2003: Interstate Compacts: An Alternative for Solving Common Problems Among States*, NAT'L CENTER FOR ST. CTS. (last visited Apr. 15, 2012), http://www.ncsconline.org/WC/Publications/KIS_Parole_Trends03.pdf.

details unfold within the four corners of a given agreement, but such agreements are limited by constitutional principles and formed through special state laws, which require participating jurisdictions to cede their sovereignty in a given area to a supra-state or sub-federal authority. In the event the federal government is a participant in a compact, the parties must obtain congressional approval, but an agreement involving only states will prompt federal approval only if it extends into areas traditionally within federal purview.¹¹⁸

The idea of putting Medicaid into a federal-state compact to better recognize and protect the interests of states appeals to political conservatives who see it as a way to restore clarity in federalism and return to the states control over Tenth Amendment activities, such as health care.¹¹⁹ In their view, the compact is a mechanism to end unilateral control by Washington and implement a more collaborative framework within which to develop policies and regulate intergovernmental programs. More specifically, proponents of compacts cite four reasons in support of such agreements: (1) they can better meet local and state needs; (2) they can add predictability in terms of obligations and enforcement; (3) they can address national considerations if structured properly with federal consent; and (4) they can push states to seek greater regional cooperation and afford state signatories with an opportunity to work collectively in matters of mutual interests, such as health policy.¹²⁰ On the other hand, there are considerable problems that must be confronted in developing a compact, including the politics and logistics of crafting a compact, the reluctance of federal and state parties to cede authority to this middle entity, and the practical problems that may arise in compliance and enforcement.¹²¹

Several state legislatures have enacted or are considering laws directing their states to form a state health compact to convert federal health regulatory programs, particularly Medicaid and Medicare (but not the Veterans Affairs and Indian Health Service programs), into block grants that would be paid by

118. *Id.*

119. See Jack McHugh, *Health Care Compact Bill Would Shift Power Back to the States*, MACKINAC CENTER FOR PUB. POL'Y (Mar. 2, 2012), <http://www.mackinac.org/article.aspx?ID=16547&print=yes>. This movement appears to be a highly partisan initiative but is gaining certain traction around the country, as now Georgia, Indiana, Missouri, Oklahoma, Texas, and Utah have enacted compact bills, and others are being considered in a number of other states, including Michigan, Minnesota, and Ohio. See generally HEALTH CARE COMPACT, <http://healthcarecompact.org> (last visited Apr. 15, 2012).

120. Bagenstos, *supra* note 114.

121. *Id.* at 28.

Washington and administered by the states.¹²² A proposed Minnesota bill, for example, articulates five core elements in the health compact: (1) congressional approval of the arrangement; (2) establishment of the primacy of state signatories for health matters in their respective jurisdictions; (3) suspension of federal laws and regulations inconsistent with state laws, with the fiscal burden passing to states accordingly; (4) receipt of a consistent annual mandatory spending amount from the federal government, not subject to the vicissitudes of annual appropriations but overseen by Congress and the General Accountability Office; and (5) oversight of the compact by an interstate advisory commission.¹²³

No doubt, the fact that a handful of states have enacted compact laws speaks to their attractiveness in some jurisdictions. There are, however, significant barriers to actualizing a regulatory compact to transfer broad authority over both Medicaid and Medicare to the states, from obtaining congressional approval to garnering a true understanding of the financial implications of a block-grant funding arrangement. Those generic barriers to compacts noted previously—logistics, power-sharing and enforcement—would all come home to roost in an ambitious scheme to devolve health regulation to states, as well as broader questions about equities of social policy left to the idiosyncrasies of multiple jurisdictions. Presumably, the proponents of a compact solution are aware of the practical barriers to implementation, raising questions as to whether such enactments are more philosophical expressions than practical policies. Furthermore, as to Medicare and Medicaid specifically, both programs will be reformed over time, and parts of Medicaid, particularly the dual-eligible population, may be blended into Medicare. Wholesaler transfer of these programs thus appears to be premature as well as legally and bureaucratically problematic.

There is, however, a certain middle ground that could be carved out with state compacts, which is less global and more tailored to Medicaid and related health reform initiatives. This alternative could be framed around an entity that seeks review and consensus of broad policy initiatives involving reframing of benefits, expansion and contraction of services, and development of state innovations.¹²⁴ Conceivably, a compact for Medicaid could

122. See LEAGUE OF WOMEN VOTERS OF UTAH (Feb. 24, 2012), <http://www.lwvutah.org/Legislative%20Updates/2012GeneralSession/Feb24.html> (discussing the bill enacted in Utah).

123. Mountjoy, *supra* note 117.

124. Much of the cooperative work in Medicaid involves private organizations, such as the National Association of State Medicaid Directors and the National Conference of State Legislatures. See *APHS*A Health Services Division, AM. PUB. HUM. SERVS. ASS'N,

involve a working commission that would vet and approve some of the major issues now on the states' and federal government's radar, such as essential benefit determination, maintenance of effort, managed care expansion, and community programming for the aged and disabled. It is also conceivable that a national Medicaid compact commission might serve as an accreditation body, which would oversee the structure and operations of signatory Medicaid programs.¹²⁵ The terms of the Medicaid compact could specify the scope of operations, governing authority, procedures, and the extent of power that the states and federal government alike would cede. This alternative compact thus would create a formal structure for core decision making that cannot be achieved via current informal mechanisms of dialogue, or through federal agency control. Though such an arrangement has significant implications for program financing and operations, its goal would be better program collaboration, not necessarily reinvention. Somewhat akin to a treaty, a state compact for Medicaid would undoubtedly introduce oversight and operational complexities that might prove frustrating to both states and federal bureaucrats.¹²⁶ In the long term, however, this alternative ideally would shape policies that would mitigate the current challenges and allow future operations to be more responsive to local needs and capacities.

Moving away from a national Medicaid compact is still a lesser idea that ties into the tradition of health governance, namely the use of a compact as a vehicle to create regional cooperation around specific programs like Medicaid. Like the regionalization of federal health programs through geographic areas, compacts could be organized to foster cooperative structures between federal authorities and state governments within a given

http://hsd.aphsa.org/Home/home_news.aspx (last visited Apr. 15, 2012); NAT'L ASS'N OF MEDICAID DIRECTORS, <http://medicaiddirectors.org/> (last visited Apr. 15, 2012); NAT'L CONF. OF ST. LEGISLATURES, <http://www.ncsl.org/> (last visited Apr. 15, 2012) (evidencing the cooperative work that takes place among private organizations).

125. The National Association of Insurance Commissioners performs accreditation of state insurance departments on a private level and could certainly fall within the orbit of a compact commission. An accreditation process, moreover, could establish standards that would enhance the viability of bureaucratic operations and staff performance and training. See *Financial Regulation Standards and Accreditation Program*, NAT'L ASS'N OF INS. COMM'RS, (2012), http://www.naic.org/documents/committees_f_FRSA_pamphlet.pdf.

126. See *Vienna Convention on the Law of Treaties 1969*, Treaty Series, No. 1155 at 331, available at http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf (Jan. 27, 1980) (discussing a treaty on treaties that demonstrates the complexity and ongoing governance challenges which are confronted in administering such legal arrangements).

region.¹²⁷ Unlike the regionalism of DHHS, however, regional state compacts could serve as legal entities to assume roles in distinct areas, from policy development to program administration. Moreover, states in a regional compact would cede Medicaid operations to regional authorities, which would become supra-states and assume the collective role of member states. Certainly, collectivizing the FMAP match would be contentious, but such collectivization might open an opportunity to apply a block-grant concept that would not yield as many variations in coverage as application of this mechanism on a state level.¹²⁸ Depending on the scope of regional authority, the future of individual state health reform initiatives would need to be harmonized with regionalization efforts, but if state reforms such as the ones in Massachusetts and Utah are compelling enough, they might serve as the foundation for regional expansion as well.¹²⁹ A more immediate regionalization might occur across states in the context of ACA, as the law allows health insurance exchanges and insurance cooperatives to exist across state lines. A regional health insurance exchange indeed might be an ideal vehicle to develop meaningful cooperation between groups of states and the federal government. Furthermore, it would lend itself to a compact agreement that would serve as a foundation on which to build a more expansive set of shared responsibilities.¹³⁰

VI. CONCLUSION

Medicaid, the nation's largest federal-state matching program, lies at the epicenter of federalism and represents the complexities of dual sovereignty at the intersections of law, economics, and health delivery. Dramatic Medicaid expansion is pivotal to the success of ACA, potentially adding twenty million new enrollees and in so doing expanding coverage to a new

127. See *HHS Region Map*, U.S. DEPT OF HEALTH & HUMAN SERVICES, <http://www.hhs.gov/about/regionmap.html> (last visited Apr. 15, 2012) (displaying the regions of the Department of Health and Human Services).

128. John Holahan & Alan Weil, *Block Grants Are the Wrong Prescription for Medicaid*, URB. INST., http://www.urban.org/uploadedpdf/900624_hponline_6.pdf (last visited Apr. 15, 2012).

129. Emily Berry, *How States Will Shape Health Reform*, AM. MED. NEWS (Aug. 29, 2011), <http://www.ama-assn.org/amednews/2011/08/29/bisa0829.htm>.

130. At present, only thirteen states and the District of Columbia have plans in place for a health insurance exchange. If states fail to create an exchange, that task reverts to the federal government. It may be far more productive for Washington to encourage regional exchanges that bring a number of states to the bureaucratic table than to try to run such a program external to the states. See Linda Blumberg, *Multi-State Health Insurance Exchanges*, URBAN INSTITUTE (April 2011), <http://www.urban.org/uploadedpdf/412325-Multi-state-Health-Insurance-Exchanges.pdf>.

category of recipient: poor, childless adults. Political and economic pressures have pushed the federal government toward more conciliatory policies toward state Medicaid programs, but the fundamental structures of the program bounded by law and expanding coverage requirements rest on an increasingly fragile foundation of dual governance. The coercion claim mounted by the states in *National Federation*, largely dismissed, underscores the vitality of dual sovereignty, and underscores the need for fundamental reforms in intergovernmental health relations. This piece highlights two possible approaches that should be considered in rebalancing the Medicaid federal-state relationship: strengthening collaboration with states through actualization of EO 13,312 and the use of state compacts for dual governance in areas central to Medicaid operations. Unquestionably, Medicaid plays a critical role in American health care. If it is to meet the needs of a growing and diverse constituency, it must evolve in ways that meet population needs, and such evolution will require creative redesign of both programmatic elements and fundamental governance structures.