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Plunging Into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius

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ARTICLES

PLUNGING INTO ENDLESS DIFFICULTIES: MEDICAID AND COERCION IN *NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS*

NICOLE HUBERFELD,* ELIZABETH WEEKS LEONARD** & KEVIN
OUTTERSON***

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“The bill . . . did not steal upon an unsuspecting legislature, and pass unobserved. Its principle was completely understood, and was opposed with equal zeal and ability.”

– Chief Justice John Marshall¹

INTRODUCTION

After a contentious partisan process, Democratic majorities in both houses of Congress succeeded in passing dramatic national reform, which became law upon the President’s signature. Opponents quickly filed suit, claiming, among other deficiencies, that the law exceeded congressional authority under the Spending Clause. In a divided opinion, the Supreme Court wrote: “The question is not what power the Federal Government ought to have but what powers in fact have been given by the people.”² Otherwise, the Spending Clause “would become the instrument for total subversion of the governmental powers reserved to the individual states.”³ The case was *United States v. Butler*, and the law struck down was the Agricultural Adjustment Act of 1933.⁴

Until the 2011 Term, no Supreme Court decision since the New Deal had struck down an act of Congress as exceeding the federal spending power.⁵ The

¹ *M’Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 402 (1819).

² *United States v. Butler*, 297 U.S. 1, 63 (1936).

³ *Id.* at 75.

⁴ *Id.* at 78.

⁵ See *Virginia Dep’t of Educ. v. Riley*, 86 F.3d 1337, 1355 (4th Cir. 1996) (Luttig, J., dissenting) (“I recognize that the Court has not invalidated an Act of Congress under the Spending Clause since *United States v. Butler*, over half a century ago.” (citation omitted)),

question of unconstitutionally coercive conditions was also novel. Indeed, no federal court had ever found any legislation to be an unconstitutionally coercive exercise of the spending power⁶ until the Court decided *National Federation of Independent Business v. Sebelius* (*NFIB*) on June 28, 2012.⁷ The only two previous Supreme Court cases mentioning the spending power coercion doctrine found it inapplicable, upholding the federal laws in question: the unemployment-compensation provisions of the Social Security Act of 1935 in *Steward Machine Co. v. Davis*⁸ and the drinking-age condition on highway funds in *South Dakota v. Dole*.⁹ In each case, the Court recognized the theoretical possibility of a federal-spending program unconstitutionally coercing states, but found no coercion on the facts presented. Accordingly, until *NFIB*, coercion had been relegated to the realm of dicta and theory.¹⁰

Most of the vast legal and political commentary on the *Healthcare Cases*,¹¹ which challenged the Patient Protection and Affordable Care Act (the Affordable Care Act or ACA),¹² centered on the individual health insurance

rev'd en banc, 106 F.3d 559 (4th Cir. 1997); *accord* *Kansas v. United States*, 214 F.3d 1196, 1202 (10th Cir. 2000) (“Most of the treatment given the [coercion] theory in the federal courts has been negative.”); *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989) (“The coercion theory has been much discussed but infrequently applied in federal case law, and never in favor of the challenging party.”); Kathleen M. Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1413, 1430-32 (1989).

⁶ Nat’l Fed’n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2630 (2012) (Ginsburg, J., concurring in part and dissenting in part) (“THE CHIEF JUSTICE therefore – *for the first time ever* – finds an exercise of Congress’ spending power unconstitutionally coercive.”). The panel decision in *Riley*, 86 F.3d at 1346-47, is not a counterexample as the majority denied Virginia’s coercion claim. The Fourth Circuit reversed en banc, adopting Judge Luttig’s panel dissent but ultimately deciding the case on grounds other than coercion. *Riley*, 106 F.3d at 561, 569 (“[I]nterpret[ing] section 1412(1) of IDEA so as not to impose upon the States the condition that they provide private tutors and other alternative educational services to handicapped students . . . [the court] need not resolve the Tenth Amendment issue that is presented upon the contrary reading of the statute.”).

⁷ *NFIB*, 132 S. Ct. at 2608 (plurality opinion). Notably, *NFIB* did not strike down any provision of the Affordable Care Act, but merely held that an existing statute, 42 U.S.C. § 1396c, constitutionally could not be applied to cut off existing Medicaid funds if states refused to implement the mandatory Medicaid expansion under the Affordable Care Act. *Id.* at 2607 (“In light of the Court’s holding, the Secretary cannot apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion. That fully remedies the constitutional violation we have identified.”).

⁸ 301 U.S. 548, 585-93 (1937).

⁹ 483 U.S. 203, 212 (1987).

¹⁰ See *infra* Part III.

¹¹ The litigation that culminated in the *NFIB* decision included dozens of cases and even more opinions in federal courts. We refer to this litigation collectively as the *Healthcare Cases*.

¹² The law we commonly refer to as the “Affordable Care Act” was actually two separate Acts of Congress: the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124

mandate's prospects under the Commerce Clause.¹³ But a few of us, familiar with Medicaid, were focused on a much more fundamental challenge to federal power that threatened not only Medicaid but also a host of other federal spending programs.¹⁴ *NFIB* presented a prime opportunity for the Roberts

Stat. 119 (2010) (codified in scattered sections of 25, 26, 29 and 42 U.S.C.), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 124 Stat. 1029, which amended Public Law 111-148. Amendments related to Medicaid are found in three locations: Title II of Public Law 111-148 (the core provisions); Title X.B of Public Law 111-148 (a later amendment to Title II); and Title I.C of Public Law 111-152 (Medicaid amendments made in reconciliation).

¹³ The literature is voluminous, but two works that provide a useful introduction are EINER ELHAGUE, *OBAMACARE ON TRIAL* (2012), and Wendy K. Mariner, Leonard H. Glantz & George J. Annas, *Reframing Federalism – The Affordable Care Act (and Broccoli) in the Supreme Court*, 367 NEW ENG. J. MED. 1154 (2012). Two symposia offer an introduction to the recent legal academic literature on the ACA. Symposium, *American Right to Health: Constitutional, Statutory, and Contractual Healthcare Rights in the United States*, 38 AM. J.L. & MED. 243 (2012); Symposium, *Everything But the Merits: Analyzing the Procedural Aspects of Healthcare Legislation*, 46 U. RICH. L. REV. 691 (2012).

¹⁴ Brief of Amici Curiae Health Law & Policy Scholars and Prescription Policy Choices in Support of Respondents on the Constitutional Validity of the Medicaid Expansion, *Florida v. Dep't of Health & Human Servs.*, 132 S. Ct. 2566 (2012) (No. 11-400) [hereinafter Health Law Brief]; see also John D. Blum & Gayland O. Hethcoat II, *Medicaid Governance in the Wake of National Federation of Independent Business v. Sebelius: Finding Federalism's Middle Pathway, from Administrative Law to State Compacts*, 45 J. MARSHALL L. REV. 601 (2012); I. Glenn Cohen & James F. Blumstein, *The Constitutionality of the ACA's Medicaid-Expansion Mandate*, 366 NEW ENG. J. MED. 103 (2012); Charlton C. Copeland, *Beyond Separation in Federalism Enforcement: Medicaid Expansion, Coercion, and the Norm of Engagement*, 15 U. PA. J. CONST. L. 91 (2012); Mark A. Hall, *The Factual Bases for Constitutional Challenges to the Constitutionality of Federal Health Insurance Reform*, 38 N. KY. L. REV. 457 (2011); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413 (2008) [hereinafter Huberfeld, *Bizarre Love Triangle*]; Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. REV. 441 (2008) [hereinafter Huberfeld, *Clear Notice*]; Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431 (2011) [hereinafter Huberfeld, *Federalizing Medicaid*]; Nicole Huberfeld, *Post-Reform Medicaid Before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS HEALTH L. 513 (2012) [hereinafter Huberfeld, *Post-Reform Medicaid*]; Elizabeth Weeks Leonard, *Rhetorical Federalism: The Role of State Resistance in Health Care Decision-Making*, 39 J.L. MED. & ETHICS 73 (2011); Elizabeth Weeks Leonard, *The Rhetoric Hits the Road: State Challenges to the Affordable Care Act Implementation*, 46 U. RICH. L. REV. 781 (2012); David G. Oedel, *Health Care Reform, the Spending Clause, and Dole's Restrictions*, 62 MERCER L. REV. 623 (2011); Kevin Outterson, *Briefing for the Supreme Court Cases*, INCIDENTALECONOMIST (Nov. 14, 2011, 12:48 PM), <http://theincidentaleconomist.com/wordpress/briefing-for-the-supreme-court-cases/>. For recent commentary on the *NFIB* decision, see Michelle Biddulph & Dwight G. Newman, *Comparativist-Structural Approaches to Interpretation of the Post-Obamacare Spending Power*, 21 CARDOZO J. INT'L & COMP. L. 1 (2012); James F.

Court to revive the Rehnquist Court's "Federalism Revolution"¹⁵ in the context of the Tenth Amendment.

Justice Cardozo long ago warned that enforcing the coercion doctrine would "plunge the law in[to] endless difficulties."¹⁶ Nevertheless, the Court held that the expansion of Medicaid to include a new category of beneficiaries¹⁷ was unconstitutionally coercive because the Secretary of the U.S. Department of Health and Human Services (HHS) could theoretically withdraw all (or part) of federal Medicaid funding in response to a state's failure to comply with federal Medicaid laws.¹⁸

Seven Justices, including two liberal members of the Court, held the ACA's Medicaid expansion to be an unconstitutionally coercive exercise of the spending power, the first such holding in the history of the Republic.¹⁹ While these Justices agreed on this result, however, they fractured into a three-vote plurality authored by Chief Justice Roberts (joined by Justices Breyer and Kagan) and a four-vote joint dissent signed by Justices Scalia, Kennedy, Thomas, and Alito. It was particularly surprising that Justice Kagan, President Obama's appointee and former Solicitor General, thought the Medicaid expansion was unconstitutional.²⁰

In the remedy phase, the Roberts plurality did not strike down any part of the Affordable Care Act. Instead, the Court held that an existing statute, on the books for almost eight decades, constitutionally could not be applied to

Blumstein, *Enforcing Limits on the Affordable Care Act's Mandated Medicaid Expansion: The Coercion Principle and the Clear Notice Rule*, 2011-2012 CATO SUP. CT. REV. 67; Timothy Stoltzfus Jost, *The Affordable Care Act Largely Survives the Supreme Court's Scrutiny – But Barely*, 31 HEALTH AFF. 1659 (2012); Timothy Stoltzfus Jost & Sara Rosenbaum, *The Supreme Court and the Future of Medicaid*, 367 NEW ENG. J. MED. 983 (2012); Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?*, 31 HEALTH AFF. 1663 (2012); Tonja Jacobi, *Strategy and Tactics in NFIB v. Sebelius* (Aug. 20, 2012) (unpublished manuscript available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2133045); and Glenn H. Reynolds & Brannon P. Denning, *National Federation of Independent Business v. Sebelius: Five Takes* (Aug. 17, 2012) (unpublished manuscript available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2133669).

¹⁵ See *infra* Part III.A; see also Nicole Huberfeld, *After the Health Care Ruling: Medicaid, But Not Medicaid*, JURIST (July 27, 2012), <http://jurist.org/forum/2012/07/nicole-huberfeld-nfib-medicaid.php>.

¹⁶ *Steward Mach. Co. v. Davis*, 301 U.S. 548, 589-90 (1937).

¹⁷ See *infra* Part I.

¹⁸ *NFIB*, 132 S. Ct. 2566, 2607 (2012) (plurality opinion) ("What Congress is not free to do is penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.").

¹⁹ See *supra* note 5 and accompanying text.

²⁰ Politics aside, after the tough questions at oral arguments from Justices Kagan and Breyer, it is indeed surprising that they joined the Roberts plurality on the Medicaid coercion issue.

withhold states' Medicaid funding for failing to implement the Medicaid expansion.²¹ Effectively, the Court allowed states to opt in or out of the expansion²² without jeopardizing their existing Medicaid programs. This severability holding, in which Justices Ginsburg, Breyer, Sotomayor, and Kagan joined the Chief Justice, saved the Medicaid expansion from the joint dissent's preferred disposition to declare the entire ACA unconstitutional. The Medicaid expansion thus remains in the U.S. Code but states that opt out cannot be penalized with a reduction in existing Medicaid funds. We will call this state of affairs the "Red State Option."²³

The Court has now decisively determined that the Tenth Amendment operates as a limit on Congress's power to spend for the general welfare when conditions are placed on states' acceptance of that spending. *NFIB* invites a host of new coercion challenges to federal conditional spending programs, but the Court has crafted little guidance for lower courts, while complicating matters by misstating the facts upon which the decision relies. Accordingly, the resulting difficulties for lower courts attempting to decide coercion challenges, legislators drafting new conditional spending programs, and federal agencies administering existing Spending Clause programs are profound. For every federal spending program since the Great Society, this case signals the beginning of a new era of litigation challenges.²⁴

This Article proceeds as follows: Part I discusses the Affordable Care Act's Medicaid expansion in the context of the history and purpose of the Medicaid Act, paying particular attention to facts about the Medicaid program the Court misunderstood. Part II summarizes the litigation from the lower courts up to the *NFIB* decision, and examines the Medicaid coercion opinions in *NFIB* in

²¹ *NFIB*, 132 S. Ct. at 2607 (plurality opinion) (referring to 42 U.S.C. § 1396c).

²² *Id.* ("[W]e determine, first, that § 1396c is unconstitutional when applied to withdraw existing Medicaid funds from States that decline to comply with the expansion."). Chief Justice Roberts also wrote: "The Court today limits the financial pressure the Secretary may apply to induce States to accept the terms of the Medicaid expansion. As a practical matter, that means States may now choose to reject the expansion; that is the whole point." *Id.* at 2608.

²³ Kevin Outterson, *The Scope of the Red State Option*, INCIDENTAL ECONOMIST (July 20, 2012, 1:44 PM), <http://theincidentaleconomist.com/wordpress/the-scope-of-the-red-state-option/>. Of course, the option is available to any state, but in the current political climate only "red" states are likely to exercise it.

²⁴ See, e.g., Eloise Pasachoff, *NFIB v. Sebelius, the Spending Clause, and the Future of Federal Education Law*, 62 AM. U. L. REV. (forthcoming Mar. 2013); Frederick M. Hess, *Edu-implications of Yesterday's Supreme Court Medicaid Ruling*, AEIDEAS (June 29, 2012, 1:18 PM), <http://www.aei-ideas.org/2012/06/edu-implications-of-yesterdays-supreme-court-medicare-ruling/> (assessing the impact of the Supreme Court's Medicaid coercion ruling on federal education funding of state and local educational institutions). But see Andrew B. Coan, *Judicial Capacity and the Conditional Spending Paradox*, 2013 WIS. L. REV. (forthcoming Apr. 2013) (manuscript at 63-66) (predicting that the *NFIB* spending power doctrine will be short lived).

detail. Part III first considers *NFIB* in the context of the Federalism Revolution,²⁵ and then discusses three weaknesses in the new coercion doctrine with an eye toward predicting difficulties of application.

These three weaknesses bear brief mention at the outset. First, although Florida and the other litigating states did not base their Medicaid challenge on any of the four *Dole* limits, the Court's coercion analysis was heavily informed by two of the four spending principles set forth in *Dole*.²⁶ Specifically, the Court considered whether Congress had given sufficiently clear notice of the condition and whether the condition was sufficiently related, or germane, to the federal program.

With respect to clear notice for Medicaid expansion, Congress warned the states from the inception of the Medicaid program that it reserved the "right to alter, amend, or repeal any provision" of the Act.²⁷ This provision of the statute has troublesome implications for the suggestion that conditional spending programs be treated as contracts between the federal government and the states. Congress did not need this language at all because subsequent Congresses always retain the power to amend legislation. Moreover, a document with an unlimited unilateral amendment provision is hardly a contract. The *NFIB* Court's failure to give controlling effect to direct language disclaiming the applicability of contract principles bodes ill for the federal government's ability to meet the clear notice standard in future cases.

On the question of relatedness, the germaneness test articulated by the Court in *Dole*, the Court determined that the Medicaid expansion was not adequately related to the pre-ACA Medicaid program. To reach that conclusion, the Roberts plurality artificially separated the existing Medicaid program from the ACA's Medicaid expansion, treating them as two distinct federal programs. The expansion, per Chief Justice Roberts, was no longer limited to the "neediest among us" because single and childless adults with incomes below \$15,415, 133% of the federal poverty level (FPL),²⁸ would now qualify for

²⁵ See *infra* Part III.A.

²⁶ Formulating what was to become the standard for evaluating the constitutionality of conditions placed on federal funding, Chief Justice Rehnquist summarized prior caselaw to create an enumerated test. That four-part test was: (1) spending must be for the general welfare; (2) conditions must be unambiguous; (3) conditions must be related to federal goals; and (4) conditions cannot themselves be unconstitutional. See *South Dakota v. Dole*, 483 U.S. 203, 207-08 (1987). Aside from these four limits, the Court then noted, "Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* at 211 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

²⁷ 42 U.S.C. § 1304 (2006) (originally enacted as Social Security Act of 1935, Pub. L. No. 74-271, § 1104, 49 Stat. 620, 648).

²⁸ The FPL for a single adult in the forty-eight contiguous states in 2012 was \$11,170. After the 5% income disregard, which is allowed by the ACA provisions regarding calculation of income eligibility, the 133% standard effectively becomes 138%, which was used to calculate this number. For discussion of the income-disregard provisions of the

assistance. If relatedness becomes a meaningful element of a coercion claim, one can imagine a host of federal programs that would be vulnerable to similar challenges.²⁹

Second, both the Roberts plurality and the joint dissent expressly declined to articulate any test or rubric for deciding whether a Spending Clause program crosses the coercion line. Instead, the Roberts plurality and the joint dissent offered slogans, suggesting that a federal condition is unconstitutionally coercive if it is a “gun to the head,” “conscripts states,” or is “economic dragooning.”³⁰ Those formulations are conspicuously fact specific and provide little guidance to future courts and litigants. Moreover, the Court’s conclusion that the Medicaid expansion qualifies under all three formulations transforms what earlier Courts had called difficult political choices into unconstitutionally coercive conditions. So transformed, the Court effectively forbids certain arrangements between the federal government and states.³¹ When considering this weakness in depth, we also evaluate the various statistical indicia of coercion, the role of political accountability, and “coercion in fact.”³²

Third, in the remedy phase, the Roberts plurality forbade the Secretary from using § 1396c of the Medicaid Act as codified³³ to cut off existing Medicaid funding, effectively making the Medicaid expansion optional for states.³⁴ It

ACA, *see infra* note 55.

²⁹ *See infra* Part III.B.1.

³⁰ *See infra* Part III.B.2.c.

³¹ By way of analogy, consider common law courts’ refusals to enforce certain contracts when parties are deemed to possess unequal bargaining power and the nature of the contract is particularly important for personal safety or the public interest, among other factors. *See, e.g.,* Tunkl v. Regents of the Univ. of Cal., 383 P.2d 441, 441-42 (Cal. 1963) (refusing to enforce a charity hospital’s exculpatory clause, signed by patient upon admission to the emergency room).

³² *See infra* Part III.B.2. Glenn Cohen analyzed *NFIB*’s coercion doctrine from the perspective of ethics, concluding that states had not been coerced. I. Glenn Cohen, *Conscientious Objection, Coercion, the Affordable Care Act, and U.S. States*, 20 ETHICAL PERSP. (forthcoming Mar. 2013) (manuscript at 16-17) (on file with authors) (describing the *NFIB* opinion as containing an unsophisticated philosophical analysis and constituting an example of “personification confusion,” improperly treating states like individual persons for the purposes of coercion analysis).

³³ 42 U.S.C. § 1396c (2006) (originally enacted as Social Security Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 351).

³⁴ Another way to think about the remedy is that the Medicaid expansion has become an unenforceable mandate. *See* E-mail from Sara Rosenbaum, Professor of Health Law & Policy, George Washington Univ. Sch. of Pub. Health & Health Servs., to Nicole Huberfeld, Professor of Law, Univ. of Kentucky Coll. of Law (Aug. 16, 2012) (on file with authors). The characterization of mandatory-but-unenforceable versus optional, while not key to the constitutional analysis of the case, may be very important for understanding how HHS will approach implementation of the expansion. This is because “mandatory” and “optional” are terms of art for the Medicaid program, indicating certain degrees of flexibility and sometimes negotiating leeway for HHS.

remains to be seen whether future decisions will, under the guise of the Tenth Amendment, similarly invoke a narrow severance remedy to reformulate existing conditional spending programs into optional state programs. The remedy, although effective in terms of salvaging the ACA from being struck down in its entirety, presents a host of unanticipated challenges and future questions.³⁵ If the Medicaid coercion was something of a sleeper issue, the question of coercion severability was almost entirely off the radar – barely raised and thinly briefed before the Court. Any attention the argument received was largely due to the political instincts of the Chief Justice and a key concession at the end of oral arguments by Mr. Clement, counsel for the States. But our analysis in Part III concludes that perhaps the Red State Option is exactly what sound principles of constitutional federalism require, a solution uniquely crafted for Tenth Amendment coercion cases.

Finally, in Part IV, we examine the post-*NFIB* struggles to administer the Medicaid expansion, including challenges to the “maintenance-of-effort” requirements and the question of the legality of tax credits in federally created exchanges. This historic decision undoubtedly will continue to surprise.

I. MEDICAID EXPANSION UNDER THE ACA

To appreciate the congressional design underlying the Medicaid expansion and the Court’s factual missteps in *NFIB*, background on the Medicaid program is necessary. The Medicaid Act is one part of the Social Security Act (SSA), a venerable and notoriously complex statute, which “is among the most intricate ever drafted by Congress. Its byzantine construction . . . makes the Act ‘almost unintelligible to the uninitiated.’”³⁶ The SSA is both intricate and interconnected: “Medicare and Medicaid are enormously complicated programs. The system is a web; a tug at one strand pulls on every other.”³⁷ Judicial confusion over government healthcare programs is notorious.³⁸

Even the Supreme Court can fall victim to the challenge of fully grasping the intricacies of federal healthcare legislation. This Part will demonstrate how the Roberts plurality mischaracterized the Medicaid expansion and failed to appreciate several fundamental features of the program. To the ACA drafters, the Medicaid expansion was a philosophically significant but statutorily

³⁵ See *infra* Part III.B.3.

³⁶ *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting *Friedman v. Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976)); see also *id.* at 43 n.14 (“The District Court in [*Friedman*] described the Medicaid statute as ‘an aggravated assault on the English language, resistant to attempts to understand it.’” (quoting *Friedman v. Berger*, 409 F. Supp. 1225, 1226 (S.D.N.Y. 1976))).

³⁷ *Stephenson v. Shalala*, 87 F.3d 350, 356 (9th Cir. 1996).

³⁸ See, e.g., Oral Argument at 19:11, *Selective Serv. Sys. v. Minn. Pub. Interest Research Grp.*, 468 U.S. 841 (1984), available at http://www.oyez.org/cases/1980-1989/1983/1983_83_276. During these oral arguments, one Justice infamously said: “Suppose there were a provision in the Medicaid or Medicare Act, I get the two of them confused . . .” *Id.*

incrementalist amendment to the existing program. To the Roberts plurality, it was “a shift in kind, not merely degree,”³⁹ transforming Medicaid into something that “is no longer a program to care for the neediest among us.”⁴⁰ This suggested distinction matters greatly in the decision itself and the discussion of coercion in Part III. By providing history and context for both the ACA and Medicaid, this Article illuminates that the Medicaid expansion was not a dramatic “shift in kind” but instead fits comfortably into familiar patterns of prior amendments to Medicaid.

A. *The ACA’s Path to Expanding Coverage*

Due to public preferences and political realities, the ACA did not radically overhaul the U.S. healthcare system. Single-payer health care was never on the table, and the so-called “public option” received only nominal consideration.⁴¹ Instead, the ACA built upon the United States’ existing path-dependent, public-private healthcare system, which is premised on the assumption that at least some individuals should not be left to fend for themselves in the private market for health care. Resulting forms of government assistance and beneficiaries have evolved through often-contentious debate over many decades. The ACA’s expansion of Medicaid eligibility and other government subsidies, as well as its creation of premium-assistance tax credits and health insurance exchanges, are the latest iterations.

Before the ACA was enacted, roughly 16% of the U.S. population was uninsured.⁴² Close to half the country, 49%, was covered by employer-sponsored health insurance, and about one-third was covered by public-benefits programs, primarily Medicare (12%) and Medicaid (17%).⁴³ Only 5% was insured in the private, non-group health insurance market.⁴⁴ From that

³⁹ *NFIB*, 132 S. Ct. 2566, 2605 (2012) (plurality opinion).

⁴⁰ *Id.* at 2606.

⁴¹ See generally M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389, 443 (2009) (discussing the possibility of single-payer or public-option approaches); James Brasfield, *The Politics of Ideas: Where Did the Public Option Come from and Where Is It Going?*, 36 J. HEALTH POL. POL’Y & L. 455, 457-58 (2011); Brendan S. Maher, *The Benefits of Opt-In Federalism*, 52 B.C. L. REV. 1733, 1750 (2011) (“In America, the current political environment suggests no epic expansion of the [healthcare] benefit as entitlement approach is in the foreseeable future.”); N. Gregory Mankiw, *The Pitfalls of the Public Option*, N.Y. TIMES, June 28, 2009, at BU5; *The End of Private Health Insurance*, WALL ST. J., Apr. 13, 2009, at A14.

⁴² *Fast Facts: Health Insurance Coverage in the U.S., 2010*, KAISER FAM. FOUND., <http://facts.kff.org/chart.aspx?ch=477> (last visited Oct. 8, 2012); see also CARMAN DENAVAS-WALT ET AL., U.S. DEP’T OF COMMERCE, U.S. CENSUS BUREAU, P60-239, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 23 (2011), available at <http://www.census.gov/prod/2011pubs/p60-239.pdf>.

⁴³ *Fast Facts: Health Insurance Coverage in the U.S., 2010*, *supra* note 42.

⁴⁴ *Id.*

baseline, the ACA sought to close the gap by increasing each of the other pieces of the pie: employer-based health insurance; private, non-group health insurance; and public health insurance programs.

The biggest piece of the pie is employer-based health insurance. In a nod to behavioral economics, the ACA implements default-enrollment requirements for large employers,⁴⁵ meaning that employees are automatically enrolled in an employer-based plan and must actively opt out. Large employers also are subject to limited penalties for failing to provide affordable health plans to employees.⁴⁶ The ACA offers generous tax credits to small employers to encourage them to offer health insurance to employees⁴⁷ and creates a new Small Business Health Options Program.⁴⁸

Strategies to expand coverage in the private, individual health insurance market include health insurance exchanges, the Minimum Coverage Provision (the individual mandate), and insurance-underwriting reforms. Lacking the advantages of large risk pools, individual health insurance plans have long been more difficult and expensive to obtain.⁴⁹ The ACA addresses known dysfunctions in the individual health insurance market by prohibiting pre-existing condition exclusions⁵⁰ and discriminatory pricing based on health status.⁵¹ The minimum essential coverage provision⁵² and the exchanges⁵³ support those reforms by expanding risk pools and minimizing medical underwriting.⁵⁴ Those provisions simultaneously create strong incentives for

⁴⁵ Patient Protection and Affordable Care Act § 1511, 29 U.S.C. § 218a (Supp. IV 2011) (applying to employers with more than 200 full-time employees).

⁴⁶ *Id.* § 1513(a) (codified as amended at I.R.C. § 4980(H)(c)(2)(A) (Supp. IV 2011)). These penalties are applicable to employers with fifty-one or more full-time equivalent employees. *Id.*

⁴⁷ *Id.* § 1421 (codified at I.R.C. § 45R(g)). A small employer is defined as an employer with “no more than 25 full-time equivalent employees for the taxable year.” *Id.* (codified at I.R.C. § 45R(d)(1)).

⁴⁸ *Id.* § 1311(b)(1)(B) (codified at 42 U.S.C. § 18031(b)(1)(B) (Supp. IV 2011)).

⁴⁹ See Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 51-53 (2010); Amy B. Monahan, *Health Insurance Risk Pooling and Social Solidarity: A Response to Professor David Hyman*, 14 CONN. INS. L.J. 325, 327-28 (2008).

⁵⁰ Patient Protection and Affordable Care Act § 1201(2)(A) (codified at 42 U.S.C. § 300gg-3).

⁵¹ *Id.* § 2701 (codified at 42 U.S.C. § 300gg); see also Brief Amici Curiae of Prescription Policy Choices et al. in Support of Petitioners on the Minimum Coverage Provision, Dep’t of Health & Human Servs. v. Florida, 132 S. Ct. 2566 (2012) (No. 11-398) (describing the ACA’s approach to addressing dysfunctions in the existing health insurance system).

⁵² Patient Protection and Affordable Care Act § 1501(b) (codified at I.R.C. § 5000A (Supp. IV 2011)).

⁵³ *Id.* § 1311 (codified at 42 U.S.C. § 18031).

⁵⁴ See generally Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577 (2011); Mark A. Hall, *The*

individuals to purchase health insurance and prohibit insurers from refusing to cover or charging higher premiums to perceived high-risk individuals.

The ACA also expands public insurance, primarily through Medicaid. After the expansion, all citizens and legal residents earning below 133%⁵⁵ FPL are now eligible for Medicaid.⁵⁶ This approach won out over other proposals, including raising Medicaid eligibility to 150% FPL,⁵⁷ offering a public option in the health insurance exchanges,⁵⁸ and providing tax subsidies for all low-income, uninsured individuals to purchase private health insurance.⁵⁹ The policy compromise was based on the idea that extremely low-income Americans should be provided public health insurance while slightly less impoverished individuals should be given federal tax credits to support private purchasing in the exchanges.⁶⁰

Three Types of Reinsurance Created by Federal Health Reform, 29 HEALTH AFF. 1168 (2010).

⁵⁵ Patient Protection and Affordable Care Act § 2001(a)(1) (codified at 42 U.S.C. § 1396a). The original language established an income threshold of 133%, but that was effectively increased to 138% through a 5% income disregard in section 1004(e) of the Health Care and Education Reconciliation Act of 2010. Health Care and Education Reconciliation Act of 2010 § 1004(e), 42 U.S.C. § 1396a(e)(14) (originally enacted as Patient Protection and Affordable Care Act § 2002(a)) (adding to the Social Security Act a provision requiring a 5% income disregard for certain qualified individuals); *see also* Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,144, 17,146 (Mar. 23, 2012) (to be codified at 42 C.F.R. pts. 431, 435, 457); Sara Rosenbaum, A “Customary and Necessary” Program – Medicaid and Health Care Reform, 362 NEW ENG. J. MED. 1952, 1953 (2010) (citing Congressional Budget Office estimates that the new income-calculation methods will effectively raise the Medicaid eligibility threshold to 138% FPL). We use 133% because that is the language of the statute, even though the practical effect of the income disregard is to raise the standard to 138%.

⁵⁶ This equates to an annual income of \$31,809 for a family of four after the 5% income disregard. *See* Annual Update of the HHS Poverty Guidelines, 77 Fed. Reg. 4034, 4035 (Jan. 26, 2012) (stating that the 2012 poverty guidelines for the forty-eight contiguous states and the District of Columbia is \$23,050 for a family of four).

⁵⁷ JOHN HOLAHAN, KAISER COMM’N ON MEDICAID & THE UNINSURED, ALTERNATIVES FOR FINANCING MEDICAID EXPANSIONS IN HEALTH REFORM 3 (2009), available at <http://www.kff.org/healthreform/upload/8029.pdf>.

⁵⁸ Robert Pear & Jackie Calmes, *Senators Reject Pair of Public Option Proposals*, N.Y. TIMES (Sept. 29, 2009), <http://www.nytimes.com/2009/09/30/health/policy/30health.html>.

⁵⁹ *See* Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U. J. HEALTH L. & POL’Y 127, 130 & n.18 (2011) (suggesting that a proposal to cover all low-income adults through the exchanges was rejected because the federal government would have assumed the full cost, as compared to Medicaid, under which states and the federal government share the cost); *see also* Leighton Ku & Matthew Broadus, *Public and Private Health Insurance: Stacking Up the Costs*, 27 HEALTH AFF. w318, w318 (2008).

⁶⁰ *See* Patient Protection and Affordable Care Act §§ 1401, 10105 (codified as amended at I.R.C. § 36B (Supp. IV 2011)) (providing premium assistance tax credits for the purchase

B. *The Medicaid Program*

1. Medicaid and the “Deserving” Poor

Medicaid has historically provided health insurance coverage to the “deserving” poor,⁶¹ including women (widows in particular) and their children, the blind, the disabled, and impoverished elderly.⁶² This normative classification, derived from the Elizabethan Poor Laws, was expressed in state welfare policies deeming the working poor and those considered “blameless” in their poverty to be deserving of assistance, while the non-working poor, or paupers, were not.⁶³

The SSA of 1935 provided the statutory basis for both Medicare and Medicaid.⁶⁴ As part of President Roosevelt’s New Deal legislation, the SSA effectively codified the historical categories of deserving poor, deeming them eligible for government assistance through income-security payments.⁶⁵ With

of qualified health plans).

⁶¹ See Sara Rosenbaum, Anne Markus & Colleen Sonosky, *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMEDICAL L. 1, 7-8 (2004); Sandra Tanenbaum, *Medicaid Eligibility Policy in the 1980s: Medical Utilitarianism and the “Deserving” Poor*, 20 J. HEALTH POL., POL’Y & L. 933, 933-34 (1995).

⁶² The very concept of the “deserving” poor is contested as racialized. See KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* 212-20 (2011). Despite criticism of the category, it is common in Medicaid. TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH PROGRAMS AND A RIGHTS-BASED RESPONSE* 80 (2003) (listing the beneficiaries of federal and state public-assistance programs); ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 6-7 (1974) (identifying traditional groups that were the target of special-assistance programs during the early twentieth century); Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 439 (“Certain categories of blameless or ‘deserving’ poor have been assisted by local, state, or federal government since the turn of the twentieth century and consistently have included women (widows) and their children, the blind, the disabled, and impoverished elderly.”); Rosenbaum, Markus & Sonosky, *supra* note 61, at 8-10 (discussing Medicaid’s coverage of low-income children and pregnant women).

⁶³ See STEVENS & STEVENS, *supra* note 62, at 11 (describing the clear division between contributing work-related social insurance to workers and giving to the “poor”); Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 439 (“Starting in the colonial period, states provided various forms of welfare assistance to so-called deserving poor based upon that state’s colonial policy as adopted from Elizabethan Poor Laws.”).

⁶⁴ Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 441; Elizabeth A. Weeks, *Cooperative Federalism and Healthcare Reform: The Medicare Part D “Clawback” Example*, 1 ST. LOUIS U. J. HEALTH L. & POL’Y 79, 83-84 (2007) (“Congress enacted Medicaid at the same time as Medicare, intending Medicaid to be a welfare program to provide healthcare to the needy, including individuals impoverished by staggeringly high medical expenses.”).

⁶⁵ Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 441 (“The SSA adopted and

the exception of limited, open-ended federal grants to states,⁶⁶ however, Roosevelt put the goal of government health insurance aside due to political objections, including widespread fear of socialized medicine and fragile political support for other reforms built into the SSA.⁶⁷ Health care was not added to the SSA until the 1960s.⁶⁸

After 1935 there were modest expansions of public assistance for health care, focused on hospital infrastructure, provider payments, and ensuring care for especially deserving groups, including the very elderly.⁶⁹ During the 1950s the elderly poor exercised more political power and pushed for health insurance benefits mirroring the workers' insurance program in the SSA.⁷⁰ Those efforts resulted in the Kerr-Mills Act, a 1960 amendment to the SSA designed to assist the impoverished elderly⁷¹ by supporting existing state programs through a limited federal grant-in-aid program.⁷²

In 1965, Congress enacted comprehensive, fully federal health insurance for the elderly in the form of Medicare.⁷³ Unlike Medicare, Medicaid was almost

codified states' categories of deserving poor into federal law by protecting the elderly, children, widows and widowers, blind, those otherwise disabled, and the unemployed through income security.”).

⁶⁶ See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 270 (1982); Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 442.

⁶⁷ See STARR, *supra* note 66, at 266-69; Robert I. Field, *Regulation, Reform and the Creation of Free Market Health Care*, 32 *HAMLINE J. PUB. L. & POL'Y* 301, 308 (2011) (“When he proposed Social Security in 1935, Roosevelt chose to leave health insurance out because of its political sensitivity. . . . [The Roosevelt] saw a threat that charges of socialized medicine would be resurrected, which could paint the entire package as too radical for the public to accept.”).

⁶⁸ See STARR, *supra* note 66, at 371.

⁶⁹ JOST, *supra* note 62, at 80 (discussing the birth and growth of public assistance healthcare programs in the 1950s and 1960s); STARR, *supra* note 66, at 270-71 (describing limited government healthcare programs, including poor farmer subsidies); Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 443; *see also, e.g.*, Federal Food, Drug, and Cosmetic Act, Pub. L. No. 75-717, 52 Stat. 1040 (1938) (expanding the FDA's regulatory role); Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (funding new hospital construction and expansion).

⁷⁰ See Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 443 (“While the elderly pushed for health insurance benefits that would mirror the SSA workers' insurance program, a political willingness to assist impoverished (if not all) elderly emerged and became the program that immediately preceded Medicaid, referred to as Kerr-Mills.”).

⁷¹ Kerr-Mills Act, Pub. L. No. 86-778, § 601, 74 Stat. 924, 987-91 (1960) (providing federal assistance to the very poor elderly); *see also* JOST, *supra* note 62, at 81 (explaining how the Social Security Act Amendments of 1960 created the Kerr-Mills program and its expanded coverage of the “medically needy”).

⁷² See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 27-30 (2d ed. 2000) (describing limited government assistance under the Kerr-Mills Act); STARR, *supra* note 66, at 368-69.

⁷³ See Weeks, *supra* note 64, at 83.

an afterthought⁷⁴ and, essentially, designed to extend the existing Kerr-Mills program.⁷⁵ Congress created Medicaid as a means-tested welfare program,⁷⁶ offering unlimited federal funding to the states so long as they complied with broad federal requirements under the Medicaid Act.⁷⁷ The carrot was the offer of federal funds; the stick was § 1396c, permitting the Secretary to limit some or all Medicaid funds if a state failed to comply with conditions imposed by federal law.⁷⁸ Medicaid was well received by the states, with the vast majority electing to participate within a few years.⁷⁹ Today, every state operates a Medicaid program supported by federal matching dollars.

Medicaid is a paradigmatic cooperative-federalism program,⁸⁰ which is one reason the *NFIB* decision is so troubling. Financial contributions by both the states and the federal government provide the “cornerstone of Medicaid.”⁸¹

⁷⁴ See STEVENS & STEVENS, *supra* note 62, at 47-51 (describing Medicaid as “ill-designed” compared to Medicare).

⁷⁵ *Id.* at 51 (“[T]he section of the Senate report dealing with Title XIX was entitled, ‘Improvement and Extension of Kerr-Mills Medical Assistance Program.’”); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL’Y 5, 9-10 (2006) (“An outgrowth of the earlier Kerr Mills grant-in-aid program, which assisted states in meeting the health care costs of the elderly poor, Medicaid reflected Congress’s decision to ‘liberalize and extend’ this system of federal grants to states for specific health care purposes.”).

⁷⁶ STARR, *supra* note 66, at 369 (describing how President Johnson signed three programs into law: first, “the Democratic plan for a compulsory hospital insurance program under Social Security” which is now Part A of Medicare; second, “the revised Republican program of government-subsidized voluntary insurance to cover physicians’ bills” which is now Part B of Medicare; and third, Medicaid, which “expanded assistance to the states for medical care for the poor”); see also *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981) (describing the enactment of the Medicaid program); *Brogan v. Miller*, 537 F. Supp. 139, 142 (N.D. Ill. 1982); Rosenbaum, Markus & Sonosky, *supra* note 61, at 7-8 (characterizing Medicaid as “an afterthought to Medicare, and a relegation to states of responsibility for insuring the poor” (internal quotation marks omitted)).

⁷⁷ Efforts to metamorphose Medicaid into a capped block grant have failed. See, e.g., Jeanne M. Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 MILBANK Q. 41, 46-47 (2005) (outlining the efforts of Speaker of the House Newt Gingrich and President George W. Bush, among others, to make a capped block grant part of federal Medicaid funding).

⁷⁸ 42 U.S.C. § 1396c (2006) (originally enacted as Social Security Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 351).

⁷⁹ Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 445 n.69 (“Arizona and Alaska were holdouts, with Arizona joining Medicaid in 1982 and Alaska joining in 1972.”).

⁸⁰ See *NFIB*, 132 S. Ct. 2566, 2629 (2012) (Ginsburg, J., concurring in part and dissenting in part) (“Medicaid is a prototypical example of federal-state cooperation in serving the Nation’s general welfare.”); *Harris v. McRae*, 448 U.S. 297, 308 (1980) (stating that Medicaid fosters cooperative federalism and describing the program); Huberfeld, *Bizarre Love Triangle*, *supra* note 14, at 419; Weeks, *supra* note 64, at 114.

⁸¹ *Harris*, 448 U.S. at 308 (“The cornerstone of Medicaid is financial contribution by

Through a federal offer of open-ended matching funds, states are incentivized to provide generous public benefits, receiving additional federal financial support for every state dollar spent.⁸² Medicaid is entirely voluntary for states.⁸³ They do not have to participate and could refuse federal dollars, establish their own indigent healthcare programs, or elect not to provide any medical assistance for low-income individuals.⁸⁴

As originally enacted, Medicaid targeted the now-familiar categories of deserving poor.⁸⁵ The groups originally entitled to Medicaid were elderly, blind, and otherwise disabled persons receiving welfare under federal cash-assistance programs, and dependent children and their caretaker relatives receiving assistance through Aid to Families with Dependent Children (AFDC).⁸⁶ The goal expressed in 1965 was to provide a broad package of medical assistance to these categories of individuals whose incomes were “insufficient to meet the costs of necessary medical services.”⁸⁷ Congress later replaced the cash-assistance programs for disabled adults and children and the impoverished elderly with Supplemental Security Income (SSI); but these groups continued to qualify for Medicaid on the basis of SSI eligibility.⁸⁸ Congress also later replaced AFDC with Temporary Assistance for Needy Families (TANF) but retained the historical AFDC eligibility requirements for Medicaid.⁸⁹ Prior to the enactment of the ACA, Medicaid covered seven discrete categories of individuals.⁹⁰ The ACA added an eighth category: all

both the Federal Government and the participating State.”).

⁸² Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111, 134-35 (2010); see also Abigail R. Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 861-64 (2009).

⁸³ *Harris*, 448 U.S. at 301 (“Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of [the Medicaid Act].”).

⁸⁴ See Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 857, 860 (1990). Both the Roberts plurality and the joint dissent discounted the political ability of states to realistically take these actions. See *infra* Part III.B.2.

⁸⁵ Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 445-46 (explaining that the Medicaid Act originally covered medically indigent individuals who fell within a traditional “welfare category”).

⁸⁶ SARA ROSENBAUM & DAVID M. FRANKFORD, *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 503 (2d ed. 2012).

⁸⁷ Social Security Amendments of 1965, Pub. L. 89-97, § 121(a), 79 Stat. 286, 343-44 (codified as amended at 42 U.S.C. § 1396 (2006)) (adding § 1901 to the Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620).

⁸⁸ ROSENBAUM & FRANKFORD, *supra* note 86, at 503.

⁸⁹ *Id.* at 503 n.*.

⁹⁰ 42 U.S.C. § 1396a(a)(10)(A)(i)(I)-(VII).

citizens and legal residents with incomes up to 133% FPL who are not otherwise eligible through another mandatory Medicaid category.⁹¹

2. The Scope of Medicaid Benefits and Coverage Prior to the ACA

Beyond the broad statutory outlines, states have considerable discretion over Medicaid eligibility requirements and program benefits.⁹² States can expand beyond the mandatory groups and services⁹³ and will receive unlimited federal matching dollars for those optional elements of their programs.⁹⁴ To receive federal funding, states must submit to the Secretary of HHS a “State Plan,” which explains how the state will comply with the Medicaid Act.⁹⁵ Once the State Plan is in place, states administer Medicaid with little federal oversight.⁹⁶ If the Secretary determines, after reasonable notice and opportunity for hearing, that a State Plan has fallen out of compliance with federal requirements, the Secretary has discretion under § 1396c to withhold federal funding due to the noncompliance until the plan is corrected.⁹⁷ Typically, the Secretary negotiates a correction plan. Not once in the nearly fifty-year history of the program has the federal government withdrawn all federal funding from a noncompliant state.⁹⁸ Section 1396c, which figures prominently in the *NFIB* decision, has been present in the Medicaid Act since its inception.⁹⁹

⁹¹ Patient Protection and Affordable Care Act § 2001(a)(1)(C) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2011)). A ninth category was also added by the ACA, effective in 2019, covering children leaving foster care. *Id.* § 10201(a)(1) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(IX)(cc)).

⁹² See *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981) (describing “categorically” and “medically” needy beneficiaries); Kinney, *supra* note 84, at 857 (“Because states have great flexibility . . . the Medicaid program is really 50 very different programs serving different populations and providing different benefits.”); Rosenbaum, *supra* note 75, at 12-13 (describing Medicaid eligibility and coverage); Weeks, *supra* note 64, at 84 (“As long as states comply with certain broad federal requirements, they receive federal matching dollars to support their state Medicaid programs.”).

⁹³ 42 U.S.C. § 1396a(a)(10)(A)(ii) (2006). Additional services also can qualify for matching funds. See *id.* § 1396d(a) (defining services that qualify as “medical assistance” and can therefore receive funding).

⁹⁴ *Id.* §§ 1396b(a)(1), 1396d(b) (setting out a formula for calculating the amount of federal matching funds due to a state for medical-assistance expenditures without including a specific monetary cap or maximum expenditure).

⁹⁵ *Id.* § 1396a(a) (defining compliance requirements necessary to create and run a State Plan); Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 447 (discussing how State Plans are administered with little federal oversight, despite the federal government paying a large portion of the plans’ administrative costs).

⁹⁶ Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 447.

⁹⁷ See 42 U.S.C. § 1396c (giving the HHS Secretary the ability, after appropriate notice and hearing procedures, to cease making payments to a state “until the Secretary is satisfied that there will no longer be any such failure to comply [with 1396a(a)’s requirements]”).

⁹⁸ For this reason, the Health Law Brief argued that the states’ question was not ripe, but

Each dollar a state spends on federally approved Medicaid programs, whether required or optional, is matched by federal funds.¹⁰⁰ The basic federal match ranges from 50% to almost 75%, based on the amount of money the state spends on Medicaid and the state's per capita income, with poorer states receiving a more generous match.¹⁰¹ In addition, states receive a federal match of at least 50% for administrative costs.¹⁰²

Prior to the ACA, State Plans were required to cover seven groups (collectively, the "categorically needy") modeled on the traditional deserving poor who earn less than specified amounts.¹⁰³ States could also extend benefits to "optional categorically needy" beneficiaries.¹⁰⁴ States could further elect to cover the "medically needy," meaning individuals who are categorically eligible (aged, disabled, blind, or families with dependent children) and who have high medical expenses despite enjoying incomes in excess of the financial eligibility levels.¹⁰⁵ Thirty-three states and the District of Columbia currently cover these optional groups.¹⁰⁶

the Court did not accept that view. Health Law Brief, *supra* note 14, at 21 ("Petitioners' fear of total funding loss . . . is not cognizable, as the Secretary has never exercised this power in forty-seven years of Medicaid administration.").

⁹⁹ Social Security Amendments of 1965, Pub. L. 89-97, § 121(a), 79 Stat. 286, 351. The language derives from section 4 of the original SSA. *See* Social Security Act of 1935, Pub. L. 74-271, § 4, 49 Stat. 620, 622 (codified as amended at 42 U.S.C. § 304).

¹⁰⁰ *See* 42 U.S.C. § 1396b(a) (listing the percentage of state spending that the federal government will match, depending on the type of expenditure); *Harris v. McRae*, 448 U.S. 297, 308 (1980) (describing the "cooperative federalism" approach enacted in order "to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan").

¹⁰¹ Federal Medicaid Assistance Percentage (FMAP) calculations are published in the Federal Register each year. *See, e.g.*, Adjusted Federal Medical Assistance Percentage (FMAP) Rate for the First Quarter of Fiscal Year 2011 (FY11), 76 Fed. Reg. 5811, 5812-13 (Feb. 2, 2011) (calculating the adjusted FMAP for the first quarter of fiscal year 2011).

¹⁰² *See* 42 U.S.C. § 1396b(a)(2)(B).

¹⁰³ *Id.* § 1396a(a)(10)(A).

¹⁰⁴ Recipients considered "categorically needy" include certain children in foster or adoptive homes, pregnant women, and certain gainfully employed individuals with disabilities. 42 C.F.R. § 435.201 (2011) (covering pregnant women and blind, aged, or disabled persons); *id.* § 435.227 (covering adoptive and foster-care children). In 2000 Medicaid coverage was also extended to certain low-income women screened for breast and cervical cancer under a federal early detection program as an "optional categorically needy group." Breast and Cervical Cancer Prevention Treatment Act of 2000 § 2, 42 U.S.C. §§ 1396(aa), 1396a(a)(10)(A)(ii)(XVIII); *see also* 42 C.F.R. §§ 410.34(b), 410.56(a).

¹⁰⁵ 42 U.S.C. § 1396a(a)(10)(C).

¹⁰⁶ *Income Eligibility Requirements Including Income Limits and Asset Limits for the Medically Needy in Medicaid*, 2009, KAISER FAM. FOUND., <http://www.statehealthfacts.org/comparereport.jsp?rep=60&cat=4> (last visited Oct. 29, 2012).

Nationwide, children represent close to 50% of the total Medicaid enrollment.¹⁰⁷ The elderly and disabled comprise 25%,¹⁰⁸ and the remaining approximately 25% are non-elderly, non-disabled adults, usually caretakers of covered children.¹⁰⁹ Before the ACA's passage, the income eligibility tests varied among categories (based on federal requirements) and states (based on states' optional coverage). For example, pregnant women were required to be covered up to 133% FPL, and states could opt to cover them at higher income levels.¹¹⁰ Federal law did not require states to cover non-pregnant caretakers or childless adults, but states could opt to do so, typically up to a much lower percentage of FPL. Children ages zero to five had to be covered up to 133% FPL, while children ages six to eighteen had to be covered only up to 100% FPL.¹¹¹ States could opt to cover higher-income children, often in combination with the separate federal block grant Children's Health Insurance Program.¹¹² Medicaid coverage is also limited to citizens and qualified aliens (with a limited exception for emergencies).¹¹³

Once a state decides which groups will be eligible, it must determine which services it will provide. The Medicaid Act mandates the provision of seven forms of medical services, including inpatient hospital, outpatient hospital, laboratory and x-ray, nursing-facility, physician, nurse-midwife, and nurse-

¹⁰⁷ *Distribution of Medicaid Enrollees by Enrollment Group, FY2009*, KAISER FAM. FOUND., <http://www.statehealthfacts.org/comparetable.jsp?ind=200&cat=4&sub=52&yr=90&typ=2> (last visited Oct. 29, 2012) (reporting that, as of fiscal year 2009, children represented forty-nine percent of Medicaid enrollees nationwide).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* (stating that adults constituted twenty-six percent of Medicaid enrollees in fiscal year 2009).

¹¹⁰ 42 U.S.C. § 1396a(a)(10)(A)(i)(III)-(V), (l)(2)(A)(ii)-(iv) (requiring coverage for pregnant women at or below 133% FPL, but giving states discretion to fund coverage up to 185% FPL).

¹¹¹ See Medicare Catastrophic Coverage Act of 1988 (MCCA) § 302, 42 U.S.C. § 1396a(a)(10)(A)(i), (l); Omnibus Budget Reconciliation Act of 1990 § 4601, 42 U.S.C. § 1396a(l)(1)(D), (2)(C) (establishing coverage for children between six and nineteen years of age, up to 100% FPL).

¹¹² 42 U.S.C. § 1396d(b), (u)(1) (allowing for the "optional use of state child health assistance funds" as part of an "enhanced Medicaid match" for low-income children); *id.* §§ 1397aa-jj (adding Title XXI to the SSA, thereby establishing the State Children's Health Insurance Program (SCHIP)). See generally Rosenbaum, Markus & Sonosky, *supra* note 61 (discussing the similarities and differences between Medicaid and SCHIP as dual programs targeting the health care of low-income children).

¹¹³ 42 U.S.C. § 1396b(v)(2)(A) (stating that payment will be made for care of aliens only for emergency services); see also Sana Loue, *Access to Health Care and the Undocumented Alien*, 13 J. LEGAL MED. 271, 288-89 (1992).

practitioner services.¹¹⁴ States may also elect to cover “optional” services, including such fundamental items as dental care and prescription drugs.¹¹⁵

Moreover, the state may not deny services solely because of a beneficiary’s diagnosis, illness, or condition.¹¹⁶ Beneficiaries are entitled to relatively prompt services with no waiting periods.¹¹⁷ Healthcare providers are not required to participate in the Medicaid program, but states are required to provide reimbursement sufficient to ensure provider participation equal to non-Medicaid patients in the geographic area.¹¹⁸ This “equal access” provision was also at stake during the Court’s 2011 Term in *Douglas v. Independent Living Center of Southern California, Inc.*, in which the Court declined to decide a Supremacy Clause challenge to a state Medicaid reimbursement methodology.¹¹⁹

C. Previous Medicaid Expansions

Medicaid has never been a static program.¹²⁰ Congress has repeatedly expanded Medicaid with both mandatory and optional features,¹²¹ often as part

¹¹⁴ 42 U.S.C. §§ 1396a(a)(10)(A)(i), 1396d(a)(1)-(5).

¹¹⁵ *Id.* §§ 1396a(a)(10)(A)(i)-(ii), 1396d(a) (listing twenty-eight categories of medical assistance and mandating coverage for seven of those categories, while allowing states the option of covering some or all of the additional twenty-one).

¹¹⁶ 42 C.F.R. § 440.230(c) (2011) (“The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.”).

¹¹⁷ 42 U.S.C. § 1396a(a)(8) (requiring that State Plans provide “all individuals wishing to make application for medical assistance under the plan [the] opportunity to do so,” and ensure “such assistance shall be furnished with reasonable promptness to all eligible individuals”); Rosenbaum, *supra* note 75, at 12 (“Unlike private health insurance, Medicaid contains no pre-existing condition exclusions and no waiting periods.”).

¹¹⁸ 42 U.S.C. § 1396a(a)(30)(A) (requiring states to adopt reimbursement procedures “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”).

¹¹⁹ See *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1207-08 (2012); Huberfeld, *Post-Reform Medicaid*, *supra* note 14, at 515-27, 534 (discussing the *Douglas* decision and juxtaposing it with *Florida v. Dep’t of Health & Human Servs.*).

¹²⁰ Sara Rosenbaum, *Medicaid*, 346 NEW ENG. J. MED. 635, 635 (2002) (“Over the years Medicaid has served as the legislative vehicle for an extraordinary range of reforms”); Sidney D. Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 405 (2007) (“Medicaid has grown to finance an astonishing range of safety net health insurance expansions, public health initiatives, and state health reform initiatives.”).

¹²¹ *Medicaid: A Timeline of Key Developments, 1965-2009*, KAISER FAM. FOUND., http://www.kff.org/medicaid/medicaid_timeline.cfm (last visited Jan. 25, 2013) (providing an interactive timeline tracking Medicaid’s expansion over time); see also Rosenbaum, *supra* note 75, at 18-19.

of broader policy initiatives.¹²² The *NFIB* plurality fundamentally misunderstood this history, leading it to overemphasize discontinuities between the existing Medicaid program and the Medicaid expansion. The plurality artificially split Medicaid into two programs: old and new. It was then a short step to find that the condition linking those “two” programs was coercive. In addition, the *NFIB* plurality minimized consideration of the previous mandatory amendments to Medicaid, leaving open the question of why mandatory amendments in 1967, 1972, 1988, and 2003 were not also coercive. In each case, all Medicaid funding for non-cooperating states was theoretically at risk under § 1396c.

Only two years after Medicaid was enacted, Congress expanded the program to address nationwide concerns regarding children’s health, including rampant poor health among preschool children and young draftees persistently failing Army physical exams.¹²³ Congress enacted a suite of reforms¹²⁴ that included a dramatic expansion of mandatory Medicaid coverage requirements, including Early and Periodic Screening Diagnosis and Treatment (EPSDT). EPSDT is a set of services and benefits for Medicaid beneficiaries under age twenty-one.¹²⁵ EPSDT expanded coverage for children to a level unparalleled in public or private health insurance at the time.¹²⁶ Since 1967 Congress has strengthened EPSDT several times, sometimes over states’ political objections.¹²⁷ In keeping

¹²² Rosenbaum, *supra* note 75, at 17-18 (explaining, for example, Congress’s use of Medicaid expansions to address healthcare access for displaced persons after Hurricane Katrina and to ensure the community integration aims of the Americans with Disabilities Act).

¹²³ SARA ROSENBAUM ET AL., GEORGE WASHINGTON UNIV., SCH. OF PUB. HEALTH & HEALTH SERVS., DEP’T OF HEALTH POL’Y, NATIONAL SECURITY AND U.S. CHILD HEALTH POLICY: THE ORIGINS AND CONTINUING ROLE OF MEDICAID AND EPSDT 6-11 (2005), available at http://www.gwumc.edu/sphhs/departments/healthpolicy/chpr/downloads/mil_pre042605.pdf.

¹²⁴ Social Security Act Amendments of 1967, Pub. L. No. 90-248, §§ 301-302, 81 Stat. 821, 921-29 (codified as amended at 42 U.S.C. §§ 701-731, 1396d (2006)) (implementing a major expansion of Medicaid coverage concerning the healthcare needs of children under twenty-one, including early screening and prevention measures to ensure continued health).

¹²⁵ 42 U.S.C. § 1396d(r) (requiring “early and periodic screening, diagnostic, and treatment services” for youth, including physicals and vision, dental, and hearing tests); see also *Frew v. Hawkins*, 540 U.S. 431, 433-34 (2004) (describing the purpose of the EPSDT program).

¹²⁶ Sara Rosenbaum & Paul H. Wise, *Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT*, 26 HEALTH AFF. 382, 383-84 (2007) (describing the “importance, power, and breadth” of the EPSDT program in ensuring the availability of diagnostic, “developmental, and ameliorative services” for children).

¹²⁷ See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403(a), 103 Stat. 2106, 2262-63 (codified at 42 U.S.C. § 1396d(r)) (delineating further the scope of EPSDT benefits, including an express mandate that states cover “[s]uch other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate

with general practice, continued Medicaid funding for states was conditioned on compliance with the new EPSDT requirements.

In 1972 Congress again amended Medicaid coverage requirements to reflect a change in traditional eligibility categories. With these amendments, Congress ended the federal-state cooperative welfare program for the aged, blind, and disabled, and replaced it with federal SSI.¹²⁸ Accordingly, Congress revised Medicaid and required states to either extend Medicaid to all individuals eligible for SSI or, under the “209(b) option,” allow those with incomes above the prior program’s eligibility limits to qualify for Medicaid by deducting medical expenses from income.¹²⁹ Although the 1972 Amendments gave states two options to comply with the new national policy, Congress did not afford states the option to forgo the Medicaid expansion entirely.¹³⁰ By all appearances, the *NFIB* Court misunderstood this point. In oral arguments, when Mr. Clement, counsel for the States, incorrectly suggested the 1972 Amendments were “totally voluntary” and did not put existing funds at risk, neither the Court nor Solicitor General Verrilli corrected his error.¹³¹ In the Roberts plurality opinion, the 1972 Amendments are misleadingly described as “extending Medicaid eligibility, but partly conditioning only the new

defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan”); Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6044(a)(1)(A), 120 Stat. 4, 88 (codified as amended at 42 U.S.C. § 1396u-7) (requiring states to preserve EPSDT coverage in benchmark packages); Children’s Health Insurance Program (CHIP) Reauthorization Act of 2009, Pub. L. No. 111-3, § 611, 123 Stat. 8, 100 (codified at 42 U.S.C. § 1396u-7) (clarifying the requirement to provide EPSDT in benchmark packages); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2201, 124 Stat. 119, 289-90 (2010) (codified at 42 U.S.C. § 1396w-3 (Supp. IV 2011)) (preserving EPSDT as part of the newly reconfigured benchmarks); Alice Sardell & Kay Johnson, *The Politics of EPSDT Policy in the 1990s: Policy Entrepreneurs, Political Streams, and Children’s Health Benefits*, 76 MILBANK Q. 175, 186, 190-92, 197-98 (1998) (cataloging states’ expressions of concern during EPSDT expansions and explaining the National Governors Association’s strong opposition to EPSDT as an infringement of state autonomy).

¹²⁸ Social Security Act Amendments of 1972, Pub. L. No. 92-603, §§ 201, 301, 86 Stat. 1329, 1370, 1465 (codified as amended in scattered sections of 42 U.S.C.).

¹²⁹ *Id.* § 209(b) (allowing for the calculation of income-based eligibility after the subtraction of medical expenses); *id.* § 301, amended by Act of July 9, 1973, Pub. L. No. 93-66, § 212, 87 Stat. 152, 155-58 (defining mandatory SSI coverage); Brief for Respondents (Medicaid) at 5-6, *Florida v. Dep’t of Health & Human Servs.*, 132 S. Ct. 2566 (2012) (No. 11-400) (explaining how previous Medicaid amendments mandated that states either expand SSI coverage or enact the “209(b) option”).

¹³⁰ Brief of National Health Law Program et al. as Amici Curiae in Support of Respondents (Suggesting Affirmance on the Medicaid Issue) at 14-15, *Florida v. HHS*, 132 S. Ct. 2566 (No. 11-400) [hereinafter National Health Law Brief] (rejecting the argument that the 1972 SSA amendments gave the states a “take-it-if-you-want-it option” because even states choosing not to adopt the SSI expansion had to comply with section 209(b)).

¹³¹ Transcript of Oral Argument at 10, *Florida v. HHS*, 132 S. Ct. 2566 (No. 11-400).

funding.”¹³² The 1972 Amendments did not impose conditions only on “new funding”; both old and new funding were at risk. The only unique feature of the 1972 reform was that it gave states the additional option of complying through section 209(b).¹³³

Further reforms came in 1988, when Congress completely delinked Medicaid eligibility for children and pregnant women from AFDC (later renamed TANF).¹³⁴ Instead, Congress created uniform mandatory eligibility categories: up to 133% FPL for pregnant woman and children from birth to age five, and up to 100% FPL for children ages six to eighteen.¹³⁵ These reforms greatly expanded the number of persons eligible for Medicaid. Again, Congress did not offer states a choice about whether to extend coverage; it became a condition of continued participation in the Medicaid program.

Congress added another significant mandatory requirement in 2003, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).¹³⁶ The MMA created coverage for outpatient prescription drugs in the Medicare program, called Medicare Part D.¹³⁷ The MMA was a response to the urgent need to extend affordable prescription-drug coverage to Medicare beneficiaries, including 8.9 million individuals covered by both Medicare and Medicaid (dual eligibles).¹³⁸ At the time, all fifty states provided outpatient

¹³² *NFIB*, 132 S. Ct. 2566, 2605 (2012) (plurality opinion). This is not the only example of the Court getting it wrong when engaging in appellate-court factfinding. See Brianne J. Gorod, *The Adversarial Myth: Appellate Court Extra-Record Factfinding*, 61 DUKE L.J. 1, 25-37 (2011).

¹³³ See Health Law Brief, *supra* note 14, at 4-6.

¹³⁴ MCCA of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 683, 750-51 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i), (I) (1988)) (requiring Medicaid coverage for pregnant women and young children).

¹³⁵ See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2106, 2258 (amending 42 U.S.C. § 1396a(a)(10)(A)(i), (I)) (mandating eligibility for pregnant women and children under six up to 133% FPL); Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, § 4601, 104 Stat. 1388, 1388-166 to -167 (amending 42 U.S.C. § 1396a(a)(10)(A)(i), (I)) (setting eligibility for children between six and eighteen years of age at 100% FPL). These eligibility categories are still the law today and will remain so after the ACA Medicaid expansion’s implementation in 2014, with income eligibility standardized at 133% FPL through the addition of the eighth category of coverage. See *supra* note 91 and accompanying text.

¹³⁶ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066.

¹³⁷ See Thomas R. Barker, *The Low-Income Subsidy in the New Medicare Drug Benefit*, 1 J. HEALTH & BIOMEDICAL L. 49, 50-53 (2005) (summarizing historical Medicare drug coverage); Susan A. Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will It Be Good Medicine for U.S. Health Policy?*, 14 ELDER L.J. 237, 241 (2006) (remarking on Medicare’s historical lack of an outpatient drug benefit).

¹³⁸ KAISER COMM’N ON MEDICAID AND THE UNINSURED, DUAL ELIGIBLES: MEDICAID’S ROLE FOR LOW-INCOME MEDICARE BENEFICIARIES 1 (2011), available at <http://www.kff.org/medicaid/upload/4091-08.pdf>.

prescription-drug coverage to beneficiaries as an optional Medicaid service.¹³⁹ The MMA displaced states' Medicaid prescription-drug-coverage programs for dual eligibles and required those beneficiaries to enroll in Part D.¹⁴⁰ To keep the new Part D within President George W. Bush's promised \$400 billion limit, Congress financed the program in part with compulsory state contributions toward the cost of Part D (known as the "clawback").¹⁴¹ If states failed or refused to pay, the MMA authorized the federal government to extract the amount due through an automatic offset against federal Medicaid funds to which states were otherwise entitled.¹⁴² The Congressional Budget Office (CBO) estimated that states would pay \$138 billion in clawback payments between 2006 and 2016.¹⁴³ Several states unsuccessfully challenged the clawback in an original-jurisdiction action in the Supreme Court, characterizing the new set of requirements as "an unprecedented intrusion into each State's sovereignty."¹⁴⁴ States have since adapted their Medicaid programs to comply with Part D's requirements.

In summary, the Roberts plurality was historically inaccurate when it suggested that prior Medicaid amendments were voluntary or did not put already-existing program funds at risk. These changes have not been mere tinkering but significant expansions in both kind and degree.

¹³⁹ See Huberfeld, *Clear Notice*, *supra* note 14, at 445 ("[S]tates historically have covered drug expenses for dual eligibles through Medicaid . . ."); William G. Weissert & Edward Alan Miller, *Punishing the Pioneers: The Medicare Modernization Act and State Pharmacy Assistance Programs*, 35 *PUBLIUS* 115, 118 (2005) ("Although it is an optional benefit, all states have elected to provide at least some level of pharmaceutical coverage under Medicaid."); Richard Cauchi, *State's Rx for Medicare Gaps*, ST. LEGISLATURES, Mar. 2006, at 28, 28 (describing states' programs to fill the prescription-drug gap in the federal Medicare program).

¹⁴⁰ Medicare Prescription Drug, Improvement, and Modernization Act § 103 (codified at 42 U.S.C. § 1396u-5 (2006)).

¹⁴¹ *Id.* (defining state contribution requirements and allowing for the HHS Secretary to automatically withhold funds otherwise due to a state in response to a failure to pay); Weeks, *supra* note 64, at 103 (explaining the "clawback" provision).

¹⁴² 42 U.S.C. § 1396u-5(c)(1)(C) ("The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State . . .").

¹⁴³ CONG. BUDGET OFFICE, *THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2007 TO 2016*, at 59 box 3.2 (2006), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/70xx/doc7027/01-26-budgetoutlook.pdf>.

¹⁴⁴ *Texas v. Leavitt*, 547 U.S. 1204 (2006) (mem.) (denying review under the Supreme Court's original jurisdiction); Brief of the States of Arizona et al. as Amici Curiae in Support of Plaintiffs at 1, *Leavitt*, 547 U.S. 1204 (No. 135). The United States was represented in this case by the then-Solicitor General, Paul Clement. See Brief for the Secretary of Health & Human Services in Opposition at 29, *Leavitt*, 547 U.S. 1204 (No. 135).

D. *The ACA Medicaid Expansion*

The ACA represents another instance of congressional use of the Medicaid program to address national healthcare needs. Most notably, Congress added a new category of individuals eligible for Medicaid, standardized income-eligibility thresholds, modified the mandatory-benefits package, and agreed to pay the lion's share of the additional costs of covering the newly eligible individuals. Chief Justice Roberts pointed to these changes in support of his characterization of the ACA as creating a "new" Medicaid program. For their part, the states were required to maintain existing voluntary program expansions during the transition period – the "maintenance of effort" (MOE) requirement – and to contribute a small amount for the costs of the expansion population. Each of these changes will be explored briefly.

First, as with prior amendments, the ACA expands Medicaid – in particular, by extending coverage to all citizens and legal residents with incomes up to 133% FPL.¹⁴⁵ Justice Roberts highlighted the additional adults covered by this provision in support of his argument that the ACA changed Medicaid "in kind, not merely degree," because unlike pre-ACA Medicaid, the Medicaid expansion does not "care for the neediest among us."¹⁴⁶ In short, Chief Justice Roberts asserted that the eighth mandatory Medicaid category does not represent the deserving poor and enrobed this distinction with constitutional significance. Each of the pre-ACA categories were both impoverished and shared a common characteristic: poor and elderly, poor and disabled, poor and pregnant, and so forth. The only difference with the categories created by the new ACA provision was that the recipients were poor adults.¹⁴⁷

Second, the ACA standardizes the income-eligibility threshold across all categories, replacing Medicaid's variable income-eligibility levels for different groups of categorically eligible beneficiaries. Under the ACA, income for purposes of Medicaid eligibility will be determined based on modified adjusted gross income, which uses a 5% income disregard, effectively raising the income threshold to 138% FPL.¹⁴⁸ The expansion is especially significant for non-elderly, non-disabled, low-income single adults or couples without children, who previously were excluded from Medicaid because they did not qualify as "deserving" poor. Coverage is also extended to 133% FPL (or 138%, taking into account the 5% disregard) for all children, not just those under age six, instead of the previous 100% FPL requirement for children between the ages of six and eighteen. States were allowed to begin covering these newly eligible individuals as early as April 1, 2010 and must cover them

¹⁴⁵ Patient Protection and Affordable Care Act § 2001(a)(1), 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2011).

¹⁴⁶ *NFIB*, 132 S. Ct. 2566, 2605-06 (2012) (plurality opinion).

¹⁴⁷ For more discussion on the coverage of poor children under this particular expansion, see *infra* Part IV.A.

¹⁴⁸ See *supra* note 55 and accompanying text.

by January 1, 2014.¹⁴⁹ This set of changes is significant but apparently did not strike Chief Justice Roberts as fundamental enough to present constitutional problems – at least for now.

The third significant amendment to Medicaid under the ACA pertains to the mandatory-benefit packages. Again, for Chief Justice Roberts, this change marked a new form of Medicaid. But the amendment actually just extends flexibility that Congress had already allowed states since 2005. For the newly eligible population, states may provide the traditional Medicaid-defined benefit package or benchmark-equivalent coverage,¹⁵⁰ as defined in a prior amendment to Medicaid.¹⁵¹ The Deficit Reduction Act of 2005 afforded states “unprecedented flexibility,”¹⁵² allowing them to modify their State Plans to provide “benchmark coverage”¹⁵³ or “benchmark equivalent coverage”¹⁵⁴ to a large portion of the Medicaid population, with some exceptions.¹⁵⁵ Benchmark-equivalent coverage is less comprehensive than the traditional defined-benefits package.¹⁵⁶ Instead of statutorily designed care and services, states can pay a private insurer who does not have to comply with the Medicaid Act.¹⁵⁷ Benchmark coverage is a departure from Medicaid’s signature “defined benefits” package that is uniform across all beneficiaries within a state,¹⁵⁸ instead permitting states to enroll some Medicaid beneficiaries in non-Medicaid managed-care plans.¹⁵⁹ The ACA extends the DRA-benchmark and benchmark-equivalent-plan options to the Medicaid-expansion population.

The ACA also revises the Deficit Reduction Act of 2005 definitions in several important respects. First, benchmark and benchmark-equivalent

¹⁴⁹ Patient Protection and Affordable Care Act § 2001(a)(1)(C) (codified at 42 U.S.C. 1396a(10)(A)(i)(VIII)).

¹⁵⁰ *Id.* §§ 1302(a)(1), 2001(a)(2)(A), (c)(3) (codified at 42 U.S.C. §§ 1396a(k)(1), 1396u-7(b)(5), 18022(b)) (requiring that states cover this new population with benchmark or benchmark-equivalent coverage, providing at least the defined “essential benefits” package).

¹⁵¹ 42 C.F.R. § 440.330 (2011) (defining benchmark coverage); *id.* § 440.335 (defining benchmark-equivalent coverage).

¹⁵² Medicaid Program; State Flexibility for Medicaid Benefit Packages, 73 Fed. Reg. 9714, 9715 (Feb. 22, 2008) (to be codified at 42 C.F.R. pt. 440).

¹⁵³ *See* Deficit Reduction Act of 2005 § 6044, 42 U.S.C. § 1396u-7(a)(1) (2006) (giving states the option of providing only “benchmark benefits” to certain populations).

¹⁵⁴ *Id.* (codified at 42 U.S.C. § 1396u-7(a)(1)-(2), (b)(2)).

¹⁵⁵ 42 U.S.C. § 1396u-7(a)(2) (listing categories of eligible beneficiaries); 42 C.F.R. § 440.315 (listing exemptions to mandatory benchmark-equivalent coverage).

¹⁵⁶ 42 U.S.C. § 1396u-7(b)(2)(A) (listing services mandatorily included in benchmark-equivalent coverage).

¹⁵⁷ *Id.* § 1396u-7(b)(2).

¹⁵⁸ *Id.* § 1396u-7(a)(1)(A) (allowing states to provide “alternative” benefits for eligible populations).

¹⁵⁹ *Id.* § 1396u-7(b)(1) (listing managed-care provider plans that “shall be considered to be benchmark coverage”).

benefits must include at least the package of “essential health benefits” (EHB) that the ACA requires for private-individual and small-group insurance plans.¹⁶⁰ The ACA broadly defined ten categories of services that must be included in EHB,¹⁶¹ and delegated rulemaking authority to HHS to further define the set of health services and items in EHB.¹⁶² The ACA further specifies that benchmark or benchmark-equivalent plans that provide medical and surgical benefits must comply with federal mental-health and substance-abuse parity laws.¹⁶³ In addition, benchmark-equivalent packages now must cover prescription drugs and mental-health services,¹⁶⁴ and both benchmark and benchmark-equivalent packages must cover family-planning services and supplies.¹⁶⁵

Fourth, the federal government will provide most of the funding for the Medicaid expansion.¹⁶⁶ For the first three years of Medicaid expansion, the federal government will pay 100% of the cost of covering newly eligible individuals in all states.¹⁶⁷ Thereafter, the federal percentage phases down gradually, from 95% in 2017 to 90% in 2020 and thereafter.¹⁶⁸ The more

¹⁶⁰ Patient Protection and Affordable Care Act § 2001(c)(3), 42 U.S.C. § 1396u-7(b)(5) (Supp. IV 2011) (requiring, after 2014, that all benchmark or benchmark-equivalent packages cover pre-defined “essential health benefits”); *id.* § 1302 (codified at 42 U.S.C. 18022) (defining essential health benefits package).

¹⁶¹ *Id.* § 1302(b)(1) (codified at 42 U.S.C. § 18022(b)(1)) (listing “essential health benefits”).

¹⁶² *Id.* § 1302(b)(2), (4) (codified at 42 U.S.C. § 18022(b)(2), (4)) (providing guidelines to the HHS for assessing and approving benchmark coverage).

¹⁶³ *Id.* § 2001(c)(3) (codified at 42 U.S.C. § 1396u-7(b)(6)(A)) (requiring benchmark and benchmark-equivalent plans, excluding those offered by Medicaid managed-care organizations, to comply with federal mental health parity laws).

¹⁶⁴ *Id.* § 2001(c)(2) (amending 42 U.S.C. § 1396u-7(b)(2)(A) (2006)) (increasing the categories of care mandatory under benchmark-equivalent coverage to include prescription drugs and mental-health services).

¹⁶⁵ *Id.* § 2303(c) (codified at 42 U.S.C. § 1396u-7(b)(7) (Supp. IV 2011)) (mandating coverage of family-planning services).

¹⁶⁶ See JOHN HOLAHAN & IRENE HEADEN, KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID COVERAGE AND SPENDING IN HEALTH REFORM: NATIONAL AND STATE-BY-STATE RESULTS FOR ADULTS AT OR BELOW 133% FPL 2 (2010), available at <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf> (estimating that 95% of new spending will be by the federal government).

¹⁶⁷ 42 U.S.C. § 1396d(y)(1) (Supp. IV 2011).

¹⁶⁸ *Id.* (decreasing the amount of the federal medical assistance percentage on a gradual basis from 100% in 2016 to 90% in 2020 and beyond); see MARTHA HEBERLEIN ET AL., KAISER FAMILY FOUND., FINANCING NEW MEDICAID COVERAGE UNDER HEALTH REFORM: THE ROLE OF THE FEDERAL GOVERNMENT AND STATES 2 (2010), available at <http://www.kff.org/healthreform/upload/8072.pdf>.

generous federal match applies only to the newly eligible population.¹⁶⁹ States that previously expanded their Medicaid plans to cover any portion of the newly eligible population will also receive the enhanced match, meaning that some of those states may actually experience savings as a result of the Medicaid expansion.¹⁷⁰ Overall, the federal government will fund 93% of the expansion, according to the CBO.¹⁷¹ The 7% state share represents less than a 3% increase in state Medicaid spending.¹⁷²

Finally, Congress was concerned that states might reduce voluntary expansions before the Medicaid expansion phases in on January 1, 2014. For states that opted to cover a portion of the newly eligible Medicaid population under State Plans in effect before the ACA was enacted, the ACA requires them to maintain those current levels,¹⁷³ pending implementation of the Medicaid expansion and establishment of health insurance exchanges, both in January 2014. Compliance with the MOE provision is “a condition for receiving any Federal payments” under the Medicaid Act for calendar quarters between March 23, 2010 and establishment of a health insurance exchange in the state.¹⁷⁴ MOE provisions are typical of prior Medicaid expansions.¹⁷⁵ In

¹⁶⁹ Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 451 (“The supermatch applies only to the newly covered population . . .”).

¹⁷⁰ See JOHN HOLAHAN ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS 3 (2012), *available at* <http://www.kff.org/medicaid/upload/8384.pdf> (stating that eight states are expected to experience savings under the Medicaid expansion); HOLAHAN & HEADEN, *supra* note 166, at 4 (citing Massachusetts as a state that will experience savings).

¹⁷¹ Peter Orszag, *Big Subsidies Will Push States to Expand Medicaid*, BLOOMBERG (July 10, 2012, 6:30 PM), <http://www.bloomberg.com/news/2012-07-10/big-subsidies-will-push-states-to-expand-medicaid.html>; see also Memorandum from Richard S. Foster, Chief Actuary, Dep’t of Health & Human Servs., Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended, at 3 fig. (Apr. 22, 2010), *available at* https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (estimating financial and coverage effects of certain provisions of the ACA through the year 2019).

¹⁷² See HOLAHAN ET AL., *supra* note 170, at 3 & fig.ES-1; Orszag, *supra* note 171 (“The 7 percent state share would generate less than a 3 percent increase in total state Medicaid spending over that time . . .”).

¹⁷³ Patient Protection and Affordable Care Act § 2001(b)(2), 42 U.S.C. § 1396a(gg) (Supp. IV 2011) (requiring states to maintain eligibility standards, methodologies, and procedures in place as of March 23, 2010); Letter from Cindy Mann, Dir., Ctr. for Medicaid, CHIP & Survey & Certification, Ctrs. for Medicare & Medicaid Servs., to State Medicaid Directors 1 (Feb. 25, 2011) [hereinafter MOE Letter], *available at* <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11001.pdf>.

¹⁷⁴ 42 U.S.C. § 1396a(gg)(1); see also *id.* § 18031 (assistance to states to establish American Health Benefits Exchanges); *id.* § 18041(c)(1) (providing that the federal government will establish exchanges in states that elect not to accept federal funding to establish their own).

fact, the ACA's MOE provision is very similar to the MOE provision in the American Recovery and Reinvestment Act of 2009,¹⁷⁶ to which states were subject before the ACA was passed.¹⁷⁷

States may receive waivers of the MOE through an administrative process¹⁷⁸: noncompliance is excused if "the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding year, the State is projected to have a budget deficit."¹⁷⁹ Once states have fully operational exchanges, the MOE provision is largely waived, meaning that states can at that time vary their optional Medicaid coverage in accordance with their approved State Plan.¹⁸⁰

The Medicaid expansion was significant. But on closer examination, it was just another step in a regular process of incrementalist modification to the existing program, akin to prior amendments over the past half century. Each of the prior coverage expansions, redefinitions of eligibility, and funding adjustments have changed the terms of the cooperative arrangement between the federal government and participating states. The ACA's Medicaid amendments were no more dramatic than these earlier changes. The Court's claim that the expansion was an entirely new program does not square with the historical record.

II. *NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS*

The litigation surrounding the ACA is voluminous and ongoing.¹⁸¹ But the present concern is the Medicaid coercion issue that ignited before the Supreme Court.

¹⁷⁵ See Mark Greenberg, *HHS Policy Guidance on Maintenance of Effort, Assistance, and Penalties: Summary and Discussion*, 4 GEO. J. ON FIGHTING POVERTY 315, 315-18 (1997) (discussing MOE provisions related to the use of state funds under TANF).

¹⁷⁶ American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, § 5001(f)(1), 123 Stat. 115, 499 (defining temporary MOE provisions for Medicaid during the financial crisis).

¹⁷⁷ See MOE Letter, *supra* note 173, at 1; see also Health Law Brief, *supra* note 14, at 34-36.

¹⁷⁸ Patient Protection and Affordable Care Act § 2001(b)(2) (codified at 42 U.S.C. § 1396a(gg)(3)); see also Memorandum from Legislative Attorney, Cong. Research Serv., to the Senate Finance Committee 1 (Mar. 3, 2011).

¹⁷⁹ Patient Protection and Affordable Care Act § 2001(b)(2) (codified at 42 U.S.C. 1396a(gg)(3)); see also MOE Letter, *supra* note 173, at 5-6 (explaining how states may waive MOE requirements).

¹⁸⁰ Patient Protection and Affordable Care Act § 2001(b)(2) (codified at 42 U.S.C. 1396a(gg)(1)) (defining MOE requirements applicable until the "Secretary determines that an Exchange established by the State . . . is fully operational").

¹⁸¹ Professor Brad Joondeph maintains a useful website containing a comprehensive record of litigation concerning the ACA. ACA LITIGATION BLOG, <http://acalitigationblog.blogspot.com>

Officials representing twenty-six states, two private plaintiffs, and the National Federation of Independent Business challenged the Medicaid expansion on federalism grounds.¹⁸² In particular, the plaintiffs argued that the ACA's requirement to expand Medicaid exceeded federal conditional spending power and amounted to unconstitutional coercion.¹⁸³ The federal district court struck down the ACA in its entirety after holding the individual mandate unconstitutional,¹⁸⁴ but rejected the States' Medicaid challenge.¹⁸⁵ The Eleventh Circuit affirmed the district court's Medicaid ruling,¹⁸⁶ holding that because states continue to have a real choice whether to participate, the Medicaid expansion did not amount to coercion.¹⁸⁷

On this issue, the circuits were entirely in agreement. No lower court had declared the Medicaid expansion unconstitutional. Nevertheless, the Supreme Court reached out for the issue of coercion and granted the petition for certiorari on the Medicaid question. By almost all accounts, the Medicaid challenge was a sleeper issue.¹⁸⁸ A few commentators, however, aptly noted that a decision striking down the Medicaid expansion would have a greater impact on constitutional law and health-reform implementation than a decision on the individual mandate.¹⁸⁹ This Part briefly describes the Eleventh Circuit's holding, the arguments presented before the Supreme Court, and the Court's highly fractured Medicaid opinions.

gspot.com/ (last visited Jan. 25, 2013). For an organized treatment of the Supreme Court briefing, see Kevin Outterson, *Obamacare Briefing Almost Finished*, INCIDENTAL ECONOMIST (Mar. 9, 2012, 11:09 AM), <http://theincidentaleconomist.com/wordpress/obamacare-briefing-almost-finished/>.

¹⁸² *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1240, 1262-64 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom.*, *NFIB*, 132 S. Ct. 2566 (2012). Only the states had standing to make this particular argument.

¹⁸³ *Id.* at 1261-62 (citing 42 U.S.C. § 1396(a) (2006)). In *Dole*, the Supreme Court stated that "[o]ur decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

¹⁸⁴ *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1304-05 (N.D. Fla. 2011), *aff'd in part, rev'd in part*, 648 F.3d 1235 (11th Cir. 2011).

¹⁸⁵ *Florida v. HHS*, 780 F. Supp. at 1267 ("[T]here is simply no support for the states' coercion argument in existing case law.").

¹⁸⁶ *Florida v. HHS*, 648 F.3d at 1268.

¹⁸⁷ *Id.* at 1267-68.

¹⁸⁸ See, e.g., Ian Millhiser, *Why the Supreme Court Probably Isn't About to Declare Medicaid Expansion Unconstitutional*, THINK PROGRESS (Nov. 14, 2011, 1:15 PM), <http://thinkprogress.org/justice/2011/11/14/367728/why-the-supreme-court-probably-isnt-about-to-declare-medicaid-expansion-unconstitutional/?mobile=nc>.

¹⁸⁹ See *supra* note 14 and accompanying text.

A. Florida v. United States Department of Health and Human Services

The plaintiff states in *Florida v. United States Department of Health and Human Services*¹⁹⁰ did not allege that Medicaid expansion violated any of the four limits on conditional spending power articulated in *South Dakota v. Dole*.¹⁹¹ Rather, their coercion challenge derived from the Tenth Amendment.¹⁹² The Eleventh Circuit noted that the Supreme Court had considered coercion in previous cases, namely *Dole* and *Stewart Machine Co. v. Davis*,¹⁹³ but declined to strike down the laws in question because “the enactment of such laws remain[ed] the prerogative of the States *not merely in theory but in fact*.”¹⁹⁴ Even though the choice might be politically difficult, when states “have a real choice, there can be no coercion.”¹⁹⁵

The Eleventh Circuit offered five reasons for finding that the Medicaid expansion was not unconstitutionally coercive. First, states were warned from the beginning of the Medicaid program that “Congress reserved the right to make changes to the program,” a right that Congress exercised several times in succeeding years.¹⁹⁶ Second, except for “incidental administration costs,” the federal government will cover virtually all of the costs of expansion up to 2020, and thereafter never less than ninety percent.¹⁹⁷ Third, states were given

¹⁹⁰ 648 F.3d 1235. In the *Healthcare Cases*, the Court granted certiorari on three cases, including *Florida v. Department of Health and Human Services*, which was docketed as No. 11-400. On the Medicaid issue, certiorari was granted only under this case. See *Florida v. Dep’t of Health & Human Servs.*, 132 S. Ct. 604 (2011) (mem.) (granting certiorari on the Medicaid question).

¹⁹¹ *South Dakota v. Dole*, 483 U.S. 203, 207 (1987) (listing the four limitations on federal government spending power: spending must be (1) “in pursuit of the general welfare”; (2) in a manner “reasonably related” to Congress’s policy goal; (3) in an “unambiguous” manner that allows states to “knowingly exercise their choice”; and (4) without requiring the states to act in violation of the Constitution).

¹⁹² *Florida v. HHS*, 648 F.3d at 1264 (reiterating the plaintiffs’ argument that the limitation on Congress’s spending power derives from the Tenth Amendment).

¹⁹³ *Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937).

¹⁹⁴ *Florida v. HHS*, 648 F.3d at 1265 (emphasis added) (quoting *Dole*, 483 U.S. at 211-12).

¹⁹⁵ *Id.* at 1268.

¹⁹⁶ *Id.* at 1267 (“The right to alter, amend, or repeal any provision of [the Medicaid Act] is hereby reserved to the Congress.” (quoting 42 U.S.C. § 1304 (2006))). This provision was mentioned in the briefs and at oral arguments. See, e.g., Brief of State Petitioners on Medicaid at 41, *Florida v. Dep’t of Health and Human Servs.*, 132 S. Ct. 2566 (2012) (11-400); Brief for Respondents at 9, *supra* note 129; Transcript of Oral Argument, *supra* note 131, at 48. This point, however, was dismissed summarily by the plurality. See *infra* Part II.D.1.

¹⁹⁷ *Florida v. HHS*, 648 F.3d at 1267-68 (citing 42 U.S.C. § 1396d(y)(1) (Supp. IV 2011)). The parties essentially did not dispute this fact, but they drew very different conclusions from the federal generosity. To the federal government, generosity was a virtue; to the states, a vice.

four years notice to determine whether to “deal with the expansion” or “develop a replacement program.”¹⁹⁸ Fourth, the states’ independent power to tax gives them the ability to fund healthcare programs of their own.¹⁹⁹ Fifth, the states did not stand to lose all Medicaid funding even if they did not agree to ACA’s eligibility expansion because HHS has “the discretion to withhold all or *merely a portion* of funding from a noncompliant state,” which the court likened to South Dakota’s potential loss of five percent of federal highway funds in *Dole*.²⁰⁰

The Eleventh Circuit’s conclusion was well supported by previous challenges to Medicaid and similar conditional spending programs.²⁰¹ Even so, and despite the absence of a circuit split, the Court agreed to hear the plaintiffs’ coercion challenge.²⁰²

B. *The States’ Merits Brief*

Language from the States’ brief shines through both the plurality and joint dissent’s opinions in *NFIB*.²⁰³ The States acknowledged “[t]hat the line between coercion and persuasion may not be bright”²⁰⁴ but insisted that judicially enforceable limits on the spending power are necessary because Congress uses the Spending Clause to reach beyond its other enumerated

¹⁹⁸ *Id.* at 1268.

¹⁹⁹ *Id.*

²⁰⁰ *Id.* (emphasis added) (citing *South Dakota v. Dole*, 483 U.S. 203, 211(1987)).

²⁰¹ *See, e.g.*, *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 22 (1980) (finding that the Developmentally Disabled Assistance and Bill of Rights Act created shared responsibilities between the federal and state governments); *Helvering v. Davis*, 301 U.S. 619, 640 (1937) (explaining the concept of conditional spending power); *Steward Mach. Co. v. Davis*, 301 U.S. 548, 593-95 (1937) (rejecting the claim that the Social Security Act’s tax collection and unemployment benefits distribution infringed on state sovereignty); *see also Florida v. HHS*, 648 F.3d at 1267 & n.66 (discussing the history of Medicaid Act amendments); *Padavan v. United States*, 82 F.3d 23, 29 (2d Cir. 1996) (“Medicaid is a voluntary program in which states are free to choose whether to participate.”); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1989) (upholding an additional Medicaid requirement to cover emergency medical care to illegal immigrants); *Oklahoma v. Schweiker*, 655 F.2d 401, 416-17 (D.C. Cir. 1981) (holding that the pass-through provision of the Social Security Act was a “conventional and appropriate” use of congressional power under the Spending Clause). In *Texas v. Leavitt*, the plaintiffs requested that the Supreme Court assert original jurisdiction to review the Medicare Part D clawback which required states to pay a portion of the new Medicare prescription-drug benefit. Plaintiffs’ Reply Brief at 1, *Texas v. Leavitt*, 547 U.S. 1204 (2006) (No. 135). The Supreme Court was unwilling even to hear the challenge, denying the states’ petition for original jurisdiction. *Texas*, 547 U.S. 1204 (mem.); *see supra* note 144.

²⁰² *See Florida v. Dep’t of Health & Human Servs.*, 132 S. Ct. 604 (2011) (mem.).

²⁰³ The States were the petitioners in No. 11-400.

²⁰⁴ Brief of State Petitioners on Medicaid, *supra* note 196, at 30.

powers. According to the States, if this Medicaid expansion did not cross the line into coercion, “no Act of Congress ever will.”²⁰⁵

In support of their coercion argument, the States contended that Congress never even considered the possibility of states opting out.²⁰⁶ By failing to provide an alternative method for those below the poverty line to comply with the individual mandate, other than Medicaid, and “threatening to withhold all funds from States that were unwilling or unable” to expand Medicaid,²⁰⁷ Congress crossed the line from pressure to unconstitutional coercion. In short, Congress failed to provide a safety net beneath the safety net.

One possible alternative to Medicaid expansion through the cooperative federal-state program would be for states to provide health care to the needy within their own borders, on their own terms. States undeniably have the independent power to tax and raise revenues from their citizens. But the States rejected that alternative because “[f]ederal funding is overwhelmingly composed of tax dollars collected from the States’ own residents.”²⁰⁸ Accordingly, the suggestion that states could “pay[] for medical care for the indigent through new [state] taxes” was an “illusory” choice²⁰⁹ that would effectively result in double taxation of state citizens.

The States also argued that the sheer size of the Medicaid program supported their coercion claim. While acknowledging that Congress has discretion in setting conditions for new funds, the States asserted that creating new conditions for existing conditional spending programs constitutes coercion when Congress uses states’ “dependency on existing funding streams to coerce compliance with new conditions.”²¹⁰ Congress’s statutory “right to alter, amend, or repeal”²¹¹ the Medicaid Act could not make the ACA constitutional because the states did not “ced[e] to Congress the power to expand the program unilaterally and coercively” and because Congress does not have the power to “hold States hostage to Congress’ later demands.”²¹² Thus, the States argued that “[n]o amount of notice will render a coercive choice any less coercive.”²¹³

Recognizing that the Court had not previously struck down a federal spending program on coercion grounds, the States analogized the Medicaid expansion to other cases recognizing federalism-based limits on federal power.

²⁰⁵ *Id.* at 21.

²⁰⁶ *Id.* at 35 (“[A] State’s failure to participate in Medicaid was . . . inconceivable to the drafters of the ACA.”).

²⁰⁷ *Id.* at 37 (emphasis omitted).

²⁰⁸ *Id.* at 43.

²⁰⁹ *Id.* at 44. Note that Florida’s constitution prohibits personal state income tax. FLA. CONST. § 5(a).

²¹⁰ Brief of State Petitioners on Medicaid, *supra* note 196, at 40.

²¹¹ 42 U.S.C. § 1304 (2006).

²¹² Brief of State Petitioners on Medicaid, *supra* note 196, at 41-42.

²¹³ *Id.* at 45.

In particular, the States likened the Medicaid expansion to the federal law struck down as impermissible commandeering in *New York v. United States* because both required the state government to take regulatory action.²¹⁴ The ACA “effectively order[s]” states to comply with the Medicaid expansion or “assume full responsibility for all medical assistance to the needy themselves.”²¹⁵ The States distinguished *Dole* because the funds at stake with Medicaid expansion are “more than 1000 times” greater than the highway funds in dispute in *Dole*.²¹⁶

C. *The United States’ Merits Brief*

The United States’ brief began by noting that Congress traditionally has broad authority to exercise the spending power and to “fix the terms on which it shall disburse federal money to the states.”²¹⁷ The brief acknowledged *Dole*’s limits on federal spending power²¹⁸ but urged that the Medicaid expansion was certainly constitutional and related to the goals of the federal program because the challenged conditions “define the Medicaid program, going to the very core of the offer of federal financial assistance that Congress has extended to the States.”²¹⁹ Invoking Justice Cardozo’s admonishment, the United States warned that applying the coercion doctrine would “plunge the law in[to] endless difficulties”²²⁰ and confuse “motive or temptation” with coercion.²²¹

The United States highlighted the Medicaid program’s history and prior expansions, observing that the Medicaid Act “always has mandated coverage for various categories of individuals and benefits,” and that these categories have been expanded numerous times.²²² Applying the coercion doctrine to federal-state cooperative arrangements would require courts to “delv[e] into essentially political questions about States’ differing policy choices and budgetary priorities.”²²³ Cooperative federalism programs have been criticized for obscuring political accountability; the federal government enacts the programs but leaves states bearing the brunt of any political opposition to program operations and costs. Turning the political accountability argument on

²¹⁴ *Id.* at 52 (citing *New York v. United States*, 505 U.S. 144, 174-75 (1992)).

²¹⁵ *Id.* Of course, the states already failed at this option in the early twentieth century, which is the reason that Medicaid exists today.

²¹⁶ *Id.* at 53 (emphasis omitted).

²¹⁷ Brief for Respondents, *supra* note 129, at 20 (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1980)). The United States was the respondent in No. 11-400.

²¹⁸ *Id.* at 21.

²¹⁹ *Id.* at 24.

²²⁰ *Id.* at 32 (quoting *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 589-90 (1937))).

²²¹ *Id.* at 32 (quoting *Dole*, 483 U.S. at 211).

²²² *Id.* at 26.

²²³ *Id.* at 35.

its head, however, the United States suggested that the States sought to avoid the political accountability of rejecting the generous federal funding for Medicaid expansion by seeking judicial intervention.²²⁴

The United States challenged the logic of the States' claim that coercion can be established based on the quantum of Medicaid money put on the table because that would mean "the Act's Medicaid eligibility expansion would have been even more coercive [had] Congress chosen to fund indefinitely 100% of all its costs."²²⁵ That suggestion cannot be squared with the Court's contract analogy for federal-state cooperative arrangements because it essentially indicates that the federal program is unconstitutional because "the other party . . . is offering *too much* consideration."²²⁶

In response to the States' suggestion that the Medicaid expansion must be coercive because Congress failed to provide an alternative means of covering low-income adults, the United States noted that the States misinterpreted the structure of the ACA and the role of the Medicaid expansion. The Medicaid expansion population will not be "'forced'" to obtain minimum essential coverage because they could choose instead to pay the tax penalty.²²⁷ Moreover, many Medicaid-eligible individuals would be statutorily exempted from the individual mandate.²²⁸ It is not surprising that Congress did not include a "contingency plan" for Medicaid expansion because all fifty states have long participated in Medicaid and have complied, sooner or later, with every previous expansion.

Almost as an afterthought, the United States pointed out the "separability" clause in § 1303,²²⁹ providing that should any provision of the Act be declared invalid, the remainder should remain unaffected.²³⁰ Based on that provision, the United States suggested that the appropriate remedy, should the Court find the Medicaid expansion coercive, would be to "enjoin the 'application' of the [Medicaid expansion] to unconsenting States,"²³¹ but otherwise enforce the ACA as written. The federal government urged the Court to recognize that

²²⁴ *Id.* at 36 ("[W]hat they seek is the ability to use the courts to tailor federal spending programs to their preferred specifications, and thereby avoid political accountability for the consequences that would follow from rejecting federal aid on the terms offered.").

²²⁵ *Id.* at 41.

²²⁶ *Id.* at 42.

²²⁷ *Id.* at 49 (quoting Brief of State Petitioners on Medicaid, *supra* note 196, at 35).

²²⁸ *Id.* at 49-50 (citing I.R.C. § 5000A(e)(1)-(2), (5) (Supp. IV 2011)).

²²⁹ 42 U.S.C. § 1303 (2006) (originally enacted as Social Security Act of 1935, Pub. L. No. 74-271, § 1103, 49 Stat. 620, 648).

²³⁰ *Id.* ("If any provision [of the SSA], or the application thereof to any person or circumstance, is held invalid, the remainder of the [Act], and the application of such provision to other persons or circumstances shall not be affected thereby.").

²³¹ Brief for Respondents, *supra* note 129, at 53.

Congress would prefer a weaker Medicaid expansion to no Medicaid expansion, or no ACA, at all.²³²

D. *The NFIB Opinions*

June 28, 2012 was full of surprises.²³³ First, a majority of the Court upheld the individual mandate as an exercise of the General Welfare Clause power to tax, even though no lower court had previously endorsed that theory.²³⁴ A majority also found the mandate unsustainable under the commerce power.²³⁵ This discussion was arguably dicta, though Chief Justice Roberts insisted it was necessary to the holding.²³⁶ Of particular importance for this Article, a plurality limited Congress's power to expand Medicaid under the Spending Clause by judicially enforcing the Tenth Amendment. Though the Medicaid expansion itself was not struck down, expansion became optional for states, with no risk to their existing Medicaid funding.²³⁷ No one predicted these peculiar outcomes. The three principal Medicaid opinions²³⁸ are described in the following Sections; analysis of the opinions begins in Part III.

1. The Roberts Plurality

Chief Justice Roberts authored the controlling decision on Medicaid coercion, joined only by Justices Breyer and Kagan as to Part IV on Medicaid.²³⁹ This plurality opinion is controlling because it is the narrowest point of law; the joint dissent also found the Medicaid expansion to be unconstitutionally coercive, but refused to join the plurality and would have struck down the ACA in its entirety.²⁴⁰ Plurality opinions are notoriously difficult to interpret, and *NFIB* does not disappoint.²⁴¹

²³² *Id.* (“There is no basis to believe Congress would have preferred no Medicaid eligibility expansion at all to an eligibility extension that applies only to consenting States.”).

²³³ For an account of the day's events by a key observer, see Tom Goldstein, *We're Getting Wildly Differing Assessments*, SCOTUSBLOG (Jul. 7, 2012, 10:04 PM), <http://www.scotusblog.com/2012/07/were-getting-wildly-differing-assessments/>.

²³⁴ *NFIB*, 132 S. Ct. 2566, 2601 (2012) (Roberts, C.J., joined on this issue by Ginsburg, Breyer, Sotomayor & Kagan, JJ.).

²³⁵ *Id.* at 2593 (Roberts, C.J., joined on this issue by Scalia, Kennedy, Thomas & Alito, JJ.).

²³⁶ See Lawrence B. Solum, *The Legal Effects of NFIB v. Sebelius and the Constitutional Gestalt 13* (Oct. 6, 2012) (unpublished manuscript available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2152653) (discussing subsequent lower court opinions that seem to treat this part of the opinion as dicta, but suggesting it is not).

²³⁷ *NFIB*, 132 S. Ct. 2608 (Roberts, C.J., joined on this issue by Breyer & Kagan, JJ.).

²³⁸ Justice Thomas also filed a brief opinion which this Article does not discuss.

²³⁹ *NFIB*, 132 S. Ct. at 2577 (plurality opinion). Justice Ginsburg's opinion concurred only in Part IV-B, the remedy. See *infra* Part II.D.2.

²⁴⁰ *Id.* at 2643 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) (“The Act before us

Chief Justice Roberts began: “There is no doubt that the [ACA] dramatically increases state obligations under Medicaid.”²⁴² He then noted that the ACA requires states “to cover *all* individuals under the age of 65 with incomes below 133 percent of the federal poverty line”²⁴³ and to provide “a new ‘[e]ssential health benefits’ package” to Medicaid recipients.²⁴⁴ The opinion acknowledged that Congress may exercise its spending power to encourage states to regulate according to federal policy and to influence state policy.²⁴⁵ Chief Justice Roberts also invoked the familiar contract analogy for conditional spending power, noting that states must voluntarily and knowingly accept the terms of the federal offer.²⁴⁶

Chief Justice Roberts’ limits on conditional spending power were grounded in the notion that “‘freedom is enhanced by the creation of two governments, not one.’”²⁴⁷ To protect individual liberty, therefore, the Court must enforce limits on both direct commandeering and indirect coercion of states.²⁴⁸ The plurality observed that those concerns have twice led the Court to strike down federal legislation that “commandeers” states.²⁴⁹ The same federalism values should prohibit Congress from using the spending power “to exert a ‘power akin to undue influence.’”²⁵⁰ When congressional “‘pressure turns into

here exceeds federal power . . . in denying nonconsenting States all Medicaid funding.”).

²⁴¹ See generally John F. Davis & William L. Reynolds, *Juridical Cripples: Plurality Opinions in the Supreme Court*, 1974 DUKE L.J. 59. Davis and Reynolds describe some of the problems that arise from plurality opinions:

First, the fact that an opinion is supported by only a plurality of the Court may compromise its professional and public acceptance. Second, within the Court itself, a no-clear-majority decision will carry less precedential weight. Third, a plurality opinion often fails to give definitive guidance as to the state of the law to lower courts – both state and federal – as well as to the legislative, administrative, and executive agencies charged with implementing the standards so ambivalently articulated by the Court. Thus, there results a collective confusion as to what has been held by the Court in the plurality case.

Id. at 62.

²⁴² *NFIB*, 132 S. Ct. at 2601 (plurality opinion).

²⁴³ *Id.*

²⁴⁴ *Id.* (quoting 42 U.S.C. §§ 1396a(k)(1), 1396u-7(b)(5), 18022(b) (Supp. IV 2011)).

²⁴⁵ *Id.* at 2601-02 (citing *New York v. United States*, 505 U.S. 144, 166 (1992)).

²⁴⁶ *Id.* (citing *Barnes v. Gorman*, 536 U.S. 181, 186 (2002)); see also Brief of James F. Blumstein, as Amicus Curiae in Support of Petitioners (Medicaid Issue) at 7-12, 25-38, *Florida v. Dep’t of Health & Human Servs.*, 132 S. Ct. 2566 (2012) (No. 11-400) [hereinafter Blumstein Brief] (developing further the contract analogy for the Medicaid coercion argument).

²⁴⁷ *NFIB*, 132 S. Ct. at 2602 (plurality opinion) (quoting *Bond v. United States*, 131 S. Ct. 2355, 2364 (2011) (quoting *Alden v. Maine*, 527 U.S. 706, 758 (1999))).

²⁴⁸ *Id.*

²⁴⁹ *Id.* (citing *Printz v. United States*, 521 U.S. 898, 933 (1997); *New York*, 505 U.S. at 174-75).

²⁵⁰ *Id.* (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

compulsion,” the statute “runs contrary to our system of federalism.”²⁵¹ Both federal commandeering and coercive spending “threaten the political accountability key to our federal system.”²⁵² The constitutional design is clear that states do not have to “yield[]” to federal policy, but the ACA crossed the line to coercion by issuing an implicit threat “to withhold . . . States’ existing Medicaid funds” if they rejected the Medicaid expansion.²⁵³

The opinion provided two reasons why the threat of losing all Medicaid funding constituted impermissible coercion. First, rejecting the federal government’s argument that the Medicaid expansion was merely a modification to an existing federal program,²⁵⁴ it claimed that the ACA transformed Medicaid, such that the expansion was “a shift in kind, not merely degree.”²⁵⁵ Two programs were at issue: “old” and “new” Medicaid.²⁵⁶ Artificially slicing Medicaid in two allowed the plurality to determine that funds for “old” Medicaid are not related to the ACA’s “new” Medicaid expansion.²⁵⁷ In Chief Justice Roberts’ view, “new” Medicaid “is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.”²⁵⁸ He described “new” Medicaid as being characterized by (1) the new category of eligible individuals, (2) the more generous federal-funding provisions in the Medicaid expansion, and (3) the less-comprehensive minimum-benefits package that states may offer to newly eligible individuals.²⁵⁹

Second, the Chief Justice held the Medicaid expansion coercive because it operated as far more than “inducement” or “relatively mild encouragement” of states.²⁶⁰ Medicaid expansion, read along with § 1396c – which allowing the Secretary to withhold payment to states for noncompliance with Medicaid

²⁵¹ *Id.* (quoting *Steward Mach. Co.*, 301 U.S. at 590).

²⁵² *Id.*

²⁵³ *Id.* at 2603 (internal quotation marks omitted).

²⁵⁴ *Id.* at 2605.

²⁵⁵ *Id.* at 2605-06 (distinguishing the ACA amendments from previous Medicaid expansions found to be non-coercive).

²⁵⁶ *Id.* at 2605 (“We cannot agree that existing Medicaid and the expansion dictated by the Affordable Care Act are all one program simply because ‘Congress styled’ them as such.” (quoting *id.* at 2635 (Ginsburg, J., dissenting))); *id.* at 2606 (characterizing the Medicaid expansion as “a new health care program”); *id.* at 2607 (“What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.”).

²⁵⁷ *Id.* at 2605-06 (concluding that while “[p]revious amendments to Medicaid eligibility merely altered and expanded the boundaries,” the ACA so fundamentally changed the nature of Medicaid as to create a “new health care program”).

²⁵⁸ *Id.* at 2606.

²⁵⁹ *Id.*

²⁶⁰ *Id.* at 2604.

requirements – coerced state governments. With Medicaid spending representing twenty percent of the average state’s budget, “[t]he threatened loss of over 10 percent of a State’s overall budget” was deemed “economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.”²⁶¹ The coercion holding was further supported by the fact that states have, over the decades of Medicaid’s existence, formed “intricate statutory and administrative regimes . . . to implement their objectives under existing Medicaid.”²⁶² Because states face considerable practical difficulties walking away from the substantial funding and disentangling their existing Medicaid programs, the Medicaid expansion operated as a “gun to the head.”²⁶³

Just as the Court in *Steward Machine* declined to “‘fix the outermost line’” where persuasion becomes coercion, the *NFIB* plurality opinion saw “no need to fix a line” to determine when Congress’s use of the spending power becomes coercive.²⁶⁴ Chief Justice Roberts simply stated, “wherever that line may be, this statute is surely beyond it.”²⁶⁵ Citing the Court’s anti-commandeering precedents, he observed that “Congress may not simply ‘conscript state [agencies] into the national bureaucratic army,’” and concluded that was precisely what Congress was attempting with Medicaid expansion.²⁶⁶ Thus, Roberts avoided creating any kind of rule, test, standard, method, or other framework for understanding coercion beyond the facts of *NFIB*.

Having concluded that the Medicaid expansion constituted coercion in violation of the Tenth Amendment’s limit on federal spending power, the Court next considered the remedy. One option, advanced by the joint dissent, would have been to strike down the entire ACA based on the unconstitutionality of one provision.²⁶⁷ The plurality, however, held the Medicaid expansion unconstitutional only to the extent that it “penalize[s] States that choose not to participate in [the] new program by taking away their existing Medicaid funding.”²⁶⁸ On this remedial issue, Justices Ginsburg and Sotomayor joined the plurality, thus creating a unique five-vote majority to preserve the ACA from being struck down in its entirety.²⁶⁹ Relying on the

²⁶¹ *Id.* at 2604-05 (“Medicaid spending accounts for over 20 percent of the average State’s total budget, with federal funds covering 50 to 83 percent of those costs.”).

²⁶² *Id.* at 2604.

²⁶³ *Id.*

²⁶⁴ *Id.* at 2606 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 591 (1937)).

²⁶⁵ *Id.*

²⁶⁶ *Id.* at 2606-07 (alteration in original) (quoting *Fed. Energy Regulatory Comm’n v. Mississippi*, 456 U.S. 742, 775 (1982) (O’Connor, J., concurring in part and dissenting in part)).

²⁶⁷ *Id.* at 2667 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) (calling invalidation of the entire ACA “[t]he most natural remedy”).

²⁶⁸ *Id.* at 2607 (plurality opinion).

²⁶⁹ *Id.* at 2642 (Ginsburg, J., concurring in part and dissenting in part) (“I agree with

SSA's "separability" clause in 42 U.S.C. § 1303, the Court "follow[ed] Congress's explicit textual instruction to leave unaffected 'the remainder of the [Medicaid] chapter.'"²⁷⁰ Accordingly, the only modification necessary to render the Medicaid expansion constitutional was that "the Secretary [of HHS] [not apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion]."²⁷¹ The Medicaid expansion thus became optional for dissenting states, the aforementioned "Red State Option."²⁷²

The plurality accepted the arguments from the United States and amici that § 1303 demands a narrow remedy.²⁷³ The Chief Justice concluded that Congress "would have wanted to preserve the rest of the Act" because some states desire the Medicaid expansion and because the rest of the statute will still function in the manner intended by Congress.²⁷⁴ Accordingly, all other reforms Congress enacted in the ACA remain "fully operative as a law."²⁷⁵

2. The Ginsburg Opinion

Justice Ginsburg, joined by Justice Sotomayor, dissented from the plurality's coercion decision, except with respect to the prescribed remedy.²⁷⁶ Justice Ginsburg recognized that "there are federalism-based limits on the use of Congress' conditional spending power" but pointed out that "[t]he Court in *Dole* mentioned, but did not adopt, a further limitation" centered on "the

[Chief Justice Roberts] that the Medicaid Act's severability clause determines the appropriate remedy."); see also *infra* Part II.D.2 (discussing the Ginsburg opinion).

²⁷⁰ *NFIB*, 132 S. Ct. at 2607 (plurality opinion) (quoting 42 U.S.C. § 1303 (2006)).

²⁷¹ *Id.* (recognizing that the Secretary, pursuant to the existing, pre-ACA Medicaid Act was authorized to withhold federal funding to noncompliant states (citing 42 U.S.C. § 1396c)).

²⁷² See *supra* note 23 and accompanying text.

²⁷³ *NFIB*, 132 S. Ct. at 2607 (plurality opinion) (citing 42 U.S.C. § 1303) (holding that severability "fully remedies the constitutional violation . . . identified," and that § 1303 "confirm[s] that we need go no further"); see also Brief for Respondents, *supra* note 129, at 53; Health Law Brief, *supra* note 14, at 39.

²⁷⁴ *NFIB*, 132 S. Ct. at 2608 (plurality opinion) (opining that "States [] may voluntarily sign up, finding the idea of expanding Medicaid coverage attractive," and that "[t]he other reforms Congress enacted . . . will still function in a way 'consistent with Congress' basic objectives in enacting the statute'" (quoting *United States v. Booker*, 543 U.S. 220, 259 (2005))).

²⁷⁵ *Id.* (quoting *Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932)).

²⁷⁶ *Id.* at 2642 (Ginsburg, J., concurring in part and dissenting in part) (finding no constitutional violation of the Spending Clause but, given the plurality's holding, agreeing that "the ACA's authorization of funds to finance the expansion remains intact, and the Secretary's authority to withhold funds for reasons other than noncompliance with the expansion remains unaffected").

indistinct line between temptation and coercion.”²⁷⁷ Justice Ginsburg observed that the concerns that caused the Court to consider the coercion doctrine in *Dole* were not present in this case.²⁷⁸ First, the condition of expanded eligibility “relates solely to the federally funded Medicaid program.”²⁷⁹ By contrast, in *Dole*, the minimum-drinking-age condition related only *indirectly* to highway construction.²⁸⁰ Second, Congress has clear authority to directly enact the same Medicaid policy, as Congress could simply make Medicaid a fully national program like Medicare. By contrast, in *Dole*, it was an “open question” whether Congress had power to enact a nationwide minimum drinking age.²⁸¹ Thus, in *Dole*, it was plausible that the Spending Clause was being used to regulate activity beyond Congress’s enumerated powers. Similar factors suggestive of coercion were not present with the Medicaid expansion.

Justice Ginsburg recognized the importance of Chief Justice Roberts’ claim that the ACA created a “new” Medicaid program. She stated that, like the original Medicaid Act, the expansion “enable[s] States to provide medical assistance to needy persons” and “leaves unchanged the vast majority” of provisions governing Medicaid.²⁸² Characterizing Title II of the ACA as an entirely new program ignored the “large measure of respect” that the courts should give to Congress’s description of its own law and created an ill-defined question of “[a]t what point does an extension become so large that it ‘transforms’ the basic law?”²⁸³ She queried why the most recent Medicaid expansion constitutes “a shift in kind, not merely degree,” when prior statutory expansions did not²⁸⁴ and charged the plurality with rewriting the 1965 Medicaid Act “to countenance only the ‘right to alter *somewhat*,’ or ‘amend, *but not too much*.’”²⁸⁵

Justice Ginsburg directly challenged Chief Justice Roberts’ reliance on features of the Medicaid expansion that he used to characterize it as a “new” program. First, to the Chief Justice’s suggestion that “unlike pre-ACA Medicaid, [the Medicaid expansion] does not ‘care for the neediest among us,’”²⁸⁶ Justice Ginsburg responded: “What makes that so? Single adults earning no more than \$14,856 per year – 133% of the current federal poverty

²⁷⁷ *Id.* at 2634.

²⁷⁸ *Id.*

²⁷⁹ *Id.*

²⁸⁰ *Id.* (“In *Dole*, the condition – set 21 as the minimum drinking age – did not tell the States how to use funds Congress provided for highway construction.”).

²⁸¹ *Id.*

²⁸² *Id.* at 2635 (internal quotation marks omitted).

²⁸³ *Id.* at 2636.

²⁸⁴ *Id.* at 2639 (“But why was Medicaid altered only in degree, not in kind, when Congress required States to cover millions of children and pregnant women?”).

²⁸⁵ *Id.* (referring to 42 U.S.C. § 1304 (2006)).

²⁸⁶ *Id.* at 2636 (quoting *id.* at 2606 (plurality opinion)).

level – surely rank among the Nation’s poor.”²⁸⁷ She also rebutted the suggestion that the ACA’s package of Medicaid benefits for newly eligible beneficiaries is “new,” noting that the ACA did not create the definitions of “benchmark” and “benchmark equivalent coverage” but expressly incorporated these definitions from the Deficit Reduction Act of 2005.²⁸⁸ Regarding the Chief Justice’s suggestion that the ACA’s more generous federal match evidenced a “new” program, Justice Ginsburg questioned the constitutional significance of the increased funding. Tracking Solicitor General Verrilli’s argument, she asked, “is it not passing strange to suggest that the purported incursion on state sovereignty might have been averted, or at least mitigated, had Congress offered States *less* money to carry out the same obligations?”²⁸⁹ Justice Ginsburg also observed that nothing would stop Congress from simply repealing the Medicaid Act and then replacing it with “Medicaid II, a new program combining the pre-2010 coverage with the expanded coverage required by the ACA.”²⁹⁰

Regarding the contract analogy, Justice Ginsburg precedent that caselaw required only that “conditions on federal funds be unambiguously clear at the time a State receives and uses the money.”²⁹¹ That moment would begin in 2014, giving states more than three years to understand what was required of them.²⁹² But if clear notice is required at the very beginning of the program, then Medicaid surely qualified in 1965 as well because Congress explicitly retained the right to amend or alter the program from the beginning.²⁹³ Relying on *Bowen v. Public Agencies Opposed to Social Security Entrapment*,²⁹⁴ Justice Ginsburg argued that states have no lawful basis to complain about the expansion of Medicaid, even if it represents a significant change in the program.²⁹⁵ In *Bowen*, the State of California and its public agencies challenged congressional amendments to the SSA’s old age, survivors, and disability insurance-benefits program that restricted the ability of states to terminate their agreements with the federal government.²⁹⁶ The Court rejected

²⁸⁷ *Id.*

²⁸⁸ *Id.* at 2636 n.20 (citing 42 U.S.C. §§ 1396a(k), 1396u-7 (2006 & Supp. IV 2011)).

²⁸⁹ *Id.* at 2636.

²⁹⁰ *Id.*

²⁹¹ *Id.* at 2638.

²⁹² *Id.* at 2637 (“Section 2001 does not take effect until 2014. The ACA makes perfectly clear what will be required of States that accept Medicaid funding after that date.”).

²⁹³ *Id.* at 2638 (citing 42 U.S.C. § 1304 (2006)).

²⁹⁴ 477 U.S. 41 (1986).

²⁹⁵ *NFIB*, 132 S. Ct. at 2638-39 (Ginsburg, J., concurring in part and dissenting in part) (citing *Bowen*, 477 U.S. at 44-46, 48-53).

²⁹⁶ *Bowen*, 477 U.S. at 49-50 (“The State claimed that the federal defendants had . . . violated the Tenth Amendment by impairing the State’s ‘ability . . . to structure its relationships with its employees.’”).

the challenge, relying on § 1304 (Congress's express reservation of the right to "alter, amend, or repeal any provision" of the Act).²⁹⁷

Justice Ginsburg also expressed serious concern about the Court's failure to "fix the outermost line" at which "persuasion gives way to coercion."²⁹⁸ She stated that the Court failed to answer a variety of questions, including whether courts measure coercion by the amount offered to the states by the federal government, the percentage of the state's budget affected, what effects on what states should figure into the constitutional analysis, and the combined effect of all plaintiff states refusing the spending conditions.²⁹⁹ Echoing Solicitor General Verrilli's argument once again, Justice Ginsburg worried that "political judgments that defy judicial calculation" will become the business of courts.³⁰⁰

Only Justice Sotomayor joined Justice Ginsburg in concluding that the Medicaid expansion was constitutional. The seven other Justices signed two opinions holding the Medicaid expansion to be unconstitutionally coercive. The remainder of the ACA was saved only on severability grounds. Justice Ginsburg agreed that § 1303 and judicial precedent required the Court to "conserve, not destroy" the statute's purpose.³⁰¹ Here, Congress's "objective was to increase access to health care for the poor by increasing" state funding.³⁰² That objective was best implemented not by jettisoning the ACA altogether, but by keeping in place as much of the law as possible.³⁰³ In the context of Medicaid, that meant allowing states the option to accept additional federal funds for Medicaid expansion without facing potential withdrawal of existing funds.

3. The Joint Dissent

The remaining four Justices filed a joint dissent signed in order of seniority.³⁰⁴ Justices Scalia, Kennedy, Thomas, and Alito joined no part of the Court's opinion despite substantially agreeing with the coercion holding, if not the reasoning. The joint dissent would have held the Medicaid expansion unconstitutional on broader grounds and would have refused to sever the application of § 1396c.³⁰⁵ According to the joint dissent, the constitutional flaws in the Medicaid expansion required striking down the entire ACA.³⁰⁶

²⁹⁷ *Id.* at 51-52.

²⁹⁸ *NFIB*, 132 S. Ct. at 2640 (Ginsburg, J., concurring in part and dissenting in part) (quoting *id.* at 2606 (plurality opinion); *Steward Mach. Co. v. Davis* 301 U.S. 548, 591 (1937)).

²⁹⁹ *Id.* at 2640-41.

³⁰⁰ *Id.* at 2641.

³⁰¹ *Id.* at 2642.

³⁰² *Id.*

³⁰³ *Id.*

³⁰⁴ *Id.* at 2642 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting).

³⁰⁵ *Id.* at 2667 ("We should not accept the Government's invitation to attempt to solve a

The joint dissent observed that “[t]he power to make any expenditure that furthers ‘the general welfare’” is an extensive power given to the federal government that includes “attach[ing] conditions” to funds disbursed to the states.³⁰⁷ Left unchecked, however, such a power “would present a grave threat to [our] system of federalism”³⁰⁸ and would allow Congress “‘to tear down the barriers . . . and to become a parliament of the whole people, subject to no restrictions save such as are self-imposed.’”³⁰⁹ The joint dissent shared the political accountability concern articulated in the States’ Brief regarding the ability of federal officials to “‘remain insulated from the electoral ramifications of their decision.’”³¹⁰ In order to protect the “‘unique role of the States in our system,’”³¹¹ the dissent urged that the Court must enforce the coercion doctrine as a limit on Congress’s spending power.

Like the Roberts plurality, the joint dissent determined that unconstitutional coercion depends on whether the states can voluntarily accept or decline an offer. Both opinions resisted defining the line beyond which the spending power becomes coercive. The joint dissent suggested that freedom to accept or decline the Medicaid expansion “as a matter of law” was insufficient to render constitutional the use of the spending power, as it ignored the “practical matter” of whether states can effectively create an alternative.³¹²

For the joint dissent, there was “no doubt” that the Medicaid expansion was unconstitutional.³¹³ The states have independent power to tax and spend and could theoretically create a new healthcare program, but “the sheer size” of Medicaid means that states would have to contribute up to “an additional 33% of all [] state expenditures to fund an equivalent state program.”³¹⁴ The dissent

constitutional problem by rewriting the Medicaid Expansion so as to allow States that reject it to retain their pre-existing Medicaid funds.”); *id.* at 2671 (discussing the non-severability of the rest of the ACA from the individual mandate and Medicaid expansion).

³⁰⁶ *Id.* at 2668-69 (describing the severability inquiry as “whether the now truncated statute will operate in the manner Congress intended” and whether “Congress would have enacted [the remaining provisions] standing alone and without the unconstitutional portion”).

³⁰⁷ *Id.* at 2658.

³⁰⁸ *Id.* at 2659.

³⁰⁹ *Id.* (quoting *South Dakota v. Dole*, 483 U.S. 203, 217 (1987) (O’Connor, J., dissenting)).

³¹⁰ *Id.* at 2660 (quoting *New York v. United States*, 505 U.S. 144, 169 (1992)).

³¹¹ *Id.* (quoting *Davis v. Monroe Cnty. Bd. of Educ.*, 526 U.S. 629, 685 (1999) (Kennedy, J., dissenting)).

³¹² *Id.* at 2661 (internal quotation marks omitted).

³¹³ *Id.* at 2662 (“[T]here can be no doubt [that the legislation is unconstitutional]. In structuring the ACA, Congress unambiguously signaled its belief that every State would have no real choice.”).

³¹⁴ *Id.* at 2663 (citing Arizona as an example, highlighting that the state “commits 12% of its state expenditures to Medicaid, and relies on the Federal Government to provide the rest: \$5.6 billion, equaling roughly one-third of Arizona’s annual state expenditures of \$17

also suggested that states that opt out of Medicaid could further face the loss of TANF funds because participation in that program is premised on participation in Medicaid.³¹⁵ Meanwhile, local hospitals and healthcare providers would be forced to bear the unfunded requirement to treat patients under the federal Emergency Medical Treatment and Labor Act, without the assurance of Medicaid reimbursement.³¹⁶

Finally, the anticipated success of the inducement was a strike against it. The joint dissent agreed with the States' argument that no one expected states to refuse the Medicaid expansion.³¹⁷ Under the joint dissent's reasoning, Congress's failure to provide backup coverage for those below the poverty line, in contrast to other new ACA programs that provide alternatives to state participation, demonstrated that "Congress well understood that refusal was not a practical option."³¹⁸ To the joint dissent, the exceedingly generous federal match, which no state was expected to decline, was therefore further evidence of coercion.³¹⁹

On the question whether Medicaid expansion operates as unconstitutional coercion, seven Justices agreed. But the joint dissent and the Court parted ways primarily on the issue of remedy and severability for several reasons. First, the dissent maintained that "the ACA depends on States' having no choice" as many individuals subject to the individual mandate cannot afford insurance outside of Medicaid.³²⁰ Put another way, the ACA was structurally dependent upon the Medicaid expansion. Second, if a state opted out, its citizens would still pay federal taxes to support the Medicaid expansion in other states that opted in.³²¹ The joint dissent warned that the Court should not create this

billion").

³¹⁵ *Id.* at 2664 (citing 42 U.S.C. § 602(a)(3) (2006)).

³¹⁶ *Id.* See generally Emergency Medical Treatment and Labor Act of 1986 § 912(b), 42 U.S.C. § 1395dd. The joint dissent referred to this statute by its old title, the "Emergency Medical Treatment and Active Labor Act." The word "Active" was removed from the statute's name in 1989. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(h)(2), 103 Stat. 2016, 2245-49.

³¹⁷ *NFIB*, 132 S. Ct. at 2664 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) ("In crafting the ACA, Congress clearly expressed its informed view that no State could possibly refuse the offer that the ACA extends.").

³¹⁸ *Id.* at 2665 (suggesting that federal health insurance exchanges should have been an alternative to state-based exchanges, or there should have been an option to cover lawful permanent residents through state Medicaid programs or federal insurance subsidies).

³¹⁹ *Id.* at 2665-66 (suggesting disparagingly that the federal government considers itself a "generous benefactor who offers \$1 million with few strings attached to 50 randomly selected individuals" but arguing that this "offer" actually includes implicit threats and will lead states to incur "substantial costs").

³²⁰ *Id.* at 2667.

³²¹ *Id.* ("States must choose between expanding Medicaid or paying huge tax sums to the federal fisc for the sole benefit of expanding Medicaid in other states.").

“divisive dynamic” but should leave such a design to “conscious congressional choice.”³²²

The joint dissent agreed with the Court that § 1303 required the unconstitutional application of § 1396c, authorizing the Secretary to withhold all Medicaid funding for states that did not implement Medicaid expansion, to be severed from the rest of the Act.³²³ But the joint dissent did not read § 1303 to authorize the Court to rewrite the statute to cure its unconstitutionality.³²⁴ By reading the ACA Medicaid expansion as optional, rather than voluntary, the Court made “‘a new law’” rather than “‘enforc[ing] an old one.’”³²⁵ Rather, the joint dissent, upon finding the Medicaid expansion unconstitutionally coercive, would have struck down the entire ACA.

III. COERCION AND CONSTITUTIONAL CONFUSION

The Court has now decisively determined, through a three-Justice plurality and a four-Justice joint dissent, that the anti-coercion principle operates as a limit on Congress’s power to spend for the general welfare when conditions are placed on states’ acceptance of that spending. The Court has previously recognized structural limits on other federal powers,³²⁶ but *NFIB* was the first clear articulation of a federalism-based limit on Congress’s spending power.

The courthouse doors have now been thrown open to challengers seeking to explore the contours of the coercion doctrine.³²⁷ This Part focuses attention on this new judicially enforceable limit. It begins by placing *NFIB* in context as a

³²² *Id.*

³²³ *Id.* (“[T]hat clause tells us only that other provisions in Chapter 7 should not be invalidated if § 1396c, the authorization for the cut-off of all Medicaid funds, is unconstitutional.”).

³²⁴ *Id.* (asserting that the severability clause “does not tell us that § 1396c can be judicially revised to say what it does not say”).

³²⁵ *Id.* (quoting *Trade-Mark Cases*, 100 U.S. 82, 99 (1879)).

³²⁶ *See, e.g.,* *Printz v. United States*, 521 U.S. 898, 921 (1997) (describing how separation between the federal government and the states protects state executive actors from federal overreaching); *New York v. United States*, 505 U.S. 144, 181-83 (1992) (applying the Tenth Amendment as a structural limit on Congress’s commerce power); *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991) (extolling, in one of the first Rehnquist Court cases to consider the issue, the virtues of federalism as a structural limitation on federal power).

³²⁷ *NFIB*, 132 S. Ct. at 2606 (plurality opinion). The plurality wrote:

The Court in *Steward Machine* did not attempt to “fix the outermost line” where persuasion gives way to coercion. The Court found it “[e]nough for present purposes that wherever the line may be, this statute is within it.” We have no need to fix a line either. It is enough for today that wherever that line may be, this statute is surely beyond it.

Id. (alteration in original) (citations omitted). At oral arguments, Justice Alito proffered a question about coercion in the context of federal education programs. Transcript of Oral Argument, *supra* note 131, at 45-47; *see also* Pasachoff, *supra* note 24.

continuation of the Rehnquist Court's Federalism Revolution. Next, it explores three key coercion issues. First, it evaluates the Court's reliance on, and potential modifications to, the *Dole* test, including the clear-notice and relatedness restrictions set forth in that case. Second, it considers the nature of coercion, including how coercion is quantified, how it relates to political accountability, and what constitutes "coercion in fact." Third, it investigates the question of severability for future conditional spending challenges.

A. *Continuing the Federalism Revolution*

The Rehnquist Court's Federalism Revolution, which otherwise recognized a Tenth Amendment limit on various exercises of federal power, notably excluded the spending power.³²⁸ Justices³²⁹ and commentators³³⁰ interested in advancing the Federalism Revolution found the exclusion of the spending power to be a fissure in the project, as demonstrated by the dissent in *Davis v.*

³²⁸ The Rehnquist Natural Court struck down all or part of federal legislation by judicially enforcing the Tenth Amendment in four cases tied, at least in part, to the commerce power. *United States v. Morrison*, 529 U.S. 598, 626-27 (2000) (striking down the Violence Against Women Act because Congress lacked the authority to enact its civil remedy); *Printz*, 521 U.S. at 933 (holding the Brady Handgun Violence Prevention Act to be an unconstitutional exercise of Congress's power); *United States v. Lopez*, 514 U.S. 549, 567-68 (1995) (holding the Gun-Free School Zones Act of 1990 beyond Congress's commerce power); *New York*, 505 U.S. at 149 ("We conclude that while Congress has substantial power under the Constitution to encourage the States to provide for the disposal of the radioactive waste generated within their borders, the Constitution does not confer upon Congress the ability simply to compel the States to do so.").

³²⁹ See, e.g., *Davis v. Monroe Cnty. Bd. of Educ.*, 526 U.S. 629, 654-55 (1999) (Kennedy, J., dissenting) (discussing the need for federalism-based limits on spending). Even before *Davis*, Justice Kennedy seemed interested in limiting the spending power. Professor Baker reported in 1998 that Justice Kennedy was concerned that "conditional federal spending . . . is the major states' rights issue facing the country today." Lynn A. Baker, *The Revival of States' Rights: A Progress Report and a Proposal*, 22 HARV. J.L. & PUB. POL'Y 95, 102-03 (1998). It seems from her dissent in *Dole* that Justice O'Connor would have taken the *Dole* test a step further by fortifying the germaneness element. See *South Dakota v. Dole*, 483 U.S. 203, 212-18 (1987) (O'Connor, J., dissenting) ("Congress . . . is not entitled to insist as a condition of the use of highway funds that the State impose or change regulations in other areas of the State's social and economic life because of an attenuated or tangential relationship to highway use or safety.").

³³⁰ See generally Lynn A. Baker, *Conditional Federal Spending After Lopez*, 95 COLUM. L. REV. 1911 (1995) (advocating for stronger federalism-based limits on the spending power); Baker, *supra* note 329 (advocating a "revival of states' rights" by strengthening *Dole*'s conditional spending analysis); James F. Blumstein & Frank A. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 VAND. L. REV. 125 (2000) (describing the perceived problem of state "lock in," and accusing the federal government of passing mandatory Medicaid amendments once states could not leave the program); Cohen & Blumstein, *supra* note 14 (suggesting the Court should adopt a stronger coercion approach).

Monroe County Board of Education.³³¹ The Rehnquist Court bypassed several opportunities to recognize a Tenth Amendment limit in direct Spending Clause challenges such as *Dole*³³² and *New York v. United States*,³³³ and in other cases such as *Pierce County v. Guillen*,³³⁴ a commerce power case that also presented a spending power issue in the lower court.³³⁵ Accordingly, the Roberts Court's keenness to revisit federalism through the vehicle of Medicaid in *NFIB* was not surprising. As a former clerk of then-Justice Rehnquist, Chief Justice Roberts may well have been oriented to this issue by his mentor. Opinions penned by other members of the Roberts Court also suggested a desire to revive the Federalism Revolution. Those seeds sprung to life in the *NFIB* plurality and joint dissent.

Indeed, several members of the Roberts Court had recently hinted at a desire to revisit conditional spending doctrine as well as other federalism-based protections for the states. For example, Justice Kennedy's concurrence in

³³¹ See *Davis*, 526 U.S. at 654-86 (Kennedy, J., dissenting). Justice Kennedy's dissent, joined by Chief Justice Rehnquist and Justices Scalia and Thomas, began with the following observation:

The Court has held that Congress' power "'to authorize expenditure of public moneys for public purposes is not limited by the direct grants of legislative power found in the Constitution.'" As a consequence, Congress can use its Spending Clause power to pursue objectives outside of "Article I's 'enumerated legislative fields'" by attaching conditions to the grant of federal funds. *So understood, the Spending Clause power, if wielded without concern for the federal balance, has the potential to obliterate distinctions between national and local spheres of interest and power by permitting the Federal Government to set policy in the most sensitive areas of traditional state concern, areas which otherwise would lie outside its reach.*

Id. at 654-55 (emphasis added) (citations omitted) (quoting *Dole*, 482 U.S. at 207); see also Richard W. Garnett, *The New Federalism, the Spending Power, and Federal Criminal Law*, 89 CORNELL L. REV. 1, 5 (2003) (observing that the power to spend was overlooked in the "Rehnquist Revolution").

³³² *Dole*, 483 U.S. at 210 ("We have also held that a perceived Tenth Amendment limitation on congressional regulation of state affairs did not concomitantly limit the range of conditions legitimately placed on federal grants." (citing *Oklahoma v. Civil Serv. Comm'n*, 330 U.S. 127 (1947))).

³³³ *New York*, 505 U.S. 144. The majority approved of federal spending as an appropriate method of influencing state policymaking. *Id.* at 166-67 ("Our cases have identified a variety of methods, short of outright coercion, by which Congress may urge a State to adopt a legislative program consistent with federal interests."). Additionally, the Court held that grants to states for radioactive waste disposal were "well within the authority of Congress under the Commerce and Spending Clauses . . . [and thus] not inconsistent with the Tenth Amendment." *Id.* at 173.

³³⁴ 537 U.S. 129, 147-48 (2003) (holding that federal regulation of information about highway failures collected by states for federal funding purposes was a proper exercise of commerce authority).

³³⁵ *Guillen v. Pierce Cnty.*, 31 P.3d 628, 651 (Wash. 2001) (holding that the federal regulation of state highway-safety regulation was not a valid federal interest and thus not a proper exercise of the spending power), *rev'd on other grounds*, 537 U.S. 129 (2003).

United States v. Comstock stated: “The limits upon the spending power have not been much discussed, but if the relevant standard is parallel to the Commerce Clause cases, then the limits and the analytic approach in those precedents should be respected.”³³⁶ Justice Kennedy was clearly asserting that the Tenth Amendment should drive judicially enforced limits on the spending power, as it has given rise to limits on the Commerce Clause in cases such as *United States v. Lopez*³³⁷ and *United States v. Morrison*.³³⁸ Moreover, Justice Kennedy articulated skepticism about the very source of the spending power in his *Comstock* concurrence, writing: “It should be remembered, moreover, that the spending power is not designated as such in the Constitution but rather is implied from the power to lay and collect taxes”³³⁹

Likewise, the Court’s 2011 decision in *Bond v. United States* was rich with federalism observations that were harbingers of *NFIB*.³⁴⁰ *Bond* could have produced a brief decision to the effect that a criminal defendant can always defend herself based upon the constitutionality of the law under which she is charged, as demonstrated by Justice Ginsburg’s two-page concurrence.³⁴¹ But because Ms. Bond defended herself by asserting a Tenth Amendment issue, Justice Kennedy wrote at length about the nature and value of federalism and the role of divided government in protecting individuals.³⁴² *Bond* contains language the States echoed in their brief³⁴³ and was reiterated by the *NFIB* plurality.³⁴⁴

³³⁶ *United States v. Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring).

³³⁷ 514 U.S. 549, 568 (1995) (Kennedy, J., concurring) (discussing the proper balance that should be struck to respect the boundaries of federalism).

³³⁸ 529 U.S. 598, 600, 626-27 (2000) (striking down portions of the Violence Against Women Act as violating the Tenth Amendment in a majority opinion joined by Justice Kennedy).

³³⁹ *Comstock*, 130 S. Ct. at 1967 (Kennedy, J., concurring).

³⁴⁰ *Bond v. United States*, 131 S. Ct. 2355, 2364-66 (2011) (outlining the multiple benefits achieved through careful attention to federalism-based interests).

³⁴¹ *Id.* at 2367 (Ginsburg, J., concurring) (“Bond, like any other defendant, has a personal right not to be convicted under a constitutionally invalid law.”).

³⁴² *Id.* at 2364-66 (majority opinion).

³⁴³ Brief of State Petitioners on Medicaid, *supra* note 196, at 24-25 (“That core limitation on Congress’ power is a necessary reflection of the fact that ‘the preservation of the States . . . are as much within the design and care of the Constitution as the preservation of the Union’” (quoting *Texas v. White*, 74 U.S. 700, 725 (1868))).

³⁴⁴ *See, e.g., NFIB*, 132 S. Ct. 2566, 2578 (2012) (plurality opinion) (“The independent power of the States also serves as a check on the power of the Federal Government: ‘By denying any one government complete jurisdiction over all the concerns of public life, federalism protects the liberty of the individual from arbitrary power.’” (quoting *Bond*, 131 S. Ct. at 2364)); *id.* at 2602 (“[F]reedom is enhanced by the creation of two governments, not one.” (quoting *Bond*, 131 S. Ct. at 2364)).

In addition, Justice Alito crafted his 2006 opinion in *Arlington Central School District Board of Education v. Murphy*³⁴⁵ as a spending power decision rather than a statutory interpretation decision, producing a narrower clear-statement rule for the unambiguous-conditions element of the *Dole* test.³⁴⁶ *Arlington* was also indicative of things to come, as the clear-statement rule the Court introduced in that case proved to be a step toward the now-stronger judicial limits on congressional spending laid down in *NFIB*.

NFIB advances the Federalism Revolution as the first decision by any federal court to hold Spending Clause legislation to be unconstitutionally coercive. Proponents of broad federal power will no doubt claim that the decision is sui generis and limited to its particular facts. But both the result and the rhetoric in *NFIB* suggest that it is a launch, not a landing.

B. *Unresolved Coercion Questions After NFIB*

1. Stealth Application of *Dole*

The four-part test articulated in *Dole* has long been the definitive test for determining whether conditions placed on federal spending are constitutional.³⁴⁷ Justice Ginsburg summarized the test thus:

[C]onditions placed on federal grants to States must (a) promote the “general welfare,” (b) “unambiguously” inform States what is demanded of them, (c) be germane “to the federal interest in particular national projects or programs,” and (d) not “induce the States to engage in activities that would themselves be unconstitutional.”³⁴⁸

Unfortunately, the manner in which the plurality addressed the four-part *Dole* test is both unclear and disorganized.³⁴⁹ The *NFIB* opinions relied

³⁴⁵ 548 U.S. 291 (2006).

³⁴⁶ Huberfeld, *Clear Notice*, *supra* note 14, at 452-65 (tracing the concurrences and dissents that led to the stricter clear-notice standard in *Arlington*). *Arlington* involved the Individuals with Disabilities in Education Act, which provides for the recovery of attorneys’ fees by parents who successfully challenge inadequate education plans. *Arlington*, 548 U.S. at 293. At issue in the case was whether this reimbursement scheme also included reimbursing expert (non-attorney) fees. *Id.* The Court held that expert fees could not be reimbursed because the state did not have clear notice of this funding requirement. *Id.* at 298.

³⁴⁷ *South Dakota v. Dole*, 483 U.S. 203, 207 (1987).

³⁴⁸ *NFIB*, 132 S. Ct. at 2634 (Ginsburg, J., concurring in part and dissenting in part) (quoting *Dole*, 483 U.S. at 207-08, 210).

³⁴⁹ Professor Samuel Bagenstos writes that this disjointed opinion should be read in the frame of an “anti-leveraging principle” and argues that the Roberts opinion requires that three factors exist for coercion to be found: that the conditions be “attached to large amounts of federal money, change the terms of participation in entrenched cooperative programs, or tie together separate programs into a package deal.” Samuel R. Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After NFIB*, 101 GEO. L.J. (forthcoming Apr.

heavily, but indirectly, on the elements of the *Dole* test, even though those elements were not argued or relied on in the decisions below. District Judge Vinson cited the *Dole* test and noted that “[t]he plaintiffs do not appear to dispute that the Act meets these restrictions.”³⁵⁰ The Eleventh Circuit acknowledged the same concession, with a footnote clarifying that the plaintiffs’ claims were not based on the germaneness requirement of *Dole*.³⁵¹ At oral argument, Solicitor General Verrilli said the Medicaid expansion “complies with all of the limits set forth in this Court’s decision in *Dole*, and the States do not contend otherwise.”³⁵² Justice Ginsburg noted the same point in her opinion.³⁵³

Even so, elements of the *Dole* test feature prominently in the plurality opinion,³⁵⁴ though not identified as such. The *Dole* test was effectively waived below and not adequately briefed, but at least two parts of the test were reanimated, potentially modified, and ambiguously incorporated into the Court’s coercion analysis.³⁵⁵ With irony that the plurality surely did not intend, the first such part concerned “clear notice.”

a. *Clear Notice*

When exercising authority under the Spending Clause, Congress must clearly express any conditions it attaches to federal funds.³⁵⁶ The Court first articulated this legislative clear-statement rule in *Pennhurst State School & Hospital v. Halderman*,³⁵⁷ authored by then-Justice Rehnquist, who later

2013) (manuscript at 3).

³⁵⁰ *Florida ex rel. McCollum v. U.S. Dep’t of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1157 (N.D. Fla. 2010).

³⁵¹ *Florida ex rel. Att’y Gen. v. U.S. Dep’t of Health & Human Servs.*, 648 F.3d 1235, 1263 & n.63 (11th Cir. 2011).

³⁵² Transcript of Oral Argument, *supra* note 131, at 40.

³⁵³ *NFIB*, 132 S. Ct. at 2634 n.18 (Ginsburg, J., concurring in part and dissenting in part) (“Although the plaintiffs, in the proceedings below, did not contest the ACA’s satisfaction of these criteria, [Chief Justice Roberts] appears to rely heavily on the second criterion.” (citation omitted)).

³⁵⁴ *See id.* at 2601-08 (plurality opinion). These issues were discussed during oral argument as well. Transcript of Oral Argument, *supra* note 131, at 41-42, 44 (discussing *Dole*’s conditions and their potential applicability to the Medicaid expansion in question).

³⁵⁵ Perhaps the *NFIB* coercion analysis could be considered entirely separate from the four-factor test in *Dole*, limited only to cases (like *NFIB*) where *Dole* was satisfied or waived. But if that were the Court’s intention, then the plurality opinion should have explained how clear notice and relatedness were satisfied for the *Dole* test, but not for purposes of the plurality’s coercion analysis. Instead, we have reanimation, potential modification, and ambiguous incorporation of the old test.

³⁵⁶ *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 24 (1981) (“Congress must express clearly its intent to impose conditions on the grant of federal funds so that the States can knowingly decide whether or not to accept those funds.”).

³⁵⁷ *Id.* at 25 (“The crucial inquiry, however, is not whether a State would knowingly

incorporated it into the *Dole* test as an “unambiguous conditions” requirement.³⁵⁸ This requirement was later given a tightened definition by Justice Alito’s majority opinion in *Arlington*, which announced that “clear notice” is required, not mere unambiguity or “adequate” notice.³⁵⁹ The *Arlington* Court stated that its task was to discern whether a state would have understood, at the outset of its decision to accept federal funding, all of the conditions attached to that funding.³⁶⁰

The clear-notice requirement is closely linked to the Court’s view of conditional spending programs as “much in the nature of a contract.”³⁶¹ The theory is that a state cannot understand the terms of the “contract” if they are not “clear.” Accordingly, the clear-notice requirement protects states from conditions that may be unanticipated. As Justice Rehnquist wrote in *Pennhurst*, the “crucial inquiry [] is not whether a State would knowingly undertake that obligation, but whether Congress spoke so clearly that we can fairly say that the State could make an informed choice.”³⁶²

The connections between conditional spending power, clear notice, and federalism are direct. State autonomy is preserved by ensuring that states knowingly and voluntarily enter into cooperative arrangements with the federal government. But it now appears that clear notice and coercion are also linked because the Court’s coercion reasoning was based, in part, on what it deemed inadequate notice to the states of the new conditions on federal Medicaid dollars. Because the Court did not evaluate the *Dole* test systematically, it is unclear as to whether the Court intended this result. The plurality and the joint dissent both suggested that states in a program as longstanding as Medicaid cannot possibly have clear notice of a dramatic new condition on the funding

undertake that obligation, but whether Congress spoke so clearly that we can fairly say that the State could make an informed choice.”). *Pennhurst* involved the requirements of the Developmentally Disabled Assistance and Bill of Rights Act, in particular the so-called Bill of Rights section, and whether the Bill of Rights created mandatory or hortatory conditions for state compliance. *Id.* at 8 (citing 42 U.S.C. § 6010(1)-(2) (1976 & Supp. III 1979)). The Court held that conditions on the grant of federal monies must be “unambiguous” so that states may “exercise their choice knowingly, cognizant of the consequences” of complying with federally imposed conditions. *Id.* at 17. Because the states could not have known the particular provision at issue would be a requirement, the Court refused to enforce it against them retroactively. *Id.* at 25.

³⁵⁸ Huberfeld, *Clear Notice*, *supra* note 14, at 446-52 (describing the progression from *Pennhurst* to *Dole*).

³⁵⁹ *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006); *see also* Huberfeld, *Clear Notice*, *supra* note 14, at 465-72 (describing the deliberate movement to “clear” notice in *Arlington*).

³⁶⁰ *Arlington*, 548 U.S. at 296, 304.

³⁶¹ *Pennhurst*, 451 U.S. at 17; *see also* Blumstein Brief, *supra* note 246 (developing further the contract analogy for the Medicaid coercion argument). The common law contractual defense of duress seems applicable here but was not discussed by the Court.

³⁶² *Pennhurst*, 451 U.S. at 25.

for that program, despite Congress's express reservation of the right to amend, revise, and thereby, implicitly, to impose new conditions on the program.³⁶³ That interpretation would seem to ossify federal programs. The resulting question is whether Congress could have avoided the Court's coercion holding in *NFIB* if it had given *clearer* notice: for example, by stating expressly that it reserved the power to impose *radically* new conditions on which all Medicaid funding could and would be conditioned. Whether the Court meant to endorse such a "clearer-statement" approach to congressional drafting we cannot know.³⁶⁴ Future Congresses could certainly repeal Medicaid entirely, as Justice Ginsburg observed,³⁶⁵ with grudging agreement from Chief Justice Roberts on this specific point.³⁶⁶

The reasoning of the plurality and the joint dissent also suggest that timing matters for clear notice, but the Court addressed timing in a haphazard manner. For the contract analogy, the time that matters is the moment of contract formation. At that moment, states must clearly understand the conditions that attach to the federal funding. Only Justice Ginsburg explored the question of exactly when cooperative-federalism contracts are formed. To Justice Ginsburg, they are formed and reformed each and every fiscal year, as Congress offers money and states accept it. This is the true import of her statement that Congress could completely eliminate Medicaid and then re-enact it.³⁶⁷ According to this view, the relevant moment is March 23, 2010 (the date of the ACA's enactment), and the question is whether states have a clear understanding of their obligations under Medicaid as of January 1, 2014 (the date of the Medicaid expansion's applicability). This is a question that is easily answered in the affirmative. Unlike the concerns in *Pennhurst* over retroactivity, the Medicaid expansion effectively provides six years of advance notice – four years until the expansion takes effect and two more years of

³⁶³ See *supra* Part II.D.1, .3.

³⁶⁴ EMILY W. PARENTO & LAWRENCE O. GOSTIN, O'NEILL INST., BRIEFING PAPER NO. 7, THE SUPREME COURT'S LANDMARK DECISION ON THE AFFORDABLE CARE ACT: HEALTHCARE REFORM'S ULTIMATE FATE REMAINS UNCERTAIN 6-7 (2012).

³⁶⁵ *NFIB*, 132 S. Ct. 2566, 2636 (2012) (Ginsburg, J., concurring in part and dissenting in part).

³⁶⁶ *Id.* at 2606 n.14 (plurality opinion). The hypothetical was suggested prior to *NFIB* by Glenn Cohen and Jim Blumstein in the *New England Journal of Medicine*. Cohen & Blumstein, *supra* note 14, at 104. While acknowledging this hypothetical was legally correct, Justice Roberts dismissed it as politically impractical. *NFIB*, 132 S. Ct. at 2606 n.14 (plurality opinion); see also Cohen & Blumstein, *supra* note 14, at 104 (discussing the political impracticability of the Medicaid unilateral amendment provision). It is not clear why this would be politically impracticable, as Congress could have just added a phrase to Title II of the Patient Protection and Affordable Care Act announcing repeal and re-enactment. Chief Justice Roberts does not describe why this would have changed a single vote in Congress or why we should require Congress to discern magic phrases that the Court will later require in legislation.

³⁶⁷ *NFIB*, 132 S. Ct. at 2636 (Ginsburg, J., concurring in part and dissenting in part).

100% federal funding. In *Pennhurst*, the Court cautioned: “Though Congress’ power to legislate under the spending power is broad, it does not include surprising participating States with post acceptance or ‘retroactive’ conditions.”³⁶⁸ The *Pennhurst* Court was concerned that states agreed to accept federal educational funds only to learn, through litigation several years later, that hortatory obligations were mandatory and had retroactive effect.³⁶⁹ Here, states have several years to decide whether to accept the conditions before agreeing to participate in the Medicaid expansion.

The lack of notice in *Arlington* is similarly distinguishable from the present case.³⁷⁰ In *NFIB*, the states fully understood the federal offer of the Medicaid expansion well in advance of the effective date. Indeed, the states’ immediate request for judicial relief from the Medicaid expansion indicates a very clear understanding of the law and ample time to challenge it. The notice was clear and prospective; some states just did not like the offer.

In the opinions and briefs in *NFIB*, much ink was spilled over whether Congress gave clear notice in 1965. But surely this is the wrong question. The original 1965 Medicaid statute included language originally enacted in the SSA of 1935: “The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress.”³⁷¹ The plurality and the joint dissent simultaneously made too much and too little of this provision. Too much, because it goes without saying that Congress retains the right to amend federal laws, assuming the votes exist. The 89th Congress, which created the Medicaid Act in 1965, cannot and did not bind subsequent Congresses; nor did any Congress need this clause to authorize the right to amend Medicaid in the future. Too little, because, if anything, this provision disclaims the contractual analogy applied by the Court. An explicit provision permitting unilateral amendment, after all, is a stranger to contract law.³⁷² Thus Congress included a provision that was substantively superfluous, but only served to emphasize that Medicaid was not a contract. The Court entirely neglected to discuss this point.

³⁶⁸ *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 25 (1981).

³⁶⁹ *Id.* at 22-25 (rejecting the argument that states were given ample notice that their receipt of funds attached conditions for the provision of mental health services and treatment).

³⁷⁰ *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (asserting that a state must have clear notice of conditions and not learn of them post hoc, through piecemeal litigation).

³⁷¹ 42 U.S.C. § 1304 (2006) (originally enacted as Social Security Act of 1935, Pub. L. No. 74-271, § 1104, 49 Stat. 620, 648).

³⁷² RESTATEMENT (SECOND) OF CONTRACTS § 77 cmt. a (1981); *see also* Cohen, *supra* note 32, at 14-16 (discussing the doctrine of illusory promise in this precise context). For further scholarly discussion of the contract analogy, clear-notice requirement, and the relevant statutory “contract” dates animating the *NFIB* opinion, *see generally* Copeland, *supra* note 14.

When discussing the question of clear notice, it is important to remember that the Court did not declare any provision of the ACA to be unconstitutional. The only federal law affected by *NFIB* is § 1396c, which authorized the Secretary to limit federal funds for noncompliance. But § 1396c was not added by the ACA; it also has been part of the Medicaid Act since 1965 and analogous language has been part of the SSA since 1935. And surely Congress could cut off future funds to states through legislation repealing, no longer funding, or otherwise amending the Medicaid Act. The Tenth Amendment gives no textual hint of this clear-notice rule, nor does the Court elucidate any precedent or theory supporting this approach.

b. *Relatedness*

The linchpin of the plurality's opinion is the artificial distinction it forges between "old" and "new" Medicaid. This factually incorrect and atheoretical assessment facilitated the conclusion that the Medicaid expansion was unconstitutionally coercive. It also may have modified the "germaneness" prong of the *Dole* test.³⁷³ Until now, the Court had not enforced relatedness in this context. But after *NFIB*, we will undoubtedly see many cases attempting to apply this new concept, especially to determine exactly how "related" the condition must be to the existing program.³⁷⁴

A major error that facilitated this mischaracterization of "old" and "new" Medicaid was the plurality's description of Medicaid eligibility, which portrayed historical coverage categories as if they had constitutional significance.³⁷⁵ This is far from the truth. As described in Part II, in 1965 Medicaid was limited to covering the "deserving" poor,³⁷⁶ but that is attributable to the historical precedent created by the Elizabethan Poor Laws.

³⁷³ *South Dakota v. Dole*, 483 U.S. 203, 207-09 (1987). The Court called this aspect of the limitations on conditional spending "relatedness" and "germaneness" interchangeably.

³⁷⁴ KENNETH R. THOMAS, CONG. RESEARCH SERV., R42367, THE CONSTITUTIONALITY OF FEDERAL GRANT CONDITIONS AFTER *NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS* 10 (2012) ("Justice Roberts' decision in *NFIB* appears to contemplate that when a court evaluates a grant condition, it must determine the relationship between that grant condition and the underlying grant program."). As the Congressional Research Service described it, this transformation created an entirely new category for constitutional-condition cases. *Id.* at 11 ("However, if the grant condition is for a new and independent program; the government threatens the funding of an existing program; and the withholding of federal funding represents a significant portion of a state's budget, then the condition would be coercive under the Tenth Amendment.").

³⁷⁵ *NFIB*, 132 S. Ct. 2566, 2636 (2012) (Ginsburg, J., concurring in part and dissenting in part) (discussing the plurality's focus on past eligibility categories as determinative of future eligibility).

³⁷⁶ Huberfeld, *Federalizing Medicaid*, *supra* note 14, at 436-49 (providing a history of Medicaid to explain why the program has persistently limited eligibility to the deserving poor and focused on states' autonomy).

The limited categories of Medicaid eligibility were not conceived of as a hard-wired, constitutional mechanism for protecting states from federal conditions.

Chief Justice Roberts suggested that individuals below 133% FPL but above the pre-expansion Medicaid eligibility levels are not “the neediest among us.”³⁷⁷ He was egregiously incorrect. As Justice Ginsburg described, the Medicaid expansion income levels under the ACA are quite modest,³⁷⁸ especially given the lack of protection from medical bankruptcy.³⁷⁹ The plurality failed to explain, for example, why a sixty-five-year-old person with income below \$15,000 per year qualifies as the “neediest among us” but a sixty-four-year-old with the same income does not. The Medicaid expansion simply replaces the anachronistic categories of “deserving” poor with an across-the-board, nondiscriminatory income test. Nonetheless, Chief Justice Roberts attributed constitutional significance to the level of poverty and deployed the Tenth Amendment to protect states from any change in the historical coverage categories.

Here the actual history of Medicaid presses for attention. Since 1965, the federal government has expanded Medicaid mandatory coverage many times. Contrary to the plurality’s assertion that this expansion was a “shift in kind, not merely degree,”³⁸⁰ extending eligibility by eliminating the categorical characterizations of poverty was entirely consistent with federal control of a program that exists to mainstream the poor into the healthcare system.³⁸¹ The plurality rejected the idea that Congress could “style” the “new” expansion as part of “old” Medicaid simply by calling it such.³⁸² But the Medicaid expansion is not merely an issue of style. It is a modernization of the Medicaid program compatible with prior expansions.³⁸³

³⁷⁷ *NFIB*, 132 S. Ct. at 2606 (plurality opinion).

³⁷⁸ *Id.* at 2636 (Ginsburg, J., concurring in part and dissenting in part) (“Single adults earning no more than \$14,856 per year – 133% of the current federal poverty level – surely rank among the Nation’s poor.”).

³⁷⁹ David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 745 (2009) (describing legal changes which have made medical bankruptcy difficult and expensive to obtain).

³⁸⁰ *NFIB*, 132 S. Ct. at 2605 (plurality opinion).

³⁸¹ *Id.* at 2639 (Ginsburg, J., concurring in part and dissenting in part) (discussing the purpose and history of Medicaid, including its expansions).

³⁸² *Id.* at 2605-06 (plurality opinion) (“Indeed, the manner in which the expansion is structured indicates that while Congress may have styled the expansion a mere alteration of existing Medicaid, it recognized it was enlisting the States in a new health care program.”). *But see* at 2635 (Ginsburg, J., concurring in part and dissenting in part) (“Congress styled and clearly viewed the Medicaid expansion as an amendment to the Medicaid Act, not as a ‘new’ healthcare program.”).

³⁸³ The alternative-benefits package for the Medicaid-expansion population is also not new; it was introduced as an element of flexibility for states in the Deficit Reduction Act of 2005. Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6044, 120 Stat. 4, 88 (codified at 42 U.S.C. § 1396u-7(a)(1) (2006)) (giving states the option of providing only “benchmark

The characterization of “new Medicaid” is dangerous because it denies deference to Congress when it sets the parameters for both new and amended conditional spending programs. The federal government has always established the baselines of Medicaid, one of which is eligibility. The federal requirements operate as a floor, according states flexibility to increase coverage but not decrease it. The plurality failed to appreciate that eligibility for a federal program is a key element of “preserv[ing] control over the use of federal funds.”³⁸⁴ If eligibility for federal funding is beyond the federal government’s control, then *NFIB* truly opens the floodgates for litigation.

Putting aside this Article’s critiques of relatedness, on this issue the views of the joint dissent and the Roberts plurality merge, suggesting a line of argument likely to garner the support of a majority of Justices in future cases. They appear willing to carefully scrutinize the relatedness of conditions on federal programs, regardless of the way in which Congress structures those programs or describes their germaneness. Thus, it appears that Justice O’Connor’s *Dole* dissent, which similarly would have given prominence to germaneness under the *Dole* test, will now surely operate in future coercion analyses.³⁸⁵

Based on its assessment of the Medicaid expansion as a “new” program, the plurality wrote:

benefits” to certain populations). For further description of the Deficit Reduction Act of 2005 and ACA amendments incorporating the EHB package as defined by ACA section 2001(c)(3), see *supra* notes 150-66 and accompanying text. It is ironic that the states now point to this option as coercion, when it was originally written to benefit them and provide them more flexibility.

³⁸⁴ *NFIB*, 132 S. Ct. at 2603 (plurality opinion).

³⁸⁵ *South Dakota v. Dole*, 483 U.S. 203, 213-18 (1987) (O’Connor, J., dissenting). Justice O’Connor wrote:

There is a clear place at which the Court can draw the line between permissible and impermissible conditions on federal grants. It is the line identified in the Brief for the National Conference of State Legislatures et al. as *Amici Curiae*:

“Congress has the power to *spend* for the general welfare, it has the power to *legislate* only for delegated purposes

“The appropriate inquiry, then, is whether the spending requirement or prohibition is a condition on a grant or whether it is regulation. The difference turns on whether the requirement specifies in some way how the money should be spent, so that Congress’ intent in making the grant will be effectuated. Congress has no power under the Spending Clause to impose requirements on a grant that go beyond specifying how the money should be spent. A requirement that is not such a specification is not a condition, but a regulation, which is valid only if it falls within one of Congress’ delegated regulatory powers.”

This approach harks back to *United States v. Butler*, the last case in which this Court struck down an Act of Congress as beyond the authority granted by the Spending Clause.

Id. at 215-16 (citations omitted) (quoting Brief of the National Conference of State Legislatures et al. as *Amici Curiae* in Support of Petitioner at 19-20, *Dole*, 483 U.S. 203 (No. 86-260)).

Conditions that do not here govern the use of the funds [] cannot be justified on that basis. When, for example, such conditions take the form of threats to terminate *other significant independent grants*, the conditions are properly viewed as a means of pressuring the States to accept policy changes.³⁸⁶

For the plurality, “old” Medicaid was a “significant independent grant” which could not be conditioned on states agreeing to accept “new” Medicaid conditions. The suggested line of attack for future challenges, therefore, is that conditions unrelated to the program for which funding is offered should be deemed non-germane, and therefore coercive, depending on the amount and percentage of funding at stake.³⁸⁷

Both the plurality and the joint dissent were opaque in their application of the four *Dole* factors, purporting instead to base their opinions on the analytically distinct coercion dicta. But the opinions’ inspection of the “relatedness” of the condition to the purpose of the program suggests a new judicial approach to Medicaid and other Spending Clause cases.³⁸⁸ *NFIB* plows new ground: first, by giving teeth to *Dole*’s germaneness limit, and, second, by injecting two *Dole* factors, relatedness and clear notice, into the coercion analysis. Federal modifications of established conditional spending programs that impose new requirements on states will now be vulnerable to constitutional challenges for violating one or both of these limits. Moreover, federal conditions that were previously found not to be coercive may be exposed to new challenges after *NFIB*. Two examples follow.

First, in *Kansas v. United States* Kansas challenged conditions imposed on states that accepted federal funds under TANF and related programs after the 1996 welfare reform.³⁸⁹ The challenged federal law called on states to adopt

³⁸⁶ *NFIB*, 132 S. Ct. at 2604 (plurality opinion) (emphasis added).

³⁸⁷ Because the majority in *Dole* had found the conditions sufficiently related to spending for the general welfare, the opinion dispensed with consideration of the third prong. *Dole*, 483 U.S. at 211 (“When we consider, for a moment, that all South Dakota would lose if she adheres to her chosen course as to a suitable minimum drinking age is 5% of the funds otherwise obtainable under specified highway grant programs, the argument as to coercion is shown to be more rhetoric than fact.”).

³⁸⁸ Justice Ginsburg acknowledged “federalism-based limits” on Congress’s power to spend. *NFIB*, 132 S. Ct. at 2634 (Ginsburg, J., concurring in part and dissenting in part). She rejected, however, the plurality’s assessment that it was constitutionally significant that the states lacked notice concerning the Medicaid expansion. *Id.* at 2630. Further, in a clear reference to the plurality’s focus on Justice O’Connor’s dissent in *Dole* (which she did not cite), Justice Ginsburg distinguished the germaneness concerns in *Dole* from the expansion of funding in *NFIB*. Justice Ginsburg noted that the condition on the spending is for the program, Medicaid, and not for anything else; therefore, the *Dole* coercion concerns were not viable. *Id.* at 2634.

³⁸⁹ *Kansas v. United States*, 214 F.3d 1196, 1197 (10th Cir. 2000). President Clinton promised to “end welfare as we know it” during his 1992 campaign and fulfilled that promise with “workfare” in 1996. See, e.g., Douglas J. Besharov, Op-Ed, *End Welfare Lite*

uniform national child-support laws and procedures, including the Uniform Interstate Family Support Act (UIFSA).³⁹⁰ More specifically, Congress required all fifty states to adopt this precise legal text or else suffer loss of all TANF funds.³⁹¹ States were also subjected to an MOE provision akin to that found in many amendments to the SSA.³⁹² Although not articulating “relatedness” as a constitutional test, the Tenth Circuit had little trouble finding an acceptable relationship between TANF funding and the UIFSA condition. The two were “clearly related,” based on the program’s goals, legislative history, and the “interrelationship” between welfare and child support.³⁹³ Arguably, TANF, a program designed to help needy families achieve self-sufficiency through job preparation, work, and marriage, and the UIFSA, a model act regarding enforcement of child-support obligations, are less related than “old” and “new” Medicaid, which involve the same program of health insurance benefits for individuals in financial need. Conceivably, the Roberts plurality may invite a renewed coercion challenge to these programs. The *Kansas* court buttressed its relatedness analysis with statutory construction, noting that both programs were codified in the same chapter of the SSA.³⁹⁴ This, however, is precisely the type of evidence Chief Justice Roberts slighted in his *NFIB* opinion.³⁹⁵

Second, in *Oklahoma v. Schweiker* eleven states challenged the 1976 SSA amendments on coercion grounds.³⁹⁶ These amendments conditioned the receipt of all Medicaid funds upon a new requirement: agreeing to pass through to SSI recipients all of the annual federal cost-of-living adjustments.³⁹⁷

as *We Know It*, N.Y. TIMES, Aug. 15, 2006, at A19 (describing the many changes attributed to the workfare law, and highlighting the impact of a strong economy on reducing welfare rolls).

³⁹⁰ See *Kansas*, 214 F.3d at 1198.

³⁹¹ *Id.* (“If a state’s child support enforcement program fails to conform . . . the state risks the denial of . . . its TANF funding.”).

³⁹² *Id.* at 1197 (“A state that elects to receive the federal block grant under the TANF program, however, must operate a child support enforcement program that meets [the litigated program’s] requirements.”).

³⁹³ *Id.* at 1200 (citing S. Rep. No. 93-1356, at 49-50 (1974)).

³⁹⁴ *Id.* (“It is no coincidence that the AFDC/TANF and the child support programs are both set forth in the same subchapter of the Social Security Act, which bears the heading ‘Grants to States for Aid and Services to Needy Families with Children and for Child-Welfare Services.’”).

³⁹⁵ *NFIB*, 132 S. Ct. 2566, 2605 n.13 (2012) (plurality opinion) (“Nor, of course, can the number of pages the amendment occupies, or the extent to which the change preserves and works within the existing program, be dispositive.”).

³⁹⁶ *Oklahoma v. Schweiker*, 655 F.2d 401, 402 & n.1 (D.C. Cir. 1981) (listing the appellants as eleven states and noting that two additional states, Colorado and Michigan, were parties before the district court but did not join the appeal).

³⁹⁷ *Id.* at 408 (“In order to induce the states to pass cost-of-living increases on to aid recipients, Congress deemed it necessary to attach the pass-through condition to the

The D.C. Circuit Court found this threat – the loss of all Medicaid funds – permissible because it was sufficiently related to SSI:

Indeed, SSI and Medicaid are two interrelated components of the comprehensive federal effort to aid the aged, the blind, and the disabled. Both programs are aimed at the same target population – in fact, eligibility for SSI payments automatically entitles one to Medicaid benefits in most states – but each focuses on satisfying a particular need.³⁹⁸

NFIB's relatedness-infused coercion analysis now suggests a potentially different outcome in *Oklahoma v. Schweiker*. First, the Court might find SSI and Medicaid not sufficiently related as they seem even more clearly different programs than “old” and “new” Medicaid.³⁹⁹ Then, it might find that conditioning states' Medicaid funds on their agreement to apply the cost-of-living adjustments to SSI recipients would be unconstitutionally coercive. Additional examples abound and are likely to arise in the near future. Indeed, at oral arguments Mr. Clement discussed CHIP and Medicaid as if they were sufficiently unrelated to be vulnerable to a coercion claim.⁴⁰⁰

Thus, it appears germaneness is no longer a silent element of the *Dole* test, though the manner in which the concept was incorporated into the plurality's coercion analysis differs from Justice O'Connor's conception of relatedness, as expressed by her dissent in *Dole*.⁴⁰¹ While it seems correct that Congress cannot condition federal funding on participation in unrelated programs, the deep problem with the plurality's analysis is that Medicaid is just one program, thus germaneness/relatedness is inapposite. Nevertheless, the Court has now created precedent that connects germaneness to coercion, which arguably expands the reach of the coercion doctrine invented by *NFIB*.

Medicaid provisions of the Act, under which funds are disbursed to the states.”).

³⁹⁸ *Id.* at 409 (footnote omitted).

³⁹⁹ *See id.* at 410 (“The legislative history of the Social Security Act and of its amendments therefore refutes appellants' suggestion that the requirement that states pass through SSI cost-of-living increases is unrelated to the purposes of the Medicaid program. On the contrary, the relevant committee reports, the evolution of the Act's structure, and other conditions set by Congress all indicate that Medicaid funds and SSI benefits are two elements of one scheme with a single aim. We find nothing impermissible in Congress' conditioning a state's receipt of Medicaid funds on its compliance with section 1618's mandate regarding the use of SSI funds.”).

⁴⁰⁰ Transcript of Oral Argument, *supra* note 131, at 16-17.

⁴⁰¹ Justice O'Connor perceived a plain germaneness problem in *Dole*; the federal highway funding was not rationally related to liquor regulation. *South Dakota v. Dole*, 483 U.S. 203, 212-18 (1987) (O'Connor, J., dissenting).

2. Failure to Define Coercion

In the absence of caselaw defining and applying the coercion doctrine, the States instead asked the Court to “fashion” a coercion doctrine.⁴⁰² And “fashion” the Court did, though the rules for unconstitutional coercion in exercises of spending power have pointedly not been supplied.⁴⁰³ Nevertheless, at least three possible coercion rubrics can be gleaned from *NFIB*: a quantitative analysis focused on financial figures, the more qualitative concept of political accountability, and the joint dissent’s concept of “coercion in fact.”

a. *Quantitative Coercion*

Dole’s coercion analysis was open-ended and could have been interpreted to mean either that Congress offered states too much money or that Congress threatened to take too much money away.⁴⁰⁴ *NFIB* settled on the latter. The plurality in *NFIB* expressly affirmed that the amount of money being offered was not an issue, writing: “Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care”⁴⁰⁵ The conclusion then must be that the coercion question does not hinge, at least directly, on the amount being offered to the states but rather on the money that can be taken away for failure to comply with conditions on spending. But the amount offered seems relevant inasmuch as the overall size of a federal program, whether measured by total federal spending on the program or the size of the federal grants to states, was central to the Court’s coercion analysis of the Medicaid expansion.

In reviewing the size of the “threat,” the Court was attuned to both the raw dollar amount and the percentage of funding that the federal government could take away.⁴⁰⁶ Chief Justice Roberts’ opinion echoed a point he made during

⁴⁰² Brief of State Petitioners on Medicaid, *supra* note 196, at 28-29 (“[I]t is incumbent on this Court to fashion judicially enforceable outer limits on the [spending] power that will ensure preservation of the federal balance and the Constitution’s broad reservation of powers to the States.” (citing U.S. CONST. amend. X)).

⁴⁰³ Though the plurality used words like “transform” to describe the effect of the Medicaid expansion, finding it coercive and dividing it from the existing Medicaid program based on this perceived extent of change, it is hard to extrapolate a rule from the Court’s characterization of the expansion other than perhaps to look for characteristics of a new program. It also seems fairly clear that not every amendment is transformative.

⁴⁰⁴ *Dole*, 483 U.S. at 211 (acknowledging the possibility that conditions imposed on federal funds could acquire a “coercive nature,” but finding that on the facts presented “the argument as to coercion is shown to be more rhetoric than fact”).

⁴⁰⁵ *NFIB*, 132 S. Ct. 2566, 2607 (2012) (plurality opinion). The plurality continued this thought: “What Congress is not free to do is to penalize States that choose not to participate in th[e] new [Medicaid] program by taking away their existing Medicaid funding.” *Id.*

⁴⁰⁶ The plurality wrote as if this were clear from *Dole*, but the interpretation is clearer than its source. *Id.* at 2604 (“By ‘financial inducement’ the Court meant the threat of losing five percent of highway funds; no new money was offered to the States to raise their

oral arguments:⁴⁰⁷ “[The] financial ‘inducement’ Congress has chosen is much more than ‘relatively mild encouragement’ – it is a gun to the head. . . . A State that opts out of the Affordable Care Act’s expansion . . . stands to lose not merely ‘a relatively small percentage’ of its existing Medicaid funding, but *all* of it.”⁴⁰⁸

The Court’s quantitative analysis was not limited to the portion or overall amount of Medicaid funding at issue, in the abstract, but in relation to several other financial measures: the percentage of states’ budgets dedicated to Medicaid, the federal government’s expenditures on Medicaid, and the legislative and executive actions (especially funding) taken by states in pursuance of the federal program over the years. These factors in their totality supported the plurality’s determination that states are effectively “locked in” to Medicaid.⁴⁰⁹ But the conflation of financial and other considerations muddles the coercion analysis; the Court failed to indicate which of these factors is decisive for a law’s constitutional status.⁴¹⁰

NFIB’s coercion analysis suggests that some subset of federal laws may now be unconstitutionally coercive, but the quantitative analysis was heavily fact dependent.⁴¹¹ According at least to the Roberts plurality, we know that offering a large sum of money is a permissible exercise of the spending power.⁴¹² But threatening to take away an equally large sum or a large percentage of already allotted money is potentially a prohibited exercise of the spending power. We do not know how much is too much or what lies between the permitted large offer and prohibited large withdrawal alternatives. *NFIB* did not provide examples of offers that would be prohibited, but simply declared that if the

drinking ages.”).

⁴⁰⁷ Transcript of Oral Argument, *supra* note 131, at 54 (describing the threat of losing federal funds as “the gun to your head”).

⁴⁰⁸ *NFIB*, 132 S. Ct. at 2604 (plurality opinion) (quoting *Dole*, 483 U.S. at 211).

⁴⁰⁹ See Blumstein Brief, *supra* note 246, at 26 (describing the political problem of state lock-in).

⁴¹⁰ But see Bagenstos, *supra* note 349 (manuscript at 7-12) (discerning a three-part test from the plurality’s opinion).

⁴¹¹ Justice Ginsburg found the concept of coercion too ethereal to be judicially administrable. Though not using the words “political question,” she invoked *Baker v. Carr* to emphasize that courts cannot determine when states “have no choice” but to accept federal funds. *NFIB*, 132 S. Ct. at 2641 (Ginsburg, J., concurring in part and dissenting in part) (“The coercion inquiry, therefore, appears to involve political judgments that defy judicial calculation.” (citing *Baker v. Carr*, 369 U.S. 186, 217 (1962))). Nevertheless, because she agreed that the penalty for non-compliance was severable, Justice Ginsburg (and Justice Sotomayor) joined the Roberts plurality to uphold the Medicaid expansion but to limit the remedy available to the Secretary for noncompliance.

⁴¹² Justice Ginsburg confirmed this reading of the plurality opinion. See *Id.* at 2630-31 (differentiating between the constitutionally permissible making of federal grants to states and the constitutionally problematic withholding of federal funding from states).

states have “no real choice”⁴¹³ then Congress has acted impermissibly. This “choice” language comes dangerously close to Justice Stewart’s “I know it when I see it” test,⁴¹⁴ and it does nothing to define the spectrum of coercive funding conditions.

Even so, it is tempting to divine a rule from the figures and percentages that the Court referenced. For instance, the plurality’s reasoning suggests that if the federal funding constitutes more than 10% of a state’s budget (that is, 50% federal funding of a typical state’s 20% budget for Medicaid), it must be coercive.⁴¹⁵ By way of contrast, the plurality noted that the federal funds being offered in *Dole* “constituted less than half of one percent of South Dakota’s budget at that time.”⁴¹⁶ Another way of thinking about state expenditures on Medicaid, however, is based on the CBO’s estimate that compliance with the Medicaid expansion would increase state spending less than 3% over the amount states would spend absent the expansion.⁴¹⁷ Thus, any rule for evaluating coercion based on quantitative figures is highly malleable, depending on which figures are presented as well as the ways in which states can manipulate their own contributions to such spending programs. As previously noted, a large percentage of the cost of Medicaid is due to states choosing to exercise their options within Medicaid.⁴¹⁸ Moreover, even the CBO’s 3% figure was likely overstated when offset against other expected state and local savings in healthcare spending for the uninsured under the ACA.⁴¹⁹ And states could inflate the impact of the loss of federal funds by, for example, eliminating state income tax, thereby decreasing state revenue and increasing the proportion of the federal spending program in question within the state’s budget. These examples underscore the lack of certainty with a

⁴¹³ See, e.g., *id.* at 2630.

⁴¹⁴ *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964) (Stewart, J., concurring). Justice Stewart famously wrote that pornography was hard to define but that he knew it when he saw it (and the movie at issue was not pornography). *Id.* He later seemed to recognize that this standard was unworkable, joining the dissent in *Miller v. California*. See *Miller v. California*, 413 U.S. 15, 16, 37, 43-44 (1973) (Douglas, J., dissenting) (disagreeing with a criminal sentence imposed under “standards defining obscenity which until today’s decision were never the part of any law” and remarking that “[t]o send men to jail for violating standards they cannot understand, construe, and apply is a monstrous thing to do”).

⁴¹⁵ *NFIB*, 132 S. Ct. at 2581-82 (plurality opinion) (“Federal funds received through the Medicaid program have become a substantial part of state budgets, now constituting over 10 percent of most States’ total revenue. . . . If a State does not comply with the Act’s new coverage requirements, it may lose not only the federal funding for those requirements, but all of its federal Medical funds.”).

⁴¹⁶ *Id.* at 2604.

⁴¹⁷ See JANUARY ANGELES, CTR. ON BUDGET & POL’Y PRIORITIES, HOW HEALTH REFORM’S MEDICAID EXPANSION WILL IMPACT STATE BUDGETS 9 (2012), available at <http://www.cbpp.org/files/7-12-12health.pdf>.

⁴¹⁸ See *supra* Part I.B.2.

⁴¹⁹ ANGELES, *supra* note 417, at 1-2; HOLOHAN ET AL., *supra* note 170, at 6-7.

quantitative approach to defining coercion, as well as the gaming that can easily occur.

The joint dissent's focus on approximated figures, like the plurality's attention to financial statistics, suggested a brighter-line coercion rule than the Court actually announced. Like the plurality, the joint dissent focused on various quantitative measures, including the amount of money the federal government offers, the amount of money the states stand to lose, and the percentage of funding that is at stake. The dissent also pondered the proportion of states' budgets that would be affected by creating state-financed Medicaid-equivalent programs⁴²⁰ and the percentage of total state expenditures that amount would represent.⁴²¹ The dissent concluded, without explaining its calculations, that "the annual federal Medicaid subsidy is equal to more than one-fifth of the State's expenditures" and based the remainder of its coercion analysis on that figure.⁴²² Further, the dissent noted that this amount would be in addition to the federal taxes that state citizens have to pay to support Medicaid programs in other states.⁴²³ The analysis has a quantitative veneer, but neither Congress nor a lower court could possibly glean from either the plurality or the joint dissent which numbers actually point to unconstitutional coercion. Because *Marks v. United States* tells us that the narrowest rule is the precedent that should be followed from a plurality opinion,⁴²⁴ the additional quantitative factors from the dissent should be ignored. But future cases may bring the plurality and dissent back into alignment, forcing consideration of the broader view in the dissent.

b. *Qualitative Coercion: Political Accountability*

Another way of articulating *NFIB*'s coercion discussion is to consider the federalism value of political accountability. The coercion discussion was a striking continuation of the Federalism Revolution. Analogizing to *New York* and *Printz*, Chief Justice Roberts wrote: "Permitting the Federal Government to force the States to implement a federal program would threaten the political

⁴²⁰ *NFIB*, 132 S. Ct. at 2657 & n.7 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting).

⁴²¹ *Id.* at 2664 ("[T]he Federal Government has threatened to withhold 42.3% of all federal outlays to the states, or approximately \$233 billion.").

⁴²² *Id.* at 2657.

⁴²³ *Id.* ("A State forced out of the program would not only lose this huge sum but would almost certainly find it necessary to increase its own health-care expenditures substantially, requiring either a drastic reduction in funding for other programs or a large increase in state taxes. And these new taxes would come on top of the federal taxes already paid by the State's citizens to fund the Medicaid program in other States.").

⁴²⁴ *Marks v. United States*, 430 U.S. 188, 193 (1977) ("When a fragmented Court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgments on the narrowest grounds . . .'" (quoting *Gregg v. Georgia*, 428 U.S. 153, 169 n.15 (1976))).

accountability key to our federal system.”⁴²⁵ He added that when states have a real choice about whether to accept federal conditional funding, state officials may fairly be held politically accountable for their decisions.⁴²⁶ But when there is no choice, the federal government accomplishes its policy objectives without being held politically accountable.⁴²⁷

Political accountability has been a remarkably consistent and central concept in decisions limiting congressional authority under the Tenth Amendment.⁴²⁸ Neither the phrase “political accountability” nor prior decisions advancing that theme, however, provide a framework for understanding how future coercion claims might play out.⁴²⁹ It is not a coherent federalism principle, and despite articulating a reason to avoid coercion, it creates no cognizable rule for lower federal courts, let alone Congress, to follow.⁴³⁰ The fact that “political accountability” is often used interchangeably with “local democracy” further increases the confusion as “local democracy” is not a legal concept but a

⁴²⁵ *NFIB*, 132 S. Ct. at 2602-03 (plurality opinion) (“[W]hen the State has no choice, the Federal Government can achieve its objectives without accountability, just as in *New York* and *Printz*.”). See generally *Printz v. United States*, 521 U.S. 898 (1997); *New York v. United States*, 505 U.S. 144, 169 (1992). Quoting *New York*, the plurality continued: “[W]here the Federal Government directs the States to regulate, it may be state officials who will bear the brunt of public disapproval, while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision.” *NFIB*, 132 S. Ct. at 2603 (plurality opinion) (quoting *New York*, 505 U.S. at 169).

⁴²⁶ *NFIB*, 132 S. Ct. at 2602-03 (plurality opinion). The joint dissent also adopted this reasoning. See *id.* at 2660 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) (“Where all Congress has done is to ‘encourag[e] state regulation rather than compe[l] it, state governments remain responsive to the local electorate’s preferences; state officials remain accountable to the people. . . .’” (quoting *New York*, 505 U.S. at 168)).

⁴²⁷ *Id.* at 2603 (plurality opinion).

⁴²⁸ Curiously, the plurality did not cite the Tenth Amendment except to introduce the discussion of congressional authority, even though it relied heavily on precedent that enforced the Tenth Amendment as a limit on congressional authority. Chief Justice Roberts paradoxically wrote: “The States are separate and independent sovereigns. Sometimes they have to act like it.” *Id.* This almost sounds like Chief Justice Roberts is unwilling to mediate between the federal government and the states except in certain circumstances.

⁴²⁹ See, e.g., *Fed. Energy Regulatory Comm’n v. Mississippi*, 456 U.S. 742, 775-97 (1982) (O’Connor, J., concurring in part and dissenting in part) (relying in part on “political accountability” to argue that the Public Utility Regulatory Policies Act should have been held unconstitutional in part). Foreshadowing *New York v. United States*, Justice O’Connor wrote: “Congressional compulsion of state agencies, unlike preemption, blurs the lines of political accountability and leaves citizens feeling that their representatives are no longer responsive to local needs.” *Id.* at 787.

⁴³⁰ For a deconstruction of judicially enforced federalism, see MALCOLM M. FEELEY & EDWARD RUBIN, *FEDERALISM: POLITICAL IDENTITY AND TRAGIC COMPROMISE* 139-43 (2008) (observing “sources of incoherence” in the Court’s “commandeering doctrine and Tenth Amendment cases”).

political one.⁴³¹ While it is important for voters to know which level of government is responsible for both popular and unpopular policy, this does not inform which level of government is responsible for creating or maintaining a particular policy, which is the real question for federalism purposes.

The political accountability trope contains two glaring problems, represented by the political climate surrounding passage of the ACA and the remedy adopted by the Court. First, the political accountability narrative is not borne out by these facts. If Congress was attempting to shield itself and force states to take responsibility for Medicaid expansion, then 100% federal funding through “ObamaCare” would seem to be an odd way to hide from voters. By fully funding the Medicaid expansion in the most visible health-policy legislation in a generation, the federal government took complete leadership responsibility. As Justice Ginsburg noted with substantial understatement, the federal role in Medicaid is “hardly hidden from view.”⁴³²

Second, the political-accountability narrative does not resonate in the ultimate remedy of allowing states to opt in or out of Medicaid expansion. In the States’ Brief and the joint dissent, much was made of the “divisive dynamic”⁴³³ that would occur if citizens in opting-out states paid federal taxes to support Medicaid expansion for citizens in opting-in states.⁴³⁴ The argument hinges on the fact that all state citizens are necessarily federal taxpayers and the implicit assumption that citizens should garner some direct benefit from the amount of taxes they pay.⁴³⁵ The point was raised in the context of coercion,⁴³⁶

⁴³¹ Political accountability has been described as the “‘answerability’ of representatives to the represented.” D. Bruce La Pierre, *Political Accountability in the National Political Process – The Alternative to Judicial Review of Federalism Issues*, 80 NW. U. L. REV. 557, 640 (1985). It has also been defined as the ability of constituents “to influence the political process that produces their representatives and governing legislation,” which depends upon the “‘connection between the representative and the represented.’” Robert A. Hammeke, Note, *State Autonomy Implications for Congressional Conditional Spending*, 24 OKLA. CITY U. L. REV. 349, 355 (1999) (quoting Lewis B. Kaden, *Politics, Money, and State Sovereignty: The Judicial Role*, 79 COLUM. L. REV. 847, 856 (1979)).

⁴³² *NFIB*, 132 S. Ct. at 2633 n.17 (Ginsburg, J., concurring in part and dissenting in part).

⁴³³ *Id.* at 2667 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting); see also *id.* at 2657 (plurality opinion) (concluding that a state that chooses to opt out of the Medicaid expansion would be forced to greatly increase state taxes to supplement lost federal funding even as state citizens were still forced to pay federal taxes to support the expansion in other states).

⁴³⁴ Brief of State Petitioners on Medicaid, *supra* note 196, at 43 (“Were a State to refuse to comply with Congress’ conditions, ‘federal taxpayers in [that State] would be deprived of the benefits of a return from the federal government to the state of a significant amount of the federal tax monies collected.’” (alteration in original) (quoting *Jim C. v. United States*, 235 F.3d 1079, 1083 (8th Cir. 2000))).

⁴³⁵ See generally Brian Galle, *Does Federal Spending “Coerce” States?: Evidence from State Budgets*, 108 NW. U. L. REV. (forthcoming 2013) (providing empirical evidence disproving that federal taxation crowds-out states’ ability to tax their citizens).

⁴³⁶ Brief of State Petitioners on Medicaid, *supra* note 196, at 43 (“[The] practical ability

but is arguably relevant to political accountability as well. At oral argument, Justice Kagan asked Mr. Clement whether it would be coercive if the federal government offered to pay for 100% of the costs to expand Medicaid.⁴³⁷ He insisted it would be,⁴³⁸ for one reason: federal taxes are raised from a state's own citizens.⁴³⁹ Mr. Clement's suggestion was that putting states to the difficult choice of having their citizens pay federal taxes to support Medicaid, while garnering a benefit to the state in terms of federal Medicaid dollars, versus paying the same taxes and receiving nothing in return, was unconstitutionally coercive. This linking of taxation and benefit evokes a political-accountability theme, and a line of argument that the States did not pursue. First, the States failed to acknowledge the controlling force of the Sixteenth Amendment, which authorizes the federal income tax on individual citizens of states.⁴⁴⁰ Second, the argument would prove too much, suggesting that any federally funded conditional spending program that gives states a choice to participate or not would be coercive. Third, *NFIB* allowed states to opt out of the Medicaid expansion, with the clear consequences of that option being loss of national redistribution of federal taxes and local responsibility for medical welfare.⁴⁴¹ The states become politically accountable for their own taxation policy choices, but this is not what "political accountability" generally means in the federalism context.

to ask residents, already taxed by the federal government to provide health insurance elsewhere, to contribute additional taxes to supplant the declined federal program is all but nil."); Reply Brief of State Petitioners on Medicaid at 1-2, *Florida v. Dep't of Health & Human Servs.*, 132 S. Ct. 2566 (2012) (No. 11-400) ("Nor does the federal government even try to explain how a State could possibly reject new terms attached to billions of dollars of pre-existing funds . . . particularly when that would mean forfeiting not only all of the tax dollars already being collected from its residents to fund Medicaid, but also billions in new federal spending that the ACA creates. . . . If the federal government can coerce States to administer federal programs, by threatening to withhold billions of dollars extracted from in-State taxpayers, then very little is left of the anti-commandeering doctrine.").

⁴³⁷ Transcript of Oral Argument, *supra* note 131, at 3-6. Justice Alito questioned Solicitor General Verrilli on similar grounds. *Id.* at 45-47.

⁴³⁸ *Id.* at 3-6.

⁴³⁹ *Id.* at 5-6. Actually, federal taxes are raised from citizens of the United States, who also happen to be citizens or residents of various states.

⁴⁴⁰ U.S. CONST. amend. XVI. At oral arguments, Justice Sotomayor asked whether this line of argument was a limit on the federal power to tax. Mr. Clement conceded that it was not. Transcript of Oral Argument, *supra* note 131, at 6-7.

⁴⁴¹ Justice Sotomayor noted at oral arguments that Florida, the lead plaintiff, receives more in federal benefits than its residents pay in federal taxes. Mr. Clement responded: "Well, then I'll make that argument on behalf of Texas." Transcript of Oral Argument, *supra* note 131, at 36.

c. *Coercion in Fact*

The joint dissent's spending-power analysis helps only slightly in deciphering coercion, and it was more extreme in its views than the plurality. At the outset, the joint dissent questioned the long-settled decision in *Butler*, which interpreted the Spending Clause as a source of federal authority separate from Congress's other enumerated powers. Grudgingly, however, the dissent accepted that the Hamiltonian view, as espoused in *Butler*, was settled law.⁴⁴² The joint dissent also relied heavily on Justice Kennedy's dissent in *Davis v. Monroe County Board of Education*, a 1999 decision in which Kennedy articulated a desire to limit congressional spending by using federalism principles.⁴⁴³ The *NFIB* joint dissent's reliance on a prior dissent amounts to double dicta – a non-binding opinion citing another non-binding opinion. Still, it provides insight into the direction the Court may take in cases involving the spending power and the coercion doctrine.

Like the plurality, the joint dissent refused to create a rule for coercion, instead simply concluding that "Congress effectively engages in this impermissible compulsion when state participation in a federal spending program is coerced, so that the States' choice whether to enact or administer a federal regulatory program is rendered illusory."⁴⁴⁴ The dissent seems to have satisfied itself by declaring that a law must be "coercive in fact" (as opposed to in theory).⁴⁴⁵ But the distinction between fact and theory is meaningless if coercion remains undefined.⁴⁴⁶ The joint dissent acknowledged that it effectively created no standard for courts to follow, writing: "The question whether a law enacted under the spending power is coercive in fact will sometimes be difficult, but where Congress has plainly 'crossed the line distinguishing encouragement from coercion,' a federal program that coopts the States' political processes must be declared unconstitutional."⁴⁴⁷

The greatest irony of the dissent's "coercion in fact" analysis is how badly wrong it got the facts on Medicaid.⁴⁴⁸ Despite that fundamental

⁴⁴² *NFIB*, 132 S. Ct. 2566, 2657-58 (2012) (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) (citing *United States v. Butler*, 297 U.S. 1, 65 (1937)).

⁴⁴³ See *id.* at 2659 (citing *Davis v. Monroe Cnty. Bd. of Educ.*, 526 U.S. 629, 654 (1999) (Kennedy, J., dissenting)).

⁴⁴⁴ *Id.* at 2660.

⁴⁴⁵ *Id.* at 2661.

⁴⁴⁶ *Id.* at 2661 ("Once it is recognized that spending power legislation cannot coerce state participation, two questions remain: (1) What is the meaning of coercion in this context? (2) Is the ACA's expanded coverage coercive?"). For an attempt to define coercion in ethical theory, see Cohen, *supra* note 32.

⁴⁴⁷ *NFIB*, 132 S. Ct. at 2661 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) (citation omitted) (quoting *New York v. United States*, 505 U.S. 144, 175 (1992)).

⁴⁴⁸ For a factual discussion of Medicaid's history, see *supra* Part I. The joint dissent reiterated its proposed non-rule only a page after articulating it, writing: "Whether federal spending legislation crosses the line from enticement to coercion is often difficult to

misunderstanding of the program, the joint dissent suggests a preference for case-by-case resolution of coercion challenges; in essence, as-applied rather than facial challenges. Under this approach, the Court should recognize that each state has different financial circumstances and priorities, which Medicaid amply illustrates. Accordingly, a federal spending program deemed coercive in Mississippi perhaps could be perfectly acceptable in Massachusetts. Of course, politicians within a state may disagree as to whether a particular piece of spending legislation is beneficial or coercive; this conflict was seen in the amicus briefs submitted on the Medicaid expansion.⁴⁴⁹ But seven members of the Court were unwilling to wait for an as-applied challenge, instead hearing a facial challenge to a statute that would not take effect until January 1, 2014. This anomaly between the dissent's stated preference for as-applied challenges and the Court's willingness to hear a facial challenge to Medicaid expansion was never explained. Moreover, the Court provided no theory, test, or set of factors to guide lower courts hearing either facial or as-applied challenges to exercises of the spending power.

The difficulty distinguishing between as-applied and facial challenges to federal spending programs is more than merely hypothetical. Lower courts have previously struggled with this precise issue in the context of § 1396c and Medicaid. For example, in *West Virginia v. United States Department of Health & Human Services*, the State challenged new cost-recovery provisions in Medicaid, claiming, "thirty years later [] Congress changed the rules of the game."⁴⁵⁰ The State asserted that loss of Medicaid funds would have caused West Virginia's healthcare system to "effectively collapse."⁴⁵¹ But the Fourth Circuit found no unconstitutional coercion. The key point was § 1396c, which grants *discretion* to the Secretary for dealing with state noncompliance with federal Medicaid rules by withholding all, or some unspecified portion, of federal funding.⁴⁵² In the view of the Fourth Circuit, "[t]his small difference in language makes all the difference in our analysis."⁴⁵³ Because the federal government had not threatened to withhold all funding, the penalty was merely

determine, and courts should not conclude that legislation is unconstitutional on this ground unless the coercive nature of an offer is unmistakably clear." *NFIB*, 132 S. Ct. at 2662 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting).

⁴⁴⁹ See, e.g., Brief of the State of Oregon et al. as Amici Curiae in Support of Respondents at 9-30, *Florida v. Dep't of Health & Human Servs.* 132 S. Ct. 2566 (2012) (No. 11-400) (explaining the benefit of the Medicaid expansion to the states and representing differences of opinion within some states).

⁴⁵⁰ *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 287 (4th Cir. 2002).

⁴⁵¹ *Id.*

⁴⁵² *Id.* at 292 (citing 42 U.S.C. § 1396c (2006)).

⁴⁵³ *Id.*

“hypothetical,” leading the Court to conclude that West Virginia was “mounting a facial challenge to the constitutionality” of the statute.⁴⁵⁴

The danger of the judicially enforced, fact-specific coercion theory is not only that it may affect a host of established cooperative-federalism programs for education, welfare, environmental protection, and highway infrastructure, to name a few, but also that we still do not know what coercion is. *NFIB*, which applied the coercion doctrine to a set of facts, provides no greater clarity than *Butler* and *Dole*, which flagged coercion as an issue but declined to apply it to the facts at hand. Both the Roberts plurality and the joint dissent expressly declined to articulate any sort of test, instead merely providing nomenclature: the “anticoercion rule.”⁴⁵⁵ The dissent’s formula was simply: “[I]f States really have no choice other than to accept the package, the offer is coercive, and the conditions cannot be sustained under the spending power.”⁴⁵⁶ Perhaps the dissent acknowledged the ambiguity in its invitation for coercion litigation by stating, at least twice, that determining the difference between influence and coercion is “difficult.”⁴⁵⁷

In lieu of a satisfactory test for “coercion in fact,” the plurality and joint dissent offered alarmist slogans. Chief Justice Roberts described the Medicaid expansion vividly as “a gun to the head” and “economic dragooning,”⁴⁵⁸ continuing the bizarre references to “dragooning” that began with *Printz*.⁴⁵⁹ Both phrases are inappropriately incendiary. Historically, “dragoons” were French monarchist cavalry units⁴⁶⁰ who destroyed Huguenot churches and closed Protestant schools, leading to the revocation of the Edict of Nantes in October 1685.⁴⁶¹ Dragoons destroyed religious freedom and drove hundreds of

⁴⁵⁴ *Id.*

⁴⁵⁵ *NFIB*, 132 S. Ct. 2566, 2662 (2012) (Scalia, Kennedy, Thomas & Alito, JJ., dissenting). While not using the same nomenclature, the plurality affirmed the same idea, insisting there was “no need to fix a line” defining coercion. *Id.* at 2606 (plurality opinion).

⁴⁵⁶ *Id.* at 2661 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting).

⁴⁵⁷ *Id.* at 2661-62.

⁴⁵⁸ *Id.* at 2604-05 (plurality opinion).

⁴⁵⁹ *Printz v. United States*, 521 U.S. 898, 928 (1997) (adopting the rhetoric of dragooning from a dissenting opinion in the court below and using it to describe the federal government’s perceived derogation of state autonomy, forcing states to “administer[] federal law”).

⁴⁶⁰ Keith P. Luria, *Conversion and Coercion: Personal Conscience and Political Conformity in Early Modern France*, 12 *MEDIEVAL HIST. J.* 221, 224-25 (2009) (“[Dragoons] were lodged in Huguenot houses and given free rein to brutalise their hosts into submission. Huguenots who did not convert had to pay heavy taxes and faced financial ruin. The dragoons worked in tandem with the Catholic clergy, who received the beleaguered neophytes’ abjurations.”)

⁴⁶¹ *Id.* at 225 (“In 1685, the royal government unleashed a new and more widespread dragonnade By October 1685, [King] Louis could claim so many Huguenots had converted that their community had essentially ceased to exist and the Edict of Nantes was no longer necessary. He revoked it”). The Edict of Nantes had been promulgated in

thousands of religious dissenters from France, without democratic legitimacy or due process of law.⁴⁶² Comparing the Medicaid expansion to “dragooning” demonstrates either an ignorance of the historical context from which the term arises or a profound misunderstanding of the program, neither of which contributes to clear constitutional guidelines. As for the “gun to the head,” this image casts the federal government as a violent criminal, threatening coldly to “shoot” unless the state/victim complies.⁴⁶³ Ironically, the only lives actually threatened will be those cut off from Medicaid as a result of choices made by states.

3. Severability After Unconstitutional Coercion

For the Minimum Coverage Provision, severability was a major issue briefed and decided in the courts below, with splits among the circuits. The Court gave the issue prominence, with separate time for oral arguments and Court-appointed amici. By comparison, the question of Medicaid severability appears to have caught nearly everyone by surprise.⁴⁶⁴ No court below had found the Medicaid expansion to be unconstitutional, so there was no prior decision on the remedial issue. Even when the Court granted certiorari, the question presented on severability focused exclusively on the Minimum Coverage Provision.⁴⁶⁵

The first substantive discussion of Medicaid severability appeared in a single paragraph in the United States’ brief,⁴⁶⁶ filed on February 10, 2012, followed by more robust discussion in amicus briefs filed a week later.⁴⁶⁷ The

1598 to ensure religious freedom for the Protestant Huguenots in Catholic France. *Id.* at 224.

⁴⁶² *Id.* at 225 (stating that more than 39,000 Huguenots abjured their Protestant beliefs based on the dragoons’ persecution).

⁴⁶³ For another, similar analogy from the oral argument, see Transcript of Oral Argument, *supra* note 131, at 31-32 (Justice Scalia comparing “your money or your life” with “your life or your wife’s”).

⁴⁶⁴ Except, that is, for those of us following the issue closely. See, e.g., Health Law Brief, *supra* note 14, at 38-41.

⁴⁶⁵ *Florida v. Dep’t of Health & Human Servs.*, 132 S. Ct. 604 (2012) (mem.). Counsel for Respondents’ amici informally discussed whether it was even proper to raise the issue, given the language of the Court’s order granting certiorari.

⁴⁶⁶ Brief for Respondents, *supra* note 129, at 52-53 (“There is no basis to believe that Congress would have preferred no Medicaid eligibility extension at all to an eligibility extension that applies only to consenting States.”).

⁴⁶⁷ See, e.g., Brief for Amici Curiae American Medical Student Association et al. in Support of the United States on Severability at 16-19, *Florida v. HHS*, 132 S. Ct. 2566 (No. 11-400) (“Because Congress expressly stated which provisions it might not have enacted if it could not have also enacted a minimum coverage provision, that express statement of legislative intent must define the outer limits of this Court’s severability inquiry.”); Health Law Brief, *supra* note 14, at 29-41 (analyzing petitioners’ arguments concerning the Medicaid Amendments); National Health Law Brief, *supra* note 130, at 4-34 (discussing

Court ultimately adopted these points as the basis of their formal decision on Medicaid severability. By contrast, the States' briefs and their amici had little to say on the subject, other than a passing mention in a footnote.⁴⁶⁸ But at the end of the oral arguments, after the allotted time had expired, Justice Ginsburg posed a remarkable question to Mr. Clement, proposing to preserve the Medicaid expansion by giving states the choice to opt out.⁴⁶⁹ Clement was amenable to the suggestion, agreeing that his clients would be "certainly happy" with that result.⁴⁷⁰ Five Justices, including Justice Ginsburg and Chief Justice Roberts, ultimately adopted this approach.

But we cannot expect and, for reasons explained below, might not welcome similar concessions in future litigation. The narrow remedy adopted by the Roberts plurality and the Ginsburg opinion creates a host of unintended consequences for Medicaid and ACA implementation.⁴⁷¹ First, this Article offers some preliminary thoughts on the effect of severability after a finding of unconstitutional coercion under the spending power. Second, it describes two of the many implementation challenges the Court's severability decision creates.

In many respects, the narrow remedy adopted by the five Justices reflects the particular context of *NFIB*, which was a pathbreaking case that carried significant political baggage. These features may have induced the majority to

whether the Medicaid Provision impermissibly coerces states into a Medicaid partnership).

⁴⁶⁸ Brief of State Petitioners on Medicaid, *supra* note 196, at 54 n.18. This was due, in part, to how the Court structured the briefing and oral arguments, giving prominence to the severability issue under the Commerce Clause challenge, but failing to mention it in the context of Medicaid coercion.

⁴⁶⁹ The exchange was as follows:

JUSTICE GINSBURG: Mr. Clement, may I ask one question about the bottom line in this case? It sounds to me like everything you said would be to the effect of, if Congress continued to do things on a voluntary basis, so we are getting these new eligibles, and say, States, you can have it or not, you can preserve the program as it existed before, you can opt into this.

But you are not asking the Court as relief to say . . . that's how we cure the constitutional infirmity; we say this has to be on a voluntary basis. . . .

MR. CLEMENT: Well, Justice Ginsburg, if we can start with the common ground that there is a need for repair because there is a coercion doctrine and this statute is coercion, then we are into the question of remedy. And . . . we do take the position that you describe in the remedy, but we would be certainly happy if we got something here, and we got a recognition that the coercion doctrine exists; this is coercive; and we get the remedy that you suggest in the alternative.

Transcript of Oral Argument, *supra* note 131, at 84-85.

⁴⁷⁰ *Id.* at 85.

⁴⁷¹ For a review of the ACA implementation challenges in the states before the *NFIB* decision, see U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-281, MEDICAID EXPANSION: STATES' IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 17-27 (2012) (describing how states are addressing changes that must be made to their existing Medicaid programs and dealing with "implementation challenges").

choose a more conciliatory approach when it came to the remedy. One commentator has gone so far as to call this decision a “*Marbury* for our time.”⁴⁷² Chief Justice Roberts’ severability analysis, like his salvaging of the Minimum Coverage Provision under the taxing power, suggests a political judgment regarding the case, asserting that “[w]e are confident that Congress would have wanted to preserve the rest of the Act.”⁴⁷³ This assessment notably conflicts with the plurality’s lack of deference to Congress elsewhere in the opinion, including the Court’s conclusion that the ACA did not simply amend Medicaid but created an entirely new conditional spending program.⁴⁷⁴ The Court similarly refused to give controlling weight to Congress’s characterization of the individual mandate as a penalty, not a tax.⁴⁷⁵ The compulsion to preserve the ACA, it seems, was more a perception of political will than a judicial finding.

Other lines of reasoning underlying the plurality’s severability analysis are specific to the facts of the case, suggesting that the decision was influenced by the political context, rather than more generally applicable legal reasoning. For example, the plurality relied on § 1303, the severability clause present in the SSA since 1935, but was unclear as to whether § 1303 was determinative of, or merely helpful to, the ultimate decision. Congress surely did not include a severability clause in the SSA for the purpose of providing a remedy for successful coercion challenges to spending power programs. But it is not difficult to imagine future decisions in which the Court holds Congress to a legislative drafting standard that could not have been known at the time a law was written.⁴⁷⁶

Ironically, the mischaracterization of Medicaid into “old” and “new” programs helped preserve the ACA from being struck down in its entirety because the severed provision, § 1396c, was part of the “old” Medicaid Act. But as a matter of statutory interpretation, the Court inexplicably deemed the Medicaid expansion part of the Medicaid Act for the statutory severability remedy, but not for purposes of the constitutionality of the Medicaid expansion. This interpretive paradox is more baffling given that the plurality expressly deferred to Congress in narrowly applying the severability remedy to the Secretary’s authority in administering Medicaid but did not defer in

⁴⁷² Brad Joondeph, *A Marbury for Our Time*, ACA LITIGATION BLOG (June 28, 2012, 10:04 AM), <http://acalitigationblog.blogspot.com/2012/06/marbury-for-our-time.html>.

⁴⁷³ *NFIB*, 132 S. Ct. 2566, 2608 (2012) (plurality opinion).

⁴⁷⁴ *Id.* at 2605 (rejecting the Government’s claim that “the Medicaid expansion is properly viewed merely as a modification of the existing program”).

⁴⁷⁵ *Id.* at 2597 (dismissing the joint dissent’s argument that “we cannot uphold [the individual mandate] as a tax because Congress did not ‘frame’ it as such”).

⁴⁷⁶ *See, e.g., United States v. Morrison*, 529 U.S. 598, 608-17 (2000) (holding elements of the Violence Against Women Act (VAWA) to be outside Congress’s Commerce Clause authority as delineated in *United States v. Lopez*, a decision announced after VAWA was passed).

determining that “new” Medicaid was unconstitutionally coercive.⁴⁷⁷ Indeed, the severability provision the Court relied on for the Medicaid remedy, § 1303, dates to the original SSA and is even older than the Medicaid Act.

Additionally, the plurality opinion raised some troubling severability questions external to the facts of this case. The first is the relationship between severability jurisprudence generally and severability in the specific context of unconstitutional coercion. While the severability issue was briefed and argued extensively for the Minimum Coverage Provision challenge, the plurality’s severability analysis for the Medicaid issue was relatively thin.⁴⁷⁸ We do not know if the plurality’s decision establishes new standards for severability of congressional statutes or a more limited holding specific to the issue of coercion under conditional spending statutes.

Second, in our Brief of Amici Curiae Health Law & Policy Scholars and Prescription Policy Choices in Support of Respondents on the Constitutional Validity of the Medicaid Expansion in *Florida v. Department of Health and Human Services*,⁴⁷⁹ we suggested a federalism rationale for a narrow view of severability in the event the Court found unconstitutional coercion.⁴⁸⁰ As observed, each state has different financial circumstances, so a federal spending program deemed coercive in Mississippi could be perfectly acceptable in Massachusetts.⁴⁸¹ But as previously explained, that approach seems consistent with the dissent’s preferred coercion-in-fact approach.⁴⁸² Put another way, why insist that all fifty states have been coerced when only twenty-six chose to sue? If a state’s political leadership deems itself coerced, the state can opt out. The narrow severability remedy bypasses subjective judicial judgments and allows the revealed preferences of each state to determine whether it has in fact felt coerced. By contrast, a holding that strikes down a conditional spending program as unconstitutional mutes states’ ability to express their support for, or objection to, the federal program. The Red State Option might be federalism’s preferred remedy as opposed to mere political expediency.

Third, the Court’s narrowly crafted remedy, as opposed to the joint dissent’s argument to strike down the entire ACA, highlights the uncertainty over whether *NFIB* was a facial challenge. The Roberts plurality ignored the issue of facial versus as-applied challenges, despite briefing and oral arguments

⁴⁷⁷ See *NFIB*, 132 S. Ct. at 2607 (plurality opinion) (“Our ‘touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature.’” (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006))).

⁴⁷⁸ For a summary of the severability briefs, see Outtersson, *supra* note 14.

⁴⁷⁹ See Health Law Brief, *supra* note 14.

⁴⁸⁰ *Id.* at 38-41.

⁴⁸¹ See, e.g., Brief of the State of Oregon et al. as Amici Curiae in Support of Respondents, *supra* note 449, at 9-14.

⁴⁸² See *supra* Part III.B.2.c.

clarifying that the Secretary had not threatened to withhold all Medicaid funding from any litigant state.⁴⁸³ Instead, at oral argument the Chief Justice focused on the worst-case hypothetical, i.e., the Secretary directly threatening to cut off all Medicaid funds, while Solicitor General Verrilli did little to dissuade him.⁴⁸⁴ Justice Breyer tried to throw the Solicitor General a bone, noting the Secretary's administrative discretion under § 1396c and the Administrative Procedure Act, but Solicitor General Verrilli did not pick it up.⁴⁸⁵ Perhaps Justice Breyer was looking for a commitment that the Secretary would never actually cut off all existing Medicaid funds, given the strong commitment of the federal government to delivering health insurance and health care to Americans in need.⁴⁸⁶ Alternatively, Justice Breyer suggested at oral argument that the Administrative Procedure Act might cabin the Secretary's discretion and provide an avenue for judicial review.⁴⁸⁷ Justice

⁴⁸³ See, e.g., Health Law Brief, *supra* note 14, at 21.

⁴⁸⁴ The discussion was as follows:

CHIEF JUSTICE ROBERTS: Well, but that's just saying that when, you know, the analogy that has been used, the gun to your head, "your money or your life," you say, well, there's no evidence that anyone has ever been shot.

GENERAL VERRILLI: But –

CHIEF JUSTICE ROBERTS: Well, it's because you have to give up your wallet. You don't have a choice.

GENERAL VERRILLI: But that –

CHIEF JUSTICE ROBERTS: And you cannot – you cannot represent that the Secretary has never said: And if you don't do it, we are going to take away all the funds.

They cite the Arizona example; I suspect there are others, because that is the leverage.

Transcript of Oral Argument, *supra* note 131, at 54-55.

⁴⁸⁵ The discussion was as follows:

JUSTICE BREYER: I don't know if that's so. And all I asked in my question was I didn't ask you to commit the Secretary to anything. I wanted to know what the facts are.

GENERAL VERRILLI: I –

JUSTICE BREYER: I wanted to know what you found in researching this case. I wanted you, in other words, to answer the question the Chief Justice has: Is it a common thing, that that happens, that this unrelated threat is made? Or isn't it?

GENERAL VERRILLI: It's – my understanding is that these situations are usually worked out back and forth between the States and the Federal Government. And I think that most –

JUSTICE BREYER: And you are not privy to what those are.

GENERAL VERRILLI: And I'm not. But –

JUSTICE SCALIA: And who wins?

Id. at 55-56.

⁴⁸⁶ In the realm of politics, one can imagine the difficulties faced by any Secretary of HHS who actually cut off all funds. Practically speaking, the Secretary would generally be "coerced" into negotiating a settlement with a wayward state.

⁴⁸⁷ Transcript of Oral Argument, *supra* note 131, at 13-14.

Scalia teased Justice Breyer about the suggestion,⁴⁸⁸ and no mention of these ideas appears in the decision.

In the near future, a federal court may be called upon to consider severability after deeming a congressional enactment unconstitutionally coercive. If so, the foregoing discussion will hopefully provide a useful set of proceed-with-caution signs through this novel territory, especially since the Court has left so much of it unmarked.

IV. MEDICAID AND THE EXCHANGES AFTER *NFIB*

This final Part briefly explores challenges to the future of Medicaid which have been created by the decision in *NFIB*. Even this exceedingly narrow severability opinion left many unanswered Medicaid questions.⁴⁸⁹ Primarily, two categories of questions arise: those concerning the uncertain scope of Medicaid severability and those concerning tax credits in the exchanges created pursuant to the ACA.

A. *The Uncertain Scope of Medicaid Severability*

The severability holding seems straightforward: the Secretary simply cannot use § 1396c to withhold existing Medicaid funds for a state's failure to adopt the Medicaid expansion. What is unclear, however, is the precise antecedent. What exactly was the "Medicaid expansion" which is now optional?⁴⁹⁰ This question is surprisingly difficult. This Article sorts all of the new Medicaid provisions⁴⁹¹ into three categories: (1) provisions clearly excluded from the coercion analysis, and therefore still mandatory for all states; (2) provisions clearly included in the coercion analysis, and therefore optional for any state; and (3) other Medicaid provisions, for which it is contestable whether they are now optional.

⁴⁸⁸ *Id.* at 62-63.

⁴⁸⁹ See Rosenbaum & Westmoreland, *supra* note 14, 1667-70 (describing the questions surrounding application of the *NFIB* opinion and its impact on Medicaid).

⁴⁹⁰ This Article limits this analysis to the new provisions of Medicaid added by the ACA. States are still responsible for following all pre-ACA requirements, such as due process when coverage or care is denied. 42 U.S.C. § 1396a(a)(3) (2006); see also JANE PERKINS, NAT'L HEALTH LAW PROGRAM, FACT SHEET: THE SUPREME COURT'S ACA DECISION & ITS IMPLICATIONS FOR MEDICAID 8 (2012), available at http://www.healthlaw.org/images/stories/ACA_July_2012_Fact_Sheet.pdf ("[B]eneficiaries covered through the Medicaid expansion will be protected by provisions requiring medical assistance to be provided with reasonable promptness and due process to be accorded where assistance is denied, reduced, or terminated." (citations omitted)).

⁴⁹¹ The Eleventh Circuit opinion lists the Medicaid provisions relevant to the litigation. See *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1261 (11th Cir. 2011) (enumerating elements of Medicaid expansion under the ACA); *id.* at 1367-68 (Marcus, J., concurring in part and dissenting in part) (same). Most of these provisions are never described as coercive by Chief Justice Roberts in *NFIB*.

First, most of the new Medicaid provisions were never challenged in *NFIB*. Examples include enhanced reimbursement for primary care doctors in Medicaid,⁴⁹² changes to the Medicaid drug-rebate rules for new formulations of existing drugs,⁴⁹³ and expansion of Medicaid coverage starting in 2019 for former foster-care children.⁴⁹⁴ Other new Medicaid provisions were discussed by the States in their complaint and briefing or by their amici, but were entirely absent from the Court's coercion analysis. Examples include the five percent "income disregard" adjustment to the calculation of "modified adjusted gross income" for income eligibility purposes,⁴⁹⁵ and section 2304 of the ACA ("Clarification of Definition of Medical Assistance"). Section 2304 was attacked by the States in their initial brief,⁴⁹⁶ but this line of argument was dropped from discussion after our Health Law and Policy Scholars' brief highlighted textual and factual errors in the States' selective reading of the statute.⁴⁹⁷ The great majority of the new Medicaid provisions fall into this category of provisions unaffected by the Court's coercion decision.

⁴⁹² Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1202(a)(1), 124 Stat. 1029, 1052-53 (codified at 42 U.S.C. § 1396a(a)(13), (jj) (Supp. IV 2011)) (adding additional amendments and reconciliation provisions to § 1396a, as previously amended by section 2303(a)(2) of the Patient Protection and Affordable Care Act).

⁴⁹³ *Id.* § 1206 (amending 42 U.S.C. § 1396r-8(c)(2)) (originally enacted as Patient Protection and Affordable Care Act § 2501(d)).

⁴⁹⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 2004, 10201, 124 Stat. 119, 283, 917-23 (2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)) (adding a ninth mandatory eligibility category, effective January 1, 2019).

⁴⁹⁵ *Id.* § 2002 (amending 42 U.S.C. 1396a(e) (2006)); *see also* Brief of State Petitioners on Medicaid, *supra* note 196, at 7 (briefing the "income disregard" provisions as potentially coercive). The Center for Constitutional Jurisprudence, writing as amici for the States, gave the "income disregard" provision more prominence, attacking it as an example of "total subversion." Brief of Amici Curiae Center for Constitutional Jurisprudence et al. in Support of Petitioners (Medicaid Spending/Coercion Issue) at 6-7, *Florida v. Dep't of Health & Human Servs.*, 132 S. Ct. 2566 (2012) (No. 11-400). For an analysis concluding that the income disregard was not affected by *NFIB*, *see* Memorandum from Kathleen S. Swendiman, Legislative Att'y, & Evelyne B. Baumrucker, Analyst in Health Care Financing, Cong. Research Serv., Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act 5-7 (July 16, 2012) [hereinafter Swendiman & Baumrucker Memo] (on file with authors). For another thoughtful analysis of the decision, *see* KENNETH R. THOMAS, CONG. RESEARCH SERV., R42367, THE CONSTITUTIONALITY OF FEDERAL GRANT CONDITIONS AFTER *NATIONAL FEDERATION OF INDEPENDENT BUSINESS v. SEBELIUS* (2012) (on file with authors). *See also* Kevin Outterson, *More Legal Analysis from CRS*, INCIDENTAL ECONOMIST (July 20, 2012, 5:43 PM), <http://theincidentaleconomist.com/wordpress/more-legal-analysis-from-crs/>.

⁴⁹⁶ Brief of State Petitioners on Medicaid, *supra* note 196, at 9 ("[Section 2304] effectively exposes States to liability if the demand for services is greater than the supply of hospitals and doctors willing to provide them.").

⁴⁹⁷ *See* Health Law Brief, *supra* note 14, at 36-38.

Second, two Medicaid provisions in the ACA were central to Chief Justice Roberts' coercion analysis: the addition of an eighth mandatory category of adults eligible for Medicaid (otherwise ineligible adults under 133% FPL)⁴⁹⁸ and the enhanced federal matching rate, starting at 100% for the first three years.⁴⁹⁹ Only the former bears directly on the coercion holding; thus, the latter seems to operate unaffected. *NFIB* makes clear that if states fail to extend eligibility to all adults under 133% FPL, the Secretary cannot use § 1396c to cut off existing Medicaid funds. Although the plurality highlighted the enhanced federal match in support of its characterization of the Medicaid expansion as a "new" program, that very generous federal offer is not, in and of itself, coercive. Accordingly, states that do elect to expand Medicaid would seem entitled to the elevated federal match for the newly eligible population. In other words, the enhanced federal match provision of the ACA is still fully applicable to opting-in states.

The third category of Medicaid provisions offers a roadmap for future litigation. The contestable provisions include: (1) the mandatory expansion of coverage to children aged six to eighteen under 133% FPL;⁵⁰⁰ (2) the MOE rules locking in previous state expansions while the ACA phases in;⁵⁰¹ (3) provisions defining the new "essential health benefits" package for the expansion populations;⁵⁰² and (4) partial or delayed Medicaid expansions for adult populations under 133% FPL.⁵⁰³ It is not entirely clear from *NFIB* whether states may choose to ignore these provisions, either individually or in combination.⁵⁰⁴ This Article will briefly explore all four.

⁴⁹⁸ *NFIB*, 132 S. Ct. 2566, 2601 (2012) (plurality opinion) ("The Medicaid provisions of the [ACA] . . . require States to expand their Medicaid programs by 2014 to cover *all* individuals under the age of 65 with incomes below 133 percent of the federal poverty line."); *see also supra* Parts II.B.1, III.B.1 and citations therein. This provision is found in the opening paragraph of Title II, section 2001(a)(1) of the ACA. Patient Protection and Affordable Care Act § 2001(a)(1) (amending 42 U.S.C. § 1396a).

⁴⁹⁹ *See supra* Part I.D and citations therein. This provision is found in section 2001(a)(3) of the ACA. *See* Patient Protection and Affordable Care Act § 2001(a)(3) (amending 42 U.S.C. § 1396a).

⁵⁰⁰ Patient Protection and Affordable Care Act § 2001(a)(1) (amending 42 U.S.C. § 1396a); *id.* §§ 2101-2102 (amending CHIP).

⁵⁰¹ *Id.* § 2001(b) (amending 42 U.S.C. § 1396a) (adding a new subsection, 1396a(gg), defining MOE requirements).

⁵⁰² *Id.* § 2001(a)(2) (amending 42 U.S.C. § 1396a) (adding subsection 1396a(k)(1), providing for minimum essential coverage); *id.* § 2001(c) (amending 42 U.S.C. § 1396a) (adding subsection 1396u-7(b)(5), setting the minimum standards for all benchmark benefit packages).

⁵⁰³ Letter from Jane Perkins, Legal Dir., NHeLP, to Cindy Mann, Deputy Adm'r & Dir., Ctr. for Medicaid, CHIP, & Survey & Certification (Aug. 26, 2012) (on file with authors) (arguing that *NFIB* did not permit partial expansions short of 133% FPL to 138% FPL after the 5% income offset).

⁵⁰⁴ The National Health Law Project views the scope of the option very narrowly. *See*

First, until the Medicaid expansion's implementation in 2014, current law requires that children up to five years old are covered up to 133% FPL. For those between the ages of six to eighteen, current law mandates eligibility only up to 100% FPL.⁵⁰⁵ The plurality's reasoning focused almost entirely on the novelty of the expansion of Medicaid to adults under 133% FPL but did not discuss any relevant constitutional distinctions regarding expansion to 133% FPL for children aged six to eighteen.⁵⁰⁶ Thus, the scope of the optional expansion population is unclear. The HHS Secretary, for one, read the Court's coercion decision as limited to newly eligible adults.⁵⁰⁷ But the ACA's new catchall eighth category extends eligibility for everyone who is under sixty-five earning 133% FPL. It is unclear whether Chief Justice Roberts believed constitutional significance attaches to celebrating one's sixth birthday with family income between 100% and 133% FPL. If so, he did not explain why this particular change for children aged six to eighteen was, or was not, a "shift in kind."⁵⁰⁸

Second, federal law frequently has resorted to mandatory MOE provisions during transition periods.⁵⁰⁹ A challenge to the MOE provision of the ACA was briefed⁵¹⁰ and discussed at oral arguments,⁵¹¹ but was not included in the *NFIB* opinions.⁵¹² A bill introduced in the 112th Congress, the State Flexibility Act, would repeal the MOE requirements under the American Recovery and Reinvestment Act of 2009, CHIP, and the ACA.⁵¹³ There is little or no basis

NAT'L HEALTH LAW PROJECT, THE SUPREME COURT'S DECISION ON THE ACA'S MEDICAID EXPANSION (2012), available at http://www.healthlaw.org/images/stories/2012_07_23_NHeLP_QA_1.pdf (stating that the coercion ruling in *NFIB* "only addresses . . . three ACA Medicaid provisions" and affirmatively answering questions regarding the continued applicability of other key provisions).

⁵⁰⁵ See *supra* Part I.D.

⁵⁰⁶ *NFIB*, 132 S. Ct. 2566, 2581-82, 2601 (2012) (plurality opinion) (discussing the effects of Medicaid expansion on adults); see also Health Law Brief, *supra* note 14, at 30-31 (arguing that Medicaid expansion to women and children is constitutional).

⁵⁰⁷ See Letter from Kathleen Sebelius, Sec'y of Health & Human Servs., to State Governors (July 10, 2012) ("The Supreme Court held that, if a state chooses not to participate in this expansion of Medicaid eligibility for low-income adults, the state may not, as a consequence, lose federal funding for its existing Medicaid program." (emphasis added)), available at <http://www.washingtonpost.com/blogs/ezra-klein/files/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf>.

⁵⁰⁸ *NFIB*, 132 S. Ct. at 2605 (plurality opinion).

⁵⁰⁹ See *supra* Part I.D.

⁵¹⁰ Brief of State Petitioners on Medicaid, *supra* note 196, at 6, 8-9, 45 n.17; Brief for Respondents, *supra* note 129, at 30-31; see also Health Law Brief, *supra* note 14, at 34-36.

⁵¹¹ Transcript of Oral Argument, *supra* note 131, at 51, 72.

⁵¹² There was also no substantive discussion in the Eleventh Circuit decision. See *Florida ex rel. Att'y Gen., v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235 (2011).

⁵¹³ H.R. 1683, 112th Cong. (2011); S. 868, 112th Cong. (2011).

for a state to conclude the MOE provision does not apply,⁵¹⁴ and yet the National Association of Medicaid Directors, in a letter issued shortly after *NFIB* was handed down, asked if states are “still subject to the MOE requirements” and what “penalty is there for non-compliance?”⁵¹⁵ Notably, the Congressional Research Service concluded that *NFIB* did not affect the MOE requirement.⁵¹⁶ Nevertheless, the State of Maine promptly filed suit in the First Circuit, claiming that *NFIB* also struck down the MOE requirement as unconstitutionally coercive.⁵¹⁷ While the claim was quickly dismissed on procedural grounds, it is likely to reappear.⁵¹⁸ Given the briefing on the MOE issue and the Court’s complete silence, it is clear that *NFIB* did not strike down the MOE requirement along with mandatory Medicaid expansion. But that will not prevent states from making the argument and asking federal courts to expand the coercion analyses in *NFIB* to also strike down the MOE provision.

Third, the definition of the Medicaid package of benefits remains an open question.⁵¹⁹ The ACA modified the mandatory Medicaid benefits package by

⁵¹⁴ NAT’L HEALTH LAW PROJECT, *supra* note 504, at 4; PERKINS, *supra* note 490, at 9 (“Whether or not a State implements the mandatory Medicaid expansion, the ACA’s maintenance of effort (MOE) provision will continue to apply.”). *But see* Matthew Stone, *Can Maine Cut Medicaid? Depends on How Broadly You Read the Supreme Court Ruling*, BANGOR DAILY NEWS (Aug. 10, 2012, 4:51 PM), <https://bangordailynews.com/2012/08/10/health/can-maine-cut-medicaid-depends-on-how-broadly-you-read-the-supreme-court-ruling/> (explaining that the gubernatorial administration of Maine interpreted the Medicaid coercion ruling in *NFIB* to mean “it could make cuts to its existing Medicaid program through a routine process” without concern for MOE requirements).

⁵¹⁵ NAT’L ASS’N OF MEDICAID DIRS., NAMD’S SCOTUS QUESTIONS 2 (2012), available at <http://www.leg.mt.gov/content/Committees/Interim/2011-2012/Children-Family/Topics/Medicaid%20Monitoring/aug2012-namd-scotus-questions.pdf>. Recently, the Obama Administration made clear that Maine was subject to these MOE requirements and could not make cuts to coverage. *See* Kevin Outtersen, *Maintenance of Effort in Maine*, INCIDENTAL ECONOMIST (Jan. 9, 2013, 12:20 PM), <http://theincidentaleconomist.com/wordpress/maintenance-of-effort-in-maine/>.

⁵¹⁶ Swendiman & Baumrucker Memo, *supra* note 495, at 5-7 (“A careful reading of the Court’s holding supports the conclusion that [the MOE provision is] unaffected by the Supreme Court’s ruling”); *see also* Outtersen, *supra* note 23.

⁵¹⁷ *Mayhew v. Sebelius*, No. 12-2059 (1st Cir. Sept. 13, 2012) (dismissing Maine’s request for review of its claim that HHS failed to consider its proposed State Plan Amendment in a timely manner); *see also*; Glenn Adams, *Federal Officials Ponder Maine’s Medicaid Request*, YAHOO! FIN. (Aug. 3, 2012, 9:59 AM), <http://www.finance.yahoo.com/news/federal-officials-ponder-maines-medicaid-request-135925254--finance.html>; Kevin Outtersen, *MOE Lawsuit*, INCIDENTAL ECONOMIST (Sept. 12, 2012, 9:50 PM), <http://theincidentaleconomist.com/wordpress/moe-lawsuit/> (“Maine is claiming that the Obamacare case also struck down the maintenance-of-effort (MOE) provisions”).

⁵¹⁸ Kevin Outtersen, *Maine, Dismissed (for Now)*, INCIDENTAL ECONOMIST (Sept. 17, 2012, 9:33 PM), <http://theincidentaleconomist.com/wordpress/maine-dismissed-for-now/>.

⁵¹⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(2)(A),

reference to the EHB provision also applicable to private health insurance plans under the ACA.⁵²⁰ HHS has authority to further define the ten categories of services included in EHB,⁵²¹ and has exercised its discretion by partially delegating the task of defining EHB to the states, through a process which is still being worked out.⁵²² In assessing the effect of the Court's coercion decision, the Congressional Research Service did not include the EHB on its list of optional Medicaid provisions,⁵²³ but the National Health Law Program did.⁵²⁴ Thus, it remains unclear whether states that opt into Medicaid expansion must provide EHB or whether the package of benefits they provide to the newly eligible population can be negotiated with the HHS. The National Health Law Project strongly opposes partial expansions and modifications by some states, unless the state plan qualifies for a demonstration waiver under SSA section 1115.⁵²⁵

Despite that uncertainty, the EHB provision is an unlikely trigger for a Tenth Amendment challenge. Of all the Medicaid provisions discussed in this Part, the EHB is by far the most flexible from a federalism perspective, giving each individual state significant room to follow the characteristics of their local commercial health insurance markets.⁵²⁶ It would be difficult to find coercion

124 Stat. 119, 271 (2010) (codified at 42 U.S.C. § 1396a(k)(1) (Supp. IV 2011)); *id.* § 2001(c) (amending 42 U.S.C. § 1396u-7(b) (2006)) (adding subsection 1396u-7(b)(5) which specifies Medicaid benchmark benefits).

⁵²⁰ *Id.* § 2001(c) (requiring all benchmark benefit packages to offer, at a minimum, coverage for essential health benefits as defined by the ACA).

⁵²¹ *Id.* § 1302(b)(1) (codified at 42 U.S.C. 18022(b)(1) (Supp. IV 2011)) (providing that “the Secretary shall define the essential health benefits” but requiring the inclusion of, at a minimum, the ten categories of coverage defined in the ACA).

⁵²² See Press Release, U.S. Dep’t of Health & Human Servs., HHS to Give States More Flexibility to Implement Health Reform (Dec. 16, 2011), *available at* <http://www.hhs.gov/news/press/2011pres/12/20111216c.html> (allowing states to select a plan to count as their Essential Health Benefits Package and to make modifications to that plan so long as such modifications are consistent with the ten defined coverage categories in the ACA).

⁵²³ Swendiman & Baumrucker Memo, *supra* note 495, at 5-7 (discussing a variety of Medicaid-expansion provisions as either mandatory or voluntary, but not including a discussion of EHB).

⁵²⁴ See NAT’L HEALTH LAW PROJECT, *supra* note 504, at 1.

⁵²⁵ 42 U.S.C. § 1315 (2006) (providing states a process to waive some Medicaid requirements for “experimental, pilot, or demonstration project[s]”); Letter from Jane Perkins to Cindy Mann, *supra* note 503, at 1-2 (stating that demonstration waivers must be budget neutral and should only be granted where the requesting state proves a valid, demonstrative purpose).

⁵²⁶ See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,893 (July 15, 2011) (to be codified at 45 C.F.R. pts. 155-56) (announcing regulations granting states “significant flexibility” in determining how to apply standards for qualified health plans to the ACA’s required health exchanges); Health Law Brief, *supra* note 14, at 33 (“[T]he federal government has, in the

in the EHB's application to Medicaid, as benchmark and benchmark-equivalent coverage were created to be less restrictive than previous Medicaid benefits standards. Chief Justice Roberts mentioned EHB only in passing, erroneously suggesting that Medicaid expansion is a "new" program because it offers a different set of benefits, even though states have had the option to offer benchmark plans since 2005.⁵²⁷ But he did not discuss the provision in any detail or suggest that this change to the Medicaid benefits package would be "unrelated" to the historical program, thus rendering it unconstitutionally coercive.

Finally, some states were exploring partial or delayed Medicaid expansions after *NFIB*. Soon after the *NFIB* decision, the National Governors Association,⁵²⁸ the Republican Governors Association,⁵²⁹ and the National Association of Medicaid Directors⁵³⁰ peppered the Administration with questions, seeking guidance. On July 10, 2012, Secretary Sebelius wrote back to the governors, promising to provide "as much flexibility as we can."⁵³¹ But in that letter, she phrased the antecedent very narrowly:

As you know, beginning in 2014, the Affordable Care Act provides for the expansion of Medicaid eligibility to those *adults under the age of 65 with incomes up to 133 percent of the federal poverty level* who were not previously eligible for Medicaid. The Supreme Court held that, if a state chooses not to participate in *this expansion of Medicaid eligibility for low-income adults*, the state may not, as a consequence, lose federal funding for its existing Medicaid program. The Court's decision did not affect other provisions of the law. For example, the decision did not change the fact that the federal government will completely pay for coverage under the eligibility expansion in 2014-2016, and for at least 90

case of the EHB, indicated an intention to delegate to the States authority to define the details of the EHB."); CTR. FOR CONSUMER INFORMATION & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 4-5 (2011), *available at* [http://cciio.cms.gov/resources/files/File s2/12162011/essential_health_benefits_bulletin.pdf](http://cciio.cms.gov/resources/files/File%20s2/12162011/essential_health_benefits_bulletin.pdf) (discussing variances in coverage across markets); INST. OF MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 21-22 (Cheryl Ulmer et al. eds., 2012) (discussing the level of flexibility in the EHB provision, as well as the ability for stakeholders, including state governments, to shape the EHB requirement's final scope).

⁵²⁷ *NFIB*, 132 S. Ct. 2566, 2601 (2012) (plurality opinion).

⁵²⁸ Letter from Dan Crippen, Exec. Dir., Nat'l Governors Ass'n, to Kathleen Sebelius, Sec'y of Health & Human Servs. (July 2, 2012), *available at* <http://www.nga.org/cms/home/federal-relations/nga-letters/executive-committee-letters/col2-content/main-content-list/july-2-2012-letter---affordable.html>.

⁵²⁹ Letter from Governor Bob McDonnell, Chairman, Republican Governors Ass'n, to President Barack Obama (July 10, 2012), *available at* <http://rgppc.com/medicaid-and-exchange-letter-2/>.

⁵³⁰ NAT'L ASS'N OF MEDICAID DIRS., *supra* note 515.

⁵³¹ Letter from Kathleen Sebelius to State Governors, *supra* note 507, at 1.

percent of such costs thereafter, or that states have flexibility to design the benefit package for the individuals covered.⁵³²

The Secretary apparently does not consider the eligibility expansion to children or the EHB to be made optional by *NFIB*.⁵³³ For the adult population below 133% FPL, the Obama Administration initially hinted at providing flexibility even beyond what the *NFIB* opinion requires, although reelection may have strengthened the Administration's position and tempered its desire to negotiate with states. In fact, HHS has recently indicated that partial expansion is not possible under the terms of ACA.⁵³⁴ Nevertheless, the level of voluntary flexibility promised has been extraordinary and, to some observers, surprising.⁵³⁵ States have been promised the ability to expand now and contract later, or miss the January 2014 deadline and join when they are ready. It also appears that states will be permitted to expand and contract piecemeal, which is not clearly supported by either the text of the ACA, including the MOE provision,⁵³⁶ or the Court's opinion. In effect, the Administration has read

⁵³² *Id.* at 1-2 (emphasis added). The letter also promises to aggressively protect otherwise eligible adults in opt-out states from the individual mandate penalty. *Id.* at 2.

⁵³³ See Rosenbaum & Westmoreland, *supra* note 14, at 1668 (reasoning that "[Chief Justice Roberts] clearly emphasized that the transformative dimension of the Affordable Care Act was the extension of coverage to 'childless adults'" and that the extension to low-income children was thus excluded from *NFIB*'s remedial holding).

⁵³⁴ Memorandum from the Dep't of Health & Human Servs., Exchanges and Market Reforms: State-based Exchanges and State Partnership Exchanges 12 (Dec. 10, 2012), available at <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf> (informing states that the ACA does not permit partial coverage expansions).

⁵³⁵ See Michael Bologna, *CMS Points to New Flexibility for States Under Health Reform's Medicaid Expansion*, BLOOMBERG BNA (Aug. 7, 2012), <http://www.bna.com/cms-points-new-n12884911073/>; Nicole Huberfeld, *The Trope of Flexibility*, HEALTHLAWPROF BLOG (Aug. 9, 2012), http://lawprofessors.typepad.com/healthlawprof_blog/2012/08/nothing-short-of-block-grants-will-do.html; Kevin Outterson, *CMS Interpreting the Red State Option After NFIB*, INCIDENTAL ECONOMIST (Aug. 7, 2012, 9:26 AM), <http://theincidentaleconomist.com/wordpress/cms-interpreting-the-red-state-option-after-nfib/>; Sara Rosenbaum & Timothy Westmoreland, *CBO's Updated Affordable Care Act Estimates: Resting on Shaky Assumptions?*, HEALTH AFF. BLOG (July 31, 2012), <http://healthaffairs.org/blog/2012/07/31/cbos-updated-affordable-care-act-estimates-resting-on-shaky-assumptions/>; Dylan Scott, *CMS: States Could Adopt Medicaid Expansion, Then Drop It*, GOVERNING STS. & LOCALITIES (Aug. 6, 2012, 2:15 PM), <http://www.governing.com/news/federal/gov-cms-no-deadline-for-state-decisions-on-medicare-expansion.html>.

⁵³⁶ PERKINS, *supra* note 490, at 7 ("[T]he new decision . . . curb[s] the power of the federal government to enforce the Medicaid expansion but maintains the ACA and the Medicaid Act in all other respects."); Rosenbaum & Westmoreland, *supra* note 14, at 1669 ("[T]reating the expansion group as an option and then beginning to disassemble and reassemble it would cross the line between reasonable 'interpretation' of the Affordable Care Act and a wholesale revision of the statute's definition of the expansion group."); Letter from Jane Perkins to Cindy Mann, *supra* note 503; Rosenbaum & Westmoreland, *supra* note 535; see also MARYBETH MUSUMECI, KAISER FAMILY FOUND., A GUIDE TO THE

NFIB as establishing an opening bid, from which states can bargain with the Secretary about the timing, covered population, and benefits package for Medicaid expansion within their individual states. But this is not a garden-variety expansion of the administrative state; the Court set the stage itself through the imprecise language in *NFIB*. At least until Congress can revisit the issue, the Court has given the Administration nearly carte blanche authority, de facto if not de jure, to cut Medicaid deals with the states.

B. *Tax Credits in the Exchanges*

A second major implementation question raised by *NFIB* concerns the premium assistance tax credits in the exchanges. For legal residents with incomes between 100% and 400% FPL, the Affordable Care Act provides tax credits to subsidize the purchase of private health insurance in the exchanges. The mechanism is § 36B of the Internal Revenue Code.

The ACA encourages states to create their own exchanges, but the federal government will create backup federal exchanges for states that fail to do so.⁵³⁷ According to the text of the statute, the tax credits are available only to people who are enrolled in a qualified health plan purchased “through an Exchange established by the State under [section] 1311” of the ACA.⁵³⁸ This was inartful wording, as it has led Michael Cannon of the Cato Institute and Jonathan Adler from Case Western Reserve University to allege that tax credits will not be available for otherwise eligible lawful residents in the backup federal exchanges because these exchanges were not “established by the State.”⁵³⁹ The textual argument is fairly straightforward.

The IRS was aware of the issue more than a year ago and issued proposed tax regulations on August 17, 2011 that broadened the definition of “exchange” to include both state and federal backup exchanges.⁵⁴⁰ A public

SUPREME COURT’S AFFORDABLE CARE ACT DECISION 7 (2012), available at <http://www.kff.org/healthreform/upload/8332.pdf>; MARYBETH MUSUMECI, KAISER FAMILY FOUND., IMPLEMENTING THE ACA’S MEDICAID-RELATED HEALTH REFORM PROVISIONS AFTER THE SUPREME COURT’S DECISION 2-3 (2012), available at <http://www.kff.org/healthreform/upload/8348.pdf>.

⁵³⁷ Patient Protection and Affordable Care Act § 1321, 42 U.S.C. § 18041 (Supp. IV 2011).

⁵³⁸ I.R.C. § 36B(b)(2)(A) (Supp. IV 2011).

⁵³⁹ Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 22 HEALTH MATRIX (forthcoming 2013).

⁵⁴⁰ The mechanism is to define “exchange” by reference to 45 C.F.R. 155.20. See Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,387 (May 23, 2012) (to be codified at 26 C.F.R. pts. 1, 602). The Code of Federal Regulations defines an exchange as “a governmental agency or non-profit entity that meets the applicable standards of this part and makes [Qualified Health Plans] available to qualified individuals and qualified employers” and specifies that “[u]nless otherwise identified, this term refers to State Exchanges,

hearing was held on November 17, 2011, and the regulations were finalized on May 23, 2012.⁵⁴¹ Congress clearly intended for the tax credits to be available to people in all fifty states, irrespective of whether the exchanges are state, federal, or multi-state operations.⁵⁴²

This issue has gained additional political salience after the *NFIB* decision. As written, the ACA provided Medicaid for individuals up to 133% FPL, and eligibility for tax credits in the exchanges for individuals between 100% and 400% FPL. The policy design was that very low-income individuals would receive full public assistance while less-impoorished individuals would purchase private insurance with some government assistance. For individuals above 400% FPL, the employer mandate, insurance market reforms, the individual mandate, and other provisions kick in to make coverage more readily available. In states that exercise their *NFIB* Red State Option to not expand adult eligibility to 133% FPL, we have a new healthcare “donut hole.”⁵⁴³ The poorest adults will still have Medicaid under current law, but to widely varying levels of eligibility. In some states, for example, unemployed

regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.” 45 C.F.R. § 155.20 (2012).

⁵⁴¹ See 77 Fed. Reg. at 30,377 (publishing, on May 23, 2012, a final regulation related to the health insurance premium tax credit that was finalized pursuant to a November 17, 2011, public hearing). *But see* Jonathan H. Adler & Michael F. Cannon, Op-Ed, *Another ObamaCare Glitch*, WALL ST. J. (Nov. 16, 2011), <http://online.wsj.com/article/SB10001424052970203687504577006322431330662.html> (opining, in an op-ed published the day before the IRS’s public hearing, that “the law has a major glitch that threatens its basic functioning,” and further that “states that refuse to create an exchange can block much of ObamaCare’s spending and practically force Congress to reopen the law for revisions”).

⁵⁴² See JUDITH SOLOMON, CTR. ON BUDGET & POL’Y PRIORITIES, HEALTH REFORM LAW MAKES CLEAR THAT SUBSIDIES WILL BE AVAILABLE IN STATES WITH FEDERALLY OPERATED EXCHANGES 1 (2012), available at <http://www.cbpp.org/files/7-16-12health.pdf> (“The argument that premium credits are not available to purchase coverage offered through a federally operated exchange rests on a distorted and incorrect reading of the ACA.”); Timothy Jost, *Tax Credits in Federally Facilitated Exchanges Are Consistent with the Affordable Care Act’s Language and History*, HEALTH AFF. BLOG (July 18, 2012), <http://healthaffairs.org/blog/2012/07/18/tax-credits-in-federally-facilitated-exchanges-are-consistent-with-the-affordable-care-acts-language-and-history/>. *But see* Michael Cannon & Jonathan Adler, *The Illegal IRS Rule to Expand Tax Credits Under the PPACA: A Response to Timothy Jost*, HEALTH AFF. BLOG (Aug. 1, 2012), <http://healthaffairs.org/blog/2012/08/01/the-illegal-irs-rule-to-expand-tax-credits-under-the-ppaca-a-response-to-timothy-jost/>; Sarah Kliff, *Could One Word Take Down Obamacare?*, WASH. POST (July 16, 2012, 4:56 PM), <http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/07/16/could-a-missing-word-take-down-obamacare/> (quoting an interview with Professor Kevin Outterson on the ambiguity of the state exchange language in the ACA).

⁵⁴³ The “old” healthcare donut hole is the out-of-pocket payments in Medicare Part D, which is addressed over time by the ACA. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3301, 124 Stat. 119, 461-68 (2010) (amending 42 U.S.C. §§ 1395w-101, 102, 153 (2006)).

adults are covered only up to 17% FPL while other states already opt to cover adults up to 133% FPL and beyond.⁵⁴⁴ Slightly less-impooverished people will have tax credits in the exchanges, that is, from 100% to 400% FPL. People in the middle will be left out, with neither a government healthcare program nor government assistance to purchase private health insurance.

If Cannon and Adler's interpretation of the non-availability of tax credits in federally operated exchanges is correct, then low-income individuals in Medicaid opt-out states with federal exchanges will be even more exposed. Citizens understandably may hold their state-elected officials politically accountable for these anomalies, even though it was Congress that drafted the ambiguous provision. One apparent political goal of the tax-credit challenge is to deny coverage to millions of additional people, while laying the blame for ACA's failures on the federal tax code rather than state officials who opt out of Medicaid expansion or a state exchange. Federalism's political accountability would thereby be further confused and muddled.

One further wrinkle is that the operative language – an exchange “established by the state” – is also used to terminate the MOE requirement.⁵⁴⁵ Most people speak of the MOE requirement terminating in 2014 when each state will have either a state or federal exchange. But if the stricter interpretation is correct, any state that failed to create an exchange would continue to be subject to the MOE requirement indefinitely.⁵⁴⁶

We are skeptical of this tax challenge on substantive and procedural grounds. Substantively, the IRS has significant discretion, especially when it is arguably being too generous to taxpayers.⁵⁴⁷ Procedurally, states would not have standing to bring this suit and the Anti-Injunction Act should delay suit in any event until no earlier than 2015.⁵⁴⁸ The Congressional Budget Office

⁵⁴⁴ *Adult Income Eligibility Limits at Application as a Percent of the Federal Poverty Level (FPL), January 2013*, KAISER FAM. FOUND., <http://www.statehealthfacts.org/comparerreport.jsp?rep=130&cat=4> (last visited Jan. 27, 2013).

⁵⁴⁵ I.R.C. § 36B(b)(2)(A) (Supp. IV 2011).

⁵⁴⁶ See Sam Baker, *GOP Attacks on Health Law's Subsidies Could Backfire on Medicaid*, HILL HEALTHWATCH (July 18, 2012, 7:30 AM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/238569-gop-attacks-on-health-laws-subsidies-could-backfire-on-medicare>.

⁵⁴⁷ See Kevin Outterson, *The Rest of the Story*, INCIDENTAL ECONOMIST (July 16, 2012, 8:34 PM), <http://theincidentaleconomist.com/wordpress/the-rest-of-the-story/> (discussing I.R.C. § 36B and remarking that the “IRS has broad regulatory authority, which they exercised in the proposed rule, defining Exchange in a [] broad[] way”).

⁵⁴⁸ See Kevin Outterson, *Cato Recycles an Attack on the Employer Mandate in Federal Exchange States*, INCIDENTAL ECONOMIST (July 17, 2012, 6:50 AM), <http://theincidentaleconomist.com/wordpress/procedural-tax-issues-with-the-new-employer-mandate-potential-law-suit/> (stating that a large employer in a federal exchange state cannot file suit “until some employer pays the mandate penalty in the federal exchange state – spring 2015 at the earliest”).

generally concurs⁵⁴⁹ as does the Congressional Research Service,⁵⁵⁰ Professor Timothy Jost,⁵⁵¹ and Judith Solomon from the Center for Budget and Policy Priorities.⁵⁵² But this issue need not be resolved for the purposes of this Article. It is sufficient to note that no federalism or coercion issue is present. The creation of tax credits under § 36B of the Internal Revenue Code is clearly a permissible exercise of the taxing power. The only question is whether the statute and regulations will be interpreted to maximize access to health insurance, which was the clear purpose of the ACA.

CONCLUSION

Of the four discrete questions presented to the Court, the Medicaid expansion issue offered the greatest potential for destabilization from both a statutory and a constitutional perspective. As this Article reveals, *NFIB* stands precipitously to fulfill that promise. The *NFIB* decision cut many corners on the actual history and facts of the Medicaid program, pounding many a square peg into round holes in order to fit a narrative of coercion. This Article has highlighted many of these missteps lest future decisions simply parrot the factual inaccuracies promulgated by the Court.

Doctrinally, the Roberts Court blazed a long-desired trail in the Federalism Revolution. The Court implicitly incorporated, seemingly modified, and reinvented two elements of the *Dole* test for conditional spending, infusing them into the coercion decision of first impression. The Court intertwined the *Dole/Pennhurst* clear-notice requirement with a beefed-up version of the *Dole* germaneness limit in order to artificially divide Medicaid in two parts: “old” and “new” Medicaid. Thus divided, the Court then concluded that the coercion doctrine barred Congress from conditioning federal funding for an “old”

⁵⁴⁹ CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 7 n.14 (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf> (“CBO and [the Joint Committee on Taxation] expect that subsidies will be available to people in exchanges run entirely by states, exchanges run entirely by the federal government, and exchanges run together by states and the federal government.”).

⁵⁵⁰ Memorandum from Jennifer Staman & Todd Garvey, Legislative Att’ys, Cong. Research Serv., Legal Analysis of Availability of Premium Tax Credits in State and Federally Created Exchanges Pursuant to the Affordable Care Act 9-10 (July 23, 2012) (“Thus, if a reviewing court determines that there is ambiguity surrounding the issue of whether premium credits are available in federal exchanges and reaches step two of the *Chevron* analysis with respect to the regulations issued under § 36B, the regulations will very likely be considered a reasonable agency interpretation on the statute and accorded deference by the court.”).

⁵⁵¹ Jost, *supra* note 542 (“Employers . . . would be barred from [bringing suit] by the Tax Anti-Injunction Act . . . probably until 2015.”).

⁵⁵² SOLOMON, *supra* note 542, at 1-4 (presenting arguments against a reading of “exchange” that would leave supplements unavailable in states that choose not to adopt the Medicaid expansion).

program on states' agreement to participation in a "new" conditional spending program. Although the Court has consistently enforced the *Dole* clear-notice requirement for conditions placed on federal spending, this was the first time the Court drew upon the relatedness prong of the *Dole* factors. Clear notice and relatedness now appear to be folded into the newly fashioned, yet undefined, coercion doctrine.

The Court left unanswered not only how those elements will operate in future cases but, even more fundamentally, what coercion means. Self-consciously avoiding any definable test, the Court instead relied on problematic quantitative as well as qualitative analyses to determine that the Medicaid expansion excessively invaded states' prerogatives. The joint dissent relied heavily on facts specific to the litigant States such as their current budgets, Medicaid funding levels, and federal expenditures on Medicaid. The Roberts plurality rested on colorful analogies: "economic dragooning" and "a gun to the head." Both opinions invoked familiar federalism principles, including political accountability, but the reasoning was muddled and failed to clarify the constitutional significance of those themes in the coercion context. With no further guidance, we can only hope that we will know a "gun to the head" when we see it. But we can be sure there will be many future challenges to a host of federal spending power programs alleging just that.

This fractured, obliquely reasoned decision leaves open a host of additional questions. Not only do we not know the meaning of coercion but also the extent to which the Court will apply *NFIB*'s unique severability analysis in future disputes. The Court's novel remedy of turning a conditional spending program into an optional provision which states are free to adopt or not could be limited to coercion challenges or could signal a new approach to severability more generally. Many questions also remain unanswered with respect to severability of other ACA Medicaid provisions and implementation of the Medicaid expansion within the larger scheme of the ACA. Judicial dockets and academic debates are already reverberating with these open questions.

Thanks to their success before the Court, the states are now facing a decision whether to exercise the Red State Option to accept or decline unprecedentedly generous federal funding for previously uninsured residents. States are no longer plaintiffs claiming coercion, powerless with a "gun to the head." Perhaps they had hoped for a different result in the 2012 Presidential election. But they must now make difficult political choices upon which the lives of some of their most medically fragile, disenfranchised citizens will rely. The effect of these decisions on the political dance between federal and state authorities to cast blame and claim credit for healthcare reform will play out over the next several years as the ACA is fully implemented. Both legally and politically, we have plunged into the "endless difficulties" that Justice Cardozo so rightly feared.