PLUNGING INTO ENDLESS DIFFICULTIES: MEDICAID AND COERCION IN THE HEALTHCARE CASES

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I. 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.” Otherwise, the Spending Clause “would become the instrument for total subversion of the governmental powers reserved to the individual states.” The case was United States v. Butler, and the law struck down was the Agricultural Adjustment Act of 1933.

Until the 2012 Term, no Supreme Court decision since the New Deal had struck down an act of Congress as exceeding the federal spending power. Indeed, no federal court had ever found any legislation to be an unconstitutionally coercive exercise of the spending power until the Court decided the National Federation of Independent
Business v. Sebelius (NFIB) on June 28, 2012. The only two previous Supreme Court cases mentioning the coercion doctrine held it inapplicable and upheld the federal laws in question: the unemployment compensation provisions of the Social Security Act of 1935 in Steward Machine Co. v. Davis, and the federal drinking age condition on highway funds in South Dakota v. Dole. In each case, the Court recognized the theoretical possibility of a federal spending program operating as unconstitutional coercion of states but found no coercion on the actual facts. Accordingly, until now, coercion has been relegated to dicta.

Most of the vast legal and political commentary on the Healthcare Cases challenging the Patient Protection and Affordable Care Act (the “Affordable Care Act” or “ACA”) centered on the prospects for the individual health insurance mandate under the Commerce Clause. 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.\textsuperscript{14} The \textit{Healthcare Cases} presented a prime opportunity for the Roberts Court to revive the Rehnquist Court’s “Federalism Revolution.”\textsuperscript{15}

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\textsuperscript{15} See infra Part IV.A.
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.\(^\text{16}\) Justice Cardozo long ago warned that enforcing the coercion doctrine would “plunge the law in endless difficulties.”\(^\text{17}\)

Nevertheless, the Court held that expansion of Medicaid to a new category of beneficiaries\(^\text{18}\) was unconstitutionally coercive because the Secretary of the U.S. Department of Health and Human Services (HHS) had authority to withdraw all (or part) of federal Medicaid funding for states’ failure to comply with federal Medicaid laws.\(^\text{19}\) Seven Justices agreed on this result, but they were 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.

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 five decades could not be constitutionally applied to withhold states’ Medicaid funding for failing to implement the Medicaid expansion.\(^\text{20}\) Effectively, the Court allowed states to opt in or out of the expansion\(^\text{21}\) 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 became optional for dissenting states, creating what we will call the “Red State Option.”\(^\text{22}\)

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 doctrine to follow, hindered by misinterpretation of the facts upon which the decision relies. Accordingly, the difficulties for lower courts attempting to decide coercion challenges, congressional drafting of new conditional spending programs, and federal administration of existing

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\(^{16}\) See supra note 5.
\(^{18}\) See infra Part II (describing the Medicaid expansion).
\(^{19}\) NFIB, 132 S. Ct. at 2607.
\(^{20}\) Id. (referring to 42 U.S.C. § 1396c).
\(^{21}\) NFIB, 132 S. Ct. at 2607 (“we determine, first, that § 1396c is unconstitutional when applied to withdraw existing Medicaid funds from States that decline to comply with the expansion….“). 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.
\(^{22}\) Kevin Outterson, The Scope of the Red State Option, THE INCIDENTAL ECONOMIST, July 20, 2012, available at http://theincidental economist.com/wordpress/the-scope-of-the-red-state-option/ [hereinafter, Outterson, 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 the option.
spending clause programs are significant. For every federal spending program since the Great Society, this case signals the beginning of a new era of litigation challenges.

This Article proceeds as follows: Part II discusses the Medicaid expansion in the ACA in the context of the history and purpose of the Medicaid Act. Part III summarizes the litigation from the lower courts up to the NFIB decision and examines the Medicaid coercion opinions in NFIB in detail. Part IV first considers NFIB in the context of the Federalism Revolution, and then discusses three weaknesses in the new coercion doctrine with an eye toward predicting potential complications.

These three weaknesses bear brief mention now. 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 Dole factors. 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. The NFIB Court’s rejection of that direct language bodes ill for the federal government’s ability to meet the clear notice standard in future cases. On the question of relatedness, the Dole germanness test, 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 Medicaid expansion, treating them as two distinct federal programs. 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.

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.” 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

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23 See infra Part IV.A.
24 South Dakota v. Dole, 483 U.S. 203 (1987). Formulating what was to become the standard for the constitutionality of conditions placed on federal funding, Chief Justice Rehnquist summarized prior caselaw to create an enumerated test for the constitutionality of conditions on spending. That four-part test was: spending must be for the general welfare, conditions must be unambiguous, the conditions placed on the funds must be related to the federal goals, and the conditions cannot themselves be unconstitutional. Id. at 207-08. Aside from the 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.
26 See infra Part IV.B.1.
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. We also evaluate the various statistical indicia of coercion, the role of political accountability, and “coercion in fact.”

Third, in the remedy phase, the Roberts plurality forbade the Secretary from using Section 1396c to cut off existing Medicaid funds to states, effectively making the Medicaid expansion optional for states. It 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. If the Medicaid coercion issue was something of a sleeper, the question of coercion severability was almost entirely off the radar – barely raised and thinly briefed before the Court, and highly dependent upon both 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 we suggest that perhaps the Red State Option is exactly what federalism requires, a solution uniquely crafted to Tenth Amendment coercion cases. Furthermore, the post-NFIB struggles to administer the Medicaid expansion have created some federalism success stories in unexpected places. This remarkable decision undoubtedly will continue to surprise.

II. 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.’” 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.” Judicial confusion over government health care programs is notorious.

27 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 public interest, among other factors. See, e.g., Tunkl v. Regents of the University of California, 60 Cal.2d 92 (1963) (refusing to enforce charity hospital’s exculpatory clause, signed by patient upon admission to the emergency room).
28 See infra Part IV.B.2.
29 See infra Part IV.B.3.
31 Stephenson v. Shalala, 87 F.3d 350, 356 (9th Cir. 1996).
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 incrementalist amendment to the existing program. To the Roberts plurality, it was “a shift in kind, not merely degree,” transforming Medicaid into something that “is no longer a program to care for the neediest among us...” This suggested distinction matters greatly in the decision itself and our discussion of coercion in Part IV. By providing history and context for both the ACA and Medicaid, we illuminate that the Medicaid expansion was not a dramatic “shift in kind” but instead fits into familiar patterns of prior amendments to Medicaid.

A. The ACA’s Path to Expanding Coverage

Due to public preferences and political reality, the ACA did not radically overhaul the United States healthcare system. Single-payer healthcare was never on the table, and the so-called “public option” received only nominal consideration. Instead, the ACA built upon the United States’ existing path-dependent, public-private healthcare sector. Government intervention is premised on the assumption that at least some individuals should not be left to fend for themselves in private markets for healthcare. The form of assistance and the designated beneficiaries have evolved through often-contentious debate over many decades. The ACA’s expansion of Medicaid eligibility, premium assistance tax credits, state insurance exchanges, and other government subsidies are the latest iterations.

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

33 NFIB, 132 S. Ct. at 2605 (Roberts, C.J.).
34 Id. at 2606.
health insurance market. From that 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 ACA seeks to maintain, or even increase, the biggest piece of the pie, employer-based health insurance. In a nod to behavioral economics, the ACA implements default enrollment requirements for large employers, meaning that employees are automatically enrolled in an employer-based plan. Large employers also are subject to limited penalties for failing to provide affordable health plans to employees. The ACA offers generous tax credits to small employers to encourage them to offer health insurance to employees and creates a new Small-Business Health Options Program.

Strategies to expand coverage in the private, individual health insurance market include health insurance exchanges, minimum essential coverage requirements (the “individual mandate”), and insurance underwriting reforms. Without the advantages of large risk pools, individual health insurance plans have long been more difficult and expensive to obtain. The ACA addresses known dysfunctions in the individual health insurance market by prohibiting pre-existing condition exclusions and discriminatory pricing based on health status. The minimum essential coverage provision and the exchanges support those reforms by expanding risk pools and minimizing medical underwriting.

The ACA also expands public insurance, primarily through Medicaid. After the expansion, all citizens and legal residents earning below 133% of the federal poverty

37 ACA § 1151 (applicable to employers with more than 200 full-time employees).
38 ACA §§ 1401, 1513 (amending I.R.C. § 4980H) (applicable to employers with 51 or more full-time equivalent employees, ACA §§ 1513, 10106).
39 I.R.C. § 45R(g). A small employer is defined as an employer with “no more than twenty-five full-time equivalent employees for the taxable year.” I.R.C. § 45R(d)(1).
43 42 U.S.C. § 300gg; see also Brief Amici Curiae of Prescription Policy Choices, et al., HHS v. Florida (No. 11-398) (describing the ACA’s approach to addressing dysfunctions in the existing system).
44 26 U.S.C. § 5000A.
47 Or 138% after application of the 5% income disregard. See ACA § 1004 (defining “modified gross adjusted income,” or MAGI); Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 FED. REG. 17144 (March 23, 2012); see Rosenbaum, A “Customary and
level (FPL) are eligible for Medicaid. This approach won out over other proposals, including raising Medicaid eligibility to 150% FPL, offering a public option in the health insurance exchanges, and providing tax subsidies for all low-income uninsured individuals to purchase private health insurance. The policy compromise was that very low income Americans will be provided public health insurance while slightly less impoverished individuals will be given federal tax credits to purchase privately in the exchanges.

B. The Medicaid Program

1. Medicaid and the “Deserving” Poor

Medicaid has historically provided health insurance coverage to the “deserving” poor, including women (particularly, widows) and their children, the blind, the disabled, and impoverished elderly. This normative grouping, derived from Elizabethan Poor Laws, was expressed in state welfare policies deeming the working poor and those deemed “blameless” in their poverty to be deserving of assistance, while non-working

Necessary” Program – Medicaid and Health Care Reform, 362 NEW ENG. J. MED. 1952,1953 (2010) (citing Congressional Budget Office estimates that new income calculation methods will effectively raise the threshold to 138% of the FPL).


51 See Sara Rosenbaum, Rethinking Medicaid in the New Normal, 5 ST. LOUIS U. J. HEALTH L. & POL’Y 127, 130 & n.18 (2011) (suggesting that 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); Leighton Ku & Matthew Broaddus, Public And Private Health Insurance: Stacking Up the Costs, HEALTH AFF., July 2008, vol. 27 no. 4, w318-w327, available at http://content.healthaffairs.org/content/27/4/w318.abstract.

52 See 26 U.S.C. § 36B (regarding premium assistance tax credits for purchase of qualified health plans).


54 TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH PROGRAMS AND A RIGHTS-BASED RESPONSE 80 (2003) (listing the beneficiaries of federal/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.
The Social Security Act of 1935 provided the statutory basis for both Medicare and Medicaid. 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. With the exception of limited, open-ended federal grants to states, Roosevelt put the goal of government health insurance aside due to political objections, including widespread fear of socialized medicine and fragile political support for the SSA itself. Healthcare was not added to the SSA until the 1960s.

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. During the 1950s, the elderly poor exercised more political power and pushed for health insurance benefits mirroring the workers’ insurance program in the Social Security Act. Those efforts resulted in Kerr-Mills, a 1960 amendment to the SSA designed to assist the impoverished elderly and support states’ existing programs through a limited grant-in-aid program.

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

55 See STEVENS & STEVENS, supra note 56, 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.
57 Huberfeld, Federalizing Medicaid, supra note 14, at 441.
58 See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 270 (1982); Huberfeld, Federalizing Medicaid, supra note 14, at 443.
60 See STARR, supra note 60, at 371.
61 Jost, supra note 56, at 80; Starr, supra note 50, at 270-71 (describing limited government healthcare programs, including poor farmer subsidies); Huberfeld, Federalizing Medicaid, supra note 14, at 443; see, e.g., Federal Food, Drug & Cosmetic Act, Pub. L. No. 75-717, 52 Stat. 1040 (1938) (expanding FDA’s regulatory role); Hospital Survey & Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (funding new hospital construction and expansion).
62 See Huberfeld, Federalizing Medicaid, supra note 14, at 443.
63 Kerr-Mills Act, Pub. L. No. 86-778, 74 Stat. 924 (1960) (providing federal assistance to the very poor elderly); see Jost, supra note 56, at 81 (expounding how the Social Security Act Amendments of 1960 created the Kerr-Mills program and its expanded coverage of the “medically needy”).
65 See Weeks, Clawback, supra note 58, at 83.
afterthought in the 1965 SSA amendments, and was clearly an extension of the existing Kerr-Mills program. Congress created Medicaid as a means-tested welfare program, offering unlimited federal funding to the states so long as they complied with broad federal requirements under the Medicaid Act. The carrot was the offer of federal funds; the stick was Section 1396c, permitting the Secretary to limit some or all Medicaid funds if a state failed to comply with the federal law. Medicaid was well received by the states, with the vast majority electing to participate within a few years. Today, every state participates in Medicaid.

Medicaid is a paradigmatic cooperative federalism program, which is one reason the NFIB decision is so troubling. Financial contribution by both the states and the federal government is the “cornerstone of Medicaid.” Through open-ended matching funds, states are incentivized to provide generous public benefits, receiving additional federal financial support for every state dollar spent. Medicaid is entirely voluntary. States do not have to participate and could refuse federal dollars, establish their own state

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66 See STEVENS & STEVENS, supra note 56, at 47-51 (describing Medicaid as “ill-designed” compared to Medicare).
67 Sara Rosenbaum, Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era, 9 J. HEALTH CARE L. & POL’Y 5, 10 (2006) [hereinafter Rosenbaum, Medicaid at Forty]; STEVENS & STEVENS, supra note 56, at 51 (“[T]he section of the Senate report dealing with Title XIX was entitled, ‘Improvement and Extension of Kerr-Mills Medical Assistance Program.’”).
68 STARR, supra note 60, at 368–70; see also Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981) (describing enactment of Medicaid program); Brogan v. Miller, 537 F. Supp. 139, 142 (N.D. Ill. 1982); Rosenbaum et al., Design for Children, supra note 55, at 7-8 (characterizing Medicaid as “an ‘afterthought’ to Medicare, and a ‘relegation’ to states of responsibility for insuring the poor”).
69 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 (2009) (outlining the efforts of Newt Gingrich and George Bush to make a capped block grant part of federal Medicaid funding).
70 42 U.S.C. § 1396c.
71 Huberfeld, Federalizing Medicaid, supra note 14, at 445 n.69 (noting that Arizona and Alaska were holdouts, with Arizona joining Medicaid in 1982 and Alaska joining in 1972).
72 See NFIB, 132 S. Ct. at 2629 (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 Act fosters cooperative federalism and describing program); Huberfeld, Bizarre Love Triangle, supra note 14, at 419; Weeks, Clawback, supra note 58, at 114.
73 Harris, 448 U.S. at 308.
75 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].”).
indigent healthcare programs, or elect not to provide any medical assistance for low-income individuals.\footnote{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 taking these actions. See infra Part IV.B.2.}

At enactment, Medicaid targeted the now-familiar categories of deserving poor.\footnote{Huberfeld, Federalizing Medicaid, supra note 14, at 445 – 46.} The original groups entitled to Medicaid on a mandatory basis were elderly and disabled persons receiving welfare under federal cash assistance programs, and dependent children and their caretaker relatives receiving Aid to Families with Dependent Children (AFDC).\footnote{SARA ROSENBAUM & DAVID M. FRANKFORD, LAW AND THE AMERICAN HEALTH CARE SYSTEM 503 (2d ed. 2012).} Congress later replaced the cash assistance programs for disabled adults and children and the impoverished elderly with Supplemental Security Income (SSI); these groups continued to qualify for Medicaid on the basis of SSI eligibility.\footnote{Id. at 503.} Congress also later replaced AFDC with Temporary Assistance for Needy Families (TANF) but retained the historical AFDC eligibility requirements for Medicaid.\footnote{Id. at 503 & n.*.} Prior to the enactment of the ACA, Medicaid covered seven discrete categories of individuals.\footnote{42 U.S.C. § 1396a(a)(10)(A)(i)(I)–(VII).} The ACA added an eighth category: all citizens and legal residents with incomes up to 133% FPL who are not otherwise eligible through another mandatory Medicaid category.\footnote{42 U.S.C. § 1396a(a)(10)(i)(VIII). A ninth category was also added by the ACA, covering children leaving foster care, effective starting in 2019.}

\section*{2. The Scope of Medicaid Benefits and Coverage}

Beyond the broad statutory outlines, states have considerable discretion over Medicaid eligibility requirements and program benefits.\footnote{See Schweiker v. Gray Panthers, 453 U.S. 34, 37 (1981) (describing “categorically” and “medically” needy beneficiaries); Weeks, Clawback, supra note 58, at 84; Rosenbaum, Medicaid at Forty, supra note 69, at 12-13 (describing Medicaid eligibility and coverage); Kinney, supra note 76, at 857 (noting that “[b]ecause states have great flexibility ... the Medicaid program is really 50 very different programs serving different populations and providing different benefits”).} States can expand beyond the mandatory groups and services\footnote{42 U.S.C. §1396d(a) (2006). Additional services also can receive matching funds. See 42 U.S.C. §1396d(a) (2006) (defining services that qualify as “medical assistance” and therefore receive funding).} and will receive unlimited federal matching dollars for those optional elements of their programs.\footnote{42 U.S.C. § 1396b (2000) (regarding payments to states).} To receive federal funding, states must submit a “State Plan” to the Secretary of HHS, which explains how the state will comply with the Medicaid Act.\footnote{42 U.S.C. § 1396a(a)(10)(A)(i)(I)–(VII).} Once the State Plan is in place, states administer Medicaid with little federal oversight.\footnote{42 U.S.C. § 1396a(a)(10)(i)(VIII).} If the Secretary determines, after reasonable notice and
opportunity for hearing, that a State Plan has fallen out of compliance with federal requirements, she has discretion under Section 1396c to withhold federal funding related to the noncompliance, until the Plan is corrected.\footnote{See 42 U.S.C. § 1396c.} Typically, the Secretary negotiates a correction plan with the state and has never withdrawn all federal funding from a noncompliant state.\footnote{For this reason, the Health Law Brief argued that the states’ question was not ripe, but the Court did not accept that view. Health Law Brief, supra note 14, at 21.} Section 1396c figures prominently in the NFIB decision, but has been present in the Medicaid Act since 1965.\footnote{Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 351. The language dates to Section 4 of the original SSA. Pub. L. 74-271, 49 Stat. 620, codified at 42 U.S.C. § 304.}

Each dollar a state spends on federally approved Medicaid programs, whether required or optional, is matched by federal funds.\footnote{See 42 U.S.C. § 1396b; see also Harris v. MCRae, 448 U.S. 297, 308 (1980) (describing “cooperative federalism” approach enacted “to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan”).} 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.\footnote{Federal Medicaid Assistance Percentage (FMAP) calculations are published in the Federal Register each year. See 76 Fed. Reg. 5811-3 (Feb. 2, 2011) (calculating the adjusted Federal Medical Assistance Percentage for the first quarter of the fiscal year 2011).} In addition, states receive a federal match of at least 50% for administrative costs.\footnote{See 42 U.S.C. §1396b(a) (2006) (listing the percentage of the state spending the federal government will match depending on the type of expenditure).}

Prior to the ACA, State Plans were required to cover seven groups (the “categorically needy”) modeled on the traditional deserving poor: the elderly, disabled, blind, pregnant women, and children.\footnote{42 U.S.C. § 1396a(a)(10)(A).} States may also extend benefits to “optional categorically needy” beneficiaries.\footnote{42 C.F.R. §§ 435.201, 436.217 (listing various additional categories, including certain children in foster or adoptive homes, women screened for breast and cervical cancer under a federal early detection program, and certain gainfully employed individuals with disabilities).} States may also elect to cover the “medically needy,” meaning individuals who are categorically eligible (aged, disabled, blind, or families with dependent children) but whose income exceeds the financial eligibility levels but nevertheless have high medical expenses.\footnote{42 U.S.C. § 1396a(10)(C); Henry J. Kaiser Family Foundation, STATE HEALTH FACTS, INCOME ELIGIBILITY REQUIREMENTS INCLUDING INCOME LIMITS AND ASSET LIMITS FOR THE MEDICALLY NEEDY IN MEDICAID, 2009, available at http://www.statehealthfacts.org/comparereport.jsp?rep=60&cat=4.} Thirty-three states and the District of Columbia currently cover these optional groups.\footnote{42 U.S.C. § 1396a(10)(C); Henry J. Kaiser Family Foundation, STATE HEALTH FACTS, INCOME ELIGIBILITY REQUIREMENTS INCLUDING INCOME LIMITS AND ASSET LIMITS FOR THE MEDICALLY NEEDY IN MEDICAID, 2009, available at http://www.statehealthfacts.org/comparereport.jsp?rep=60&cat=4.}
Nationwide, children represent close to half of the total Medicaid enrollment. The elderly and disabled comprise 25%, and the remaining 25% are non-elderly, non-disabled adults, usually caretakers of covered children. The income eligibility tests for vary among categories, based on federal requirements, and states, based on states’ optional coverage. For example, pregnant women must be covered up to 133% FLP, and states may opt to cover them to higher income levels. Federal law does not require states to cover non-pregnant caretakers or childless adults, but states may opt to do so, typically up to much lower FPL. Children age zero to five must be covered up to 133% FPL, while children age six to eighteen must be covered only up to 100% FPL. States may opt to cover higher income children, often in combination with the separate federal block grant Children’s Health Insurance Program. Medicaid coverage is also limited to citizens and qualified aliens (with a limited exception for emergencies). Once a state decides which groups will be eligible, it must decide which services it will provide. The Medicaid Act lists seven broad mandatory medical services, including inpatient hospital, outpatient hospital, laboratory and x-ray, nursing facility, physician, nurse-midwife, and nurse-practitioner services. States may also elect to cover “optional” services, including such fundamental items as dental care and prescription drugs.

Moreover, the state may not deny services solely because of a beneficiary’s diagnosis, illness, or condition. Beneficiaries are entitled to relatively prompt services with no waiting periods. 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.

99 Id.
100 Id.
105 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(1)–(5).
106 42 U.S.C. § 1396a(10)(A), 1396d(a) (listing various categories of medical assistance, only seven of which are mandatory).
107 42 C.F.R. § 440.230(c).
108 42 U.S.C. § 1396(a)(34); Rosenbaum, Medicaid at Forty, supra note 69, at 12.
“equal access” provision was at stake last Term in *Douglas v. Independent Living Center*.110

C. Congress Has Frequently Expanded Medicaid

Medicaid has never been a static program.111 Congress has repeatedly expanded Medicaid with both mandatory and optional features,112 often as part of broader policy initiatives.113 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 a short step to find the condition linking those “two” programs to be coercive. In addition, the *NFIB* plurality minimized 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 at risk under Section 1396c. These amendments are discussed immediately below.

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.114 Congress enacted a suite of reform115 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 to which all individuals under age twenty-one who are enrolled in Medicaid are entitled.116 EPSDT expanded coverage standards for children to a level unequaled in public or private health

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110 See *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 565 U.S. _ (2012), 132 S. Ct. 1204 (No. 09-958) (2012); see also Nicole Huberfeld, *Post-Reform Medicaid before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS OF HEALTH L. XXX (forthcoming 2012) (discussing the *Douglas* decision and juxtaposing it with *NFIB*).
insurance at the time. Since 1967, Congress has strengthened EPSDT several times, sometimes over states’ political objections.

Soon thereafter, Congress again expanded Medicaid coverage to reflect a change in traditional eligibility categories. In 1972, Congress ended the federal-state cooperative welfare program for the aged, blind, and disabled and replaced it with federal SSI. 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. Although the 1972 Amendments allowed states two options to comply with the new national policy, Congress did not afford states the option to forgo Medicaid expansion entirely. The Court misunderstood this point. In oral arguments, Mr. Clement, counsel for the states, incorrectly suggested the 1972 Amendments were “totally voluntary” and did not put existing funds at risk, and his error was not corrected by the Court or by General Verrilli. In the Roberts plurality, the 1972 Amendments are misleadingly described as “extending Medicaid eligibility, but partially conditioning only the new funding.” The 1972 Amendments were not voluntary, and both old and new funding were at risk; the only unique feature was that states were given the additional option of complying through 209(b).

In 1988, Congress completely delinked Medicaid eligibility for children and pregnant women from AFDC (later, TANF). Instead, Congress created uniform mandatory eligibility categories that are still the law today: up to 133% FPL for children from birth to age five and for pregnant women, and up to 100% FPL for children ages six

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118 See 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); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2106 (further delineating the scope of EPSDT benefit, including an express mandate that states cover “Such other necessary health care, diagnostic services, treatment, and other measures … to correct or ameliorate 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, 120 Stat. 4, (requires states to preserve EPSDT coverage in benchmark packages); Children’s Health Insurance Program (CHIP) Reauthorization Act of 2009, 111-3, § 611, 123 Stat. 8 (clarifying requirement to provide EPSDT in benchmark packages); ACA, § 2201 (preserving EPSDT as part of the newly reconfigured benchmarks).
120 Id. §§ 209, 301, as amended by Pub. L. No. 93-66, 87 Stat. 152, § 212 (1973); Gov’t Br. 6.
122 Transcript of Oral Argument at 10:8-10, Florida v. HHS (No. 11-400, Mar. 28, 2012) [hereinafter Transcript].
123 NFIB, 132 S. Ct. at 2605.
124 Health Law Brief, supra note 14, at 4-6.
to eighteen. Again, Congress did not offer states a choice about extending coverage; it became a condition of continued participation in the Medicaid program.

Congress added another significant mandatory requirement in 2003, as part the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA created coverage for outpatient prescription drugs in the Medicare program, called Medicare Part D. 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). At the time, all fifty states provided outpatient prescription drug coverage to beneficiaries as an optional Medicaid service. The MMA displaced states’ Medicaid prescription drug coverage programs for dual eligibles and required those beneficiaries to enroll in Part D. To keep the new Part D within President George W. Bush’s promised $400 billion limit, Congress’s financing for the program included compulsory state contributions toward the cost of Part D (known as the “clawback”). 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. The Congressional Budget Office estimated that states would pay a $155 billion in clawback payments between 2007 and 2016. Several states unsuccessfully challenged the clawback in an original jurisdiction petition to the Supreme Court, characterizing it as “an unprecedented intrusion into each State’s sovereignty.” States have since adapted their Medicaid programs to comply with Part D’s requirements.

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129 See Huberfeld, Clear Notice, supra note 14, at 445 (noting that “states historically have covered drug expenses for dual eligibles through Medicaid”); William G. Weisrett & Edward A. 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 Medicare.”); Richard Cauchi, State’s Rx for Medicare Gaps, ST. LEGISLATURES, Mar. 2006, at 28, 28 (describing states’ programs to fill prescription drug gap in federal Medicare program)
130 MMA §103.
131 MMA §103; Weeks, Clawback, supra note 58, at 103.
134 Texas v. Leavitt, 547 U.S. 1204 (2006) (mem.) (denying original jurisdiction to States seeking an injunction against implementation of the Part D clawback); Brief of Arizona et al. as Amici
In summary, the Roberts plurality was not historically accurate when it suggested that prior Medicaid amendments were voluntary or did not put existing program funds at risk.

D. The ACA Medicaid Expansion

The ACA represents another instance of Congress relying on Medicaid to address national healthcare needs. Most of the major Medicaid provisions take effect in 2014. Congress added a new category of individuals eligible for Medicaid, increased the income thresholds, modified the mandatory benefits package, and agreed to pay the lion’s share of the additional costs. 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.

The ACA expands Medicaid, just like prior mandatory amendments to the program, to all citizens and legal residents with incomes up to 133% FPL.\textsuperscript{135} This provision led Justice Roberts to say that the ACA changed Medicaid “in kind, not merely degree”\textsuperscript{136} because “unlike pre-ACA Medicaid, [the Medicaid expansion] does not ‘care for the neediest among us.’”\textsuperscript{137} In short, Justice Roberts asserted that the eighth mandatory Medicaid category does not represent the deserving poor and enrobed this distinction with constitutional significance.

The ACA also standardizes the income threshold for certain currently eligible groups, but these changes did not attract constitutional scrutiny. Income eligibility for Medicaid will be determined based on modified adjusted gross income, which uses a 5% income disregard, effectively raising the income level to 138% FPL.\textsuperscript{138} The expansion is especially significant for non-elderly, non-disabled, low-income single adults or couples without children, who previously were excluded from Medicaid as non-deserving poor. Coverage is also extended to 133% FPL for all children, not just those under age 6, instead of the current 100% FPL requirement for children between the ages of six and eighteen. States may cover these newly eligible individuals as early as April 1, 2010 and must cover them by January 1, 2014.\textsuperscript{139} These changes are significant but apparently did not strike Chief Justice Roberts as fundamental changes.

The third major Medicaid reform modified the mandatory benefit packages. For the newly eligible population, states may provide the traditional Medicaid defined benefit

\textsuperscript{135} 42 U.S.C. § 1396a(a)(10)(i)(VIII).
\textsuperscript{136} \textit{Id.} at 2605-06.
\textsuperscript{137} \textit{Id.}
\textsuperscript{138} \textit{See supra} note 51 and text accompanying.
\textsuperscript{139} ACA §2001(a)(1)(C), 124 Stat. at 271.
package, or benchmark or benchmark equivalent coverage\textsuperscript{140} (according to a 2005 definition from a prior amendment to Medicaid, known as the DRA).\textsuperscript{141} The Deficit Reduction Act (DRA) afforded states “unprecedented flexibility,”\textsuperscript{142} allowing states to modify their State Plans to provide “benchmark coverage”\textsuperscript{143} or “benchmark equivalent coverage.”\textsuperscript{144} Benchmark equivalent coverage is less comprehensive than the traditional defined benefits package.\textsuperscript{145} Instead of carefully planned, statutorily-designed care and services, states can pay a private insurer who does not have to comply with the Medicaid Act.\textsuperscript{146} Benchmark coverage is a departure from Medicaid’s signature “defined benefits” package on an equal basis,\textsuperscript{147} instead permitting states to enroll Medicaid beneficiaries in non-Medicaid managed care plans.\textsuperscript{148} Since 2005, states have had the option to require a large portion of the Medicaid population to enroll in benchmark coverage and provide different benefits within eligibility categories, with some exceptions.\textsuperscript{149} The ACA extends this option to the Medicaid expansion population.

The ACA revises the DRA definitions in several important respects. First, benchmark and benchmark equivalent benefits must include at least the package of “essential health benefits” that the ACA requires for private individual and small group insurance plans.\textsuperscript{150} 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.\textsuperscript{151} In addition, benchmark equivalent packages now must cover prescription drugs and mental health services,\textsuperscript{152} and both benchmark and benchmark equivalent packages must cover family planning services and supplies.\textsuperscript{153}

Fourth, the federal government will provide most of the funding for the Medicaid expansion.\textsuperscript{154} For the first three years of Medicaid expansion, the federal government

\begin{itemize}
\item \textsuperscript{140} 42 U.S.C. § 1396a(k)(1), 1396u-7(b)(5), 18022(b).
\item \textsuperscript{141} 42 C.F.R. §§ 440.330 (defining benchmark coverage), 440.335 (defining benchmark equivalent coverage).
\item \textsuperscript{142} Medicaid Program; State Flexibility for Medicaid Benefit Packages, 73 Fed. Reg. 9714, 9715 (Feb. 22, 2008).
\item \textsuperscript{143} See 42 U.S.C. §1396u-7(a)(1) (giving states the option of providing only “benchmark benefits” to certain populations).
\item \textsuperscript{144} 42 U.S.C. §§ 1396u-7(a)(1), (a)(2), (b)(2).
\item \textsuperscript{145} Id. § 1396u-7(b)(2)(A).
\item \textsuperscript{146} 42 U.S.C. § 1396u-7.
\item \textsuperscript{147} 42 U.S.C. § 1396u-7(a)(1)(A) (2006).
\item \textsuperscript{148} Id. § 1396u-7(b)(1).
\item \textsuperscript{149} 42 U.S.C. § 1396u-7(a)(2); 42 C.F.R. § 440.315.
\item \textsuperscript{150} 42 U.S.C. § 1396u–7(b)(5); 42 U.S.C. § 18022 (defining essential health benefits package).
\item \textsuperscript{151} 42 U.S.C. § 1396u–7(b)(6)(A) (excluding those offered by Medicaid managed care organizations).
\item \textsuperscript{152} 42 U.S.C. § 1396u-7(b)(2)(A).
\item \textsuperscript{153} 42 U.S.C. § 1396u–7(b)(7).
\item \textsuperscript{154} 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, at 2 (May 2010), available at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-
will pay 100% of the cost of newly eligibles in all states.\textsuperscript{155} Thereafter, the federal percentage phases down gradually, from 95\% in 2017 to 90\% in 2020 and thereafter.\textsuperscript{156} The more generous federal match applies only to the newly eligible population.\textsuperscript{157} 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 a savings as a result of the Medicaid expansion.\textsuperscript{158} Overall, the federal government funds 93\% of the expansion, according to the CBO.\textsuperscript{159} The 7\% state share represents a less than 3\% increase in state Medicaid spending.\textsuperscript{160} 

Finally, because the Medicaid expansions phase in on January 1, 2014, Congress was concerned that states might reduce voluntary expansions in the interim. 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,\textsuperscript{161} pending implementation of the Medicaid expansion and establishment of health insurance exchanges in January 2014. Compliance with the “maintenance of effort” (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.\textsuperscript{162} MOE provisions are typical of prior Medicaid expansions.\textsuperscript{163} In fact, the ACA’s MOE is very similar to the MOE in the American
Recovery and Reinvestment Act (ARRA) of 2009, to which states were subject before the ACA was passed.164

States may receive waivers of the MOE through an administrative process: 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.”167 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.168

The Medicaid expansion was significant, but was clearly an incrementalist modification to the existing program. The Court’s claim that the expansion was an entirely new program doesn’t square with the historical record.

III. National Federation of Independent Business v. Sebelius

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

Officials representing twenty-six states, two private plaintiffs, and the National Federation of Independent Business challenged the Medicaid expansion on federalism grounds. In particular, the plaintiffs argued that the ACA’s requirement to expand Medicaid exceeded federal conditional spending power and constituted unconstitutional coercion. The federal district court struck down the ACA in its entirety after holding the individual mandate unconstitutional but rejected the states’ Medicaid challenge.173

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164 ARRA § 5001(f)(1).
165 See MOE LETTER, supra note 164, at 1; see also Health Law Brief, at 34-36.
167 Id.; see MOE LETTER, supra note 164, at Q.5.
168 ACA § 2001(b)(2).
170 Florida v. U.S. Dep’t of Health & Human Servs., 648 F.3d 1235, 1240, 1262-64 (11th Cir. 2011), aff’d in part and rev’d in part, NFIB, 132 S.Ct. 2566 (2012). Only the states had standing to make this particular argument.
171 Id. at 1261-62 (citing 42 U.S.C. § 1396(a)). In South Dakota v. 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.” 483 U.S. 203, 211 (1987).
The Eleventh Circuit affirmed Judge Vinson’s Medicaid ruling, holding that because states continue to have a real choice whether to participate, the Medicaid expansion did not amount to coercion.

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. 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. This Part briefly describes the Eleventh Circuit’s holding, the arguments presented before the Supreme Court, and the Court’s highly fractured Medicaid opinions.

A. Florida v. Department of Health and Human Services

The plaintiff states in Florida v. HHS did not allege that Medicaid expansion violated any of the four limits on conditional spending power articulated in South Dakota v. Dole. Rather, their coercion challenge derived from the Tenth Amendment. The Eleventh Circuit noted that the Supreme Court had considered coercion in previous cases, namely Dole and Stewart Machine Co. v. Davis, 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.” Even though the choice might be politically difficult, when states “have a real choice, there can be no coercion.”

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

174 Florida, 648 F.3d at 1268.
175 Id. at 1267-68.
177 See supra note 14.
178 Florida, 648 F.3d at 1263. In the Healthcare Cases, the Court granted certiorari on three cases, including Florida, id., which was docketed as No. 11-400. On the Medicaid issue, certiorari was granted only under this case. Florida v. U.S. Dep't of Health & Human Servs., 132 S.Ct. 604 (Mem.) (U.S. Nov. 14, 2011) (granting certiorari to the Medicaid question).
179 South Dakota v. Dole, 483 U.S. 203 (1987) described in Florida, 648 F.3d at 1263 (including the requirement to use the spending power “in pursuit of the general welfare,” in a manner “reasonably related” to Congress’ policy goal, in an “unambiguous” manner that allows states to “knowingly exercise their choice,” and without requiring the states to act in violation of the Constitution).
180 Id. at 1264
182 Florida, 648 F.3d at 1265 (quoting Dole, 483 U.S. at 211).
183 Id. at 1268.
Medicaid program that “Congress reserved the right to make changes to the program,” a right that Congress exercised several times in the succeeding years. The federal government will cover virtually all of the costs of expansion, and never less than ninety percent after 2020, except for “incidental administration costs” and a portion of the expansion costs. Third, states were given four years’ notice to determine whether to “deal with the expansion” or “develop a replacement program.” Fourth, the states’ independent power to tax gives them the ability to fund healthcare programs of their own. Finally, the court rejected the states’ argument that they stood to lose all Medicaid funding if they did not agree to ACA’s eligibility expansion, noting that HHS has “the discretion to withhold all or merely a portion of funding from a non-compliant state,” which the court likened to South Dakota’s potential loss of five percent of federal highway funds in Dole.

The Eleventh Circuit's conclusion was well supported by previous challenges to Medicaid and similar conditional spending programs. Despite the consistency of lower courts’ reasoning and the absence of a circuit split, the Court agreed to hear the plaintiffs’ coercion question.

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184 Id. at 1267 (“The right to alter, amend, or repeal any provision of this chapter of the [Medicaid Act] is hereby reserved to the Congress.” (quoting 42 U.S.C. § 1304 (2006)) (internal quotation marks omitted)). This provision was mentioned in the briefs, __ [cite Fed, States & our briefs], and at oral arguments, Transcript, supra note 122, at 48:15, but was dismissed summarily by the plurality, as we describe below.

185 Florida, 648 F.3d at 1267-68 (citing 42 U.S.C. § 1396d(y)(1) (Supp. IV 2010)). The parties did not essentially dispute this fact, but they drew very different conclusion from federal generosity. To the federal government, generosity is a virtue; to the states, a vice.

186 Id. at 1268.

187 Id. at 1268 (emphasis added).

188 See, e.g., Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 22 (1980) (finding the Developmentally Disabled Assistance and Bill of Rights Act created shared responsibilities between the federal and state governments); 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 infringes on state sovereignty); Helvering v. Davis, 301 U.S. 619, 640 (1937) (explaining the concept of conditional spending power); see also Florida ex rel. Attorney Gen., 648 F.3d at 1267 (discussing the history of Medicaid Act amendments); Padavan v. United States, 82 F.3d 23, 29 (2d Cir. 1996) (finding that “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 for original jurisdiction to review 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), 2006 WL 1491289. The Supreme Court was unwilling even to hear the challenge, denying the states' petition for original jurisdiction. Texas, 547 U.S. at 1204. See infra note 134.

B. The States’ Merits Brief

Language from the states’ Brief shines through both the plurality’s and the joint dissent’s opinions in *NFIB*.190 The States acknowledged “[t]hat the line between coercion and persuasion may not be bright”191 but insisted that judicially enforceable limits on the spending power are necessary because Congress uses the Spending Clause to reach beyond the other enumerated powers. According to the States, if this Medicaid expansion does not cross the line into coercion, “no Act of Congress ever will.”192

In support of their coercion argument, the states contended that Congress never even considered the possibility of states opting out.193 By failing to provide an alternative method for those below the poverty line to comply with the individual mandate (other than Medicaid) and “threat[ing] to withhold all funds from States that were unwilling or unable” to expand Medicaid, 194 Congress passed 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 in their states, 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.”195 Accordingly, the suggestion that states could “pay[] for medical care for the indigent through new [state] taxes” was an “illusory” choice, 196 effectively resulting in double taxation of state citizens.

The states also urged that the sheer size of the Medicaid program supported the 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.”197 Congress’s statutory “right to alter, amend, or repeal”198 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

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190 The states were the Petitioners in No. 11-400.
192 States’ Brief, supra note 194, at 33.
193 Id. at 35.
194 Id. at 36-37.
195 Id. at 43.
196 Id. at 44. Note that Florida’s constitution prohibits state income tax.
197 States’ Brief, supra note 194, at 40.
“hold States hostage to Congress’ later demands.” Thus, the states argued that “no amount of notice will render a coercive choice any less coercive.”

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 limits on federal power. 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. The ACA “effectively order[s]” states to comply with the Medicaid expansion or “take full responsibility for all medical assistance to the needy themselves.” They distinguished *Dole* because the funds at stake with Medicaid expansion are “more than 1000 times” greater than the highway funds in dispute in *Dole*.

### 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.” The brief acknowledged *Dole* limits on federal spending power 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.” Invoking Justice Cardozo’s admonishment, the United States warned that applying the coercion doctrine would “plunge the law in[to] endless difficulties” and confuse “motive or temptation” with coercion.

The U.S. Government highlighted the history of the Medicaid program and prior expansions, noting that the Medicaid Act “has always mandated coverage for various categories of individuals and benefits,” and these categories have been expanded numerous times. 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.” 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

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199 States’ Brief, *supra* note 194, at 41-42.
200 *Id.* at 45.
201 States’ Brief, *supra* note 194, at 52. Of course, the states already failed at this option in the early twentieth century, which is the reason that Medicaid exists today.
202 *Id.* at 53.
204 *Id.* at 32 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 589-90 (1937)).
205 *Id.* at 26.
206 *Id.* at 21, 24.
argument on its head, 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.208

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.”209 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.”210

Responding 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.211 Moreover, many Medicaid-eligible individuals would be statutorily exempted from the individual mandate.212 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 Section 1303 of the SSA, providing that should any provision of the Act be declared invalid, the remainder should remain unaffected.213 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”214 but otherwise enforce the ACA as written. The federal government urged the Court to recognize that Congress would prefer a weaker Medicaid expansion to no Medicaid expansion – or no ACA – at all.215

D. The NFIB Opinions

June 28, 2012 was full of surprises.216 First, a majority of the Court upheld the individual mandate as an exercise of the General Welfare Clause power to tax, rather than...
under the anticipated Commerce Clause grounds. 217 Second, 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.218 Finally, the Court did not reach a precedential decision on the Commerce Clause, relegating discussions of the individual mandate to what are arguably *dicta*. No one predicted these peculiar outcomes. The three principal Medicaid opinions219 are described in the following sections; our analysis begins in Part IV, infra.

1. The Roberts Plurality

Chief Justice Roberts authored the controlling plurality decision on Medicaid coercion, joined by only Justices Breyer and Kagan as to Part IV on Medicaid.220 This decision is controlling because the joint dissent also found the Medicaid expansion to be unconstitutionally coercive, but refused to join the plurality.221 Pluralities are notoriously difficult to interpret, and *NFIB* does not disappoint.222

Chief Justice Roberts’ began: “There is no doubt that the [ACA] dramatically increases state obligations under Medicaid.”223 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”224 and to provide “a new ‘[e]ssential health benefits’ package’” to Medicaid recipients. 225 The opinion acknowledged that Congress may exercise its spending power to encourage states to regulate according to federal policy and to

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218 *Id.* at 2608 (Roberts, C.J., joined on this issue by Justices Breyer and Kagan).
219 Justice Thomas also filed a brief opinion which we do not discuss.
220 *Id.* at 2601. As described below, Justice Ginsburg’s opinion concurred only in Part IV-B, the remedy.
221 *NFIB*, 132 S. Ct. at 2642 (Scalia, Kennedy, Thomas and Alito, JJ., dissenting).
222 See, e.g., John F. Davis & William L. Reynolds, *Juridical Cripples: Plurality Opinions in the Supreme Court*, 1974 DUKE L.J. 59 (discussing the increasing incidence of plurality decisions and the confusion they create for lower courts and for developments in constitutional law). The authors note 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 to 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.
223 *NFIB*, 132 S. Ct. at 2601.
224 *Id.* (emphasis in the original).
225 *Id.*
Chief Justice Roberts’ limits on conditional spending power were grounded in federalism and the notion that “freedom is enhanced by the creation of two governments, not one.”\textsuperscript{228} To protect individual liberty, the Court must similarly enforce limits on federal direct commandeer and indirect coercion of states.\textsuperscript{229} The plurality observed that those concerns have twice led the Court to strike down federal legislation that “commandeers” states. The same federalism values should prohibit Congress from using the spending power “to exert ‘a power akin to undue influence.’”\textsuperscript{230} When congressional “pressure turns into compulsion,”\textsuperscript{231} the statute “runs contrary to our system of federalism.” Both federal commandeer and coercive spending “threaten the political accountability key to our federal system.”\textsuperscript{232} Under federalism, 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.\textsuperscript{233}

The opinion provided two reasons that the threat of losing all Medicaid funding constituted impermissible coercion. First, it rejected the federal government’s argument that Medicaid expansion was merely a modification to an existing federal program, which Congress reserved the right to amend or revise.\textsuperscript{234} To Roberts, under the ACA, “Medicaid is transformed,” and the expansion is “a shift in kind, not merely degree.”\textsuperscript{235} Two programs were at issue: “old” and “new” Medicaid.\textsuperscript{236} 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.\textsuperscript{237} In Chief Justice Roberts’s view, “new” Medicaid “is no longer a program to care for the neediest among us, but rather an element

\textsuperscript{226} Id. at 2602 (citing \textit{New York}, 505 U.S. at 166).
\textsuperscript{228} \textit{NFIB}, 132 S. Ct. at 2602 (citing \textit{Bond v. United States}, 131 S.Ct. 2355, 2364 (2011) and \textit{Alden v. Maine}, 527 U.S. 706, 758 (1999)).
\textsuperscript{229} Id.
\textsuperscript{230} Id. (citing \textit{Steward Machine Co. v. Davis}, 301 U.S. 548, 590 (1937)).
\textsuperscript{231} Id. (citing \textit{id}.).
\textsuperscript{232} Id.
\textsuperscript{233} Id. at 2603.
\textsuperscript{234} Id. at 2605.
\textsuperscript{235} Id. at 2605-06.
\textsuperscript{236} 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” (citing Justice Ginsburg’s dissent); \textit{id}. at 2606 (characterizing Medicaid expansion as “a new health care program”); \textit{id}. at 2607 (urging that “[w]hat 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”).
\textsuperscript{237} Id. at 2605-06.
of a comprehensive national plan to provide universal health insurance coverage.”238 He
described “new” Medicaid as characterized by the new category of eligible individuals,
the more generous federal funding provisions in Medicaid expansion, and the less
comprehensive minimum benefits package that states may offer to newly eligible
individuals.239

Second, the Chief Justice held the Medicaid expansion coercive because it
operated as far more than “inducement” or “relatively mild encouragement” of states.240
Medicaid expansion, read along with Section 1396c (allowing the Secretary to withhold
payment to states for noncompliance with Medicaid requirements) was effectively “a gun
to the head” of state governments.241 With Medicaid spending representing 20% of the
average state’s budget, “the 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.”242 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.”243 Because states face considerable practical difficulties walking away from
the substantial funding and disentangling their existing Medicaid programs, Medicaid
expansion operated as a “gun to the head.”

Just as the Court in Steward Machine declined to “fix the outermost” line where
persuasion becomes coercion, the plurality opinion saw “no need to fix a line” to
determine when Congress’s use of the spending power becomes coercive. Chief Justice
Roberts simply noted, “wherever that line may be, this statute is surely beyond it.”244
Citing a Commerce Clause and Tenth Amendment challenge to a different federal
program, 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.245 Thus, Roberts avoided creating any kind of rule,
test, standard, method, or other structure 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.246 The plurality,
however, held the Medicaid expansion unconstitutional only to the extent that it

238 Id.
239 Id. at 2606.
240 Id. at 2604.
241 Id.
242 Id. at 2604-05.
243 Id.
244 Id. at 2606.
245 Id. at 2606-07 (citing FERC v. Mississippi, 456 U.S. 742, 775 (1982) (O’Connor, J.,
concurring in judgment in part and dissenting in part)).
246 Id. at 2667-68 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).
“penalize[s] States that choose not to participate in [the] new program by taking away their existing Medicaid funding.” On this remedial issue, the plurality was joined by Justices Ginsburg and Sotomayor, thus a five-vote majority preserved the ACA from being struck down in its entirety. Relying on the SSA’s “separability” clause in 42 U.S.C. § 1303 (Section 1303), the Court “follow[ed] Congress’s explicit textual instruction to leave unaffected ‘the remainder of [the Medicaid] chapter.’” Accordingly, the only modification necessary to render the Medicaid expansion constitutional was that “the Secretary [of HHS] cannot apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.” The Medicaid expansion thus became optional for dissenting states, the above-mentioned “Red State Option.”

The plurality accepted the arguments from the United States and amici that Section 1303 demands a narrow remedy. 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. Accordingly, all other reforms Congress enacted in the ACA remain “fully operative as a law.”

2. The Ginsburg Opinion

Justice Ginsburg, joined by Justice Sotomayor, dissented from the plurality’s coercion decision, except with respect to the result on severability. 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 indistinct line between temptation and coercion.” Justice Ginsburg observed that the concerns that caused the Court to consider the coercion doctrine in Dole were not present in this case. First, the condition of expanded eligibility “relates solely to the federally funded Medicaid program.” By contrast, in Dole, the minimum drinking age condition related only indirectly to highway

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247 Id. at 2607.
248 Id. at 2641-42 (Part V.D.) (Ginsburg, J., concurring in part and dissenting in part). See infra section [III.B.2].
249 Id.
250 Id. (citing 42 U.S.C. § 1396c of the existing, pre-ACA Medicaid Act (authorizing the Secretary to withhold federal funding to noncompliant states)).
251 Outterson, Red State Option, supra note 23.
252 Id. (citing 42 U.S.C. § 1303); Health Law Brief, supra note 14.
253 Id. at 2608.
254 Id.
255 Id. at 2642 (Ginsburg, J., concurring in part and dissenting in part) (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”).
256 Id. at 2634.
257 Id.
258 Id.
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 could enact a nationwide minimum drinking age. Thus in *Dole*, it was plausible that the Spending Clause was being used to regulate activity beyond the enumerated powers. For the Medicaid expansion, these factors were absent.

Justice Ginsburg recognized the importance of Chief Justice Roberts’s claim that the ACA created a “new” Medicaid program. She noted that, like the original Medicaid Act, the expansion “enable[s] States to provide medical assistance to ‘needy persons,’” and it “leaves unchanged the vast majority” of provisions governing Medicaid. 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 “what point does an extension become so large that it ‘transforms’ the basic law?” She queried why the most recent Medicaid expansion constitutes “a shift in kind, not merely degree,” when prior statutory expansions did not, and charges the plurality with rewriting the 1965 Medicaid Act “to countenance only the ‘right to alter somewhat,’ or ‘amend, but not too much.’”

Justice Ginsburg directly challenged the features of the Medicaid expansion on which Chief Justice Roberts relied to characterize it as a “new” program. First, the Chief Justice suggested that “unlike pre-ACA Medicaid, [the Medicaid expansion] does not ‘care for the neediest among us.’” Justice Ginsburg responded: “What makes that so? Single adults earning no more than $14,856 per year—133% of the current federal poverty level—surely rank among the Nation's poor.” She also rebutted the suggestion that the ACA’s package of Medicaid benefits for newly eligible beneficiaries is “new,” noting the ACA did not create the definitions of “benchmark” and “benchmark equivalent coverage” but expressly incorporated these definitions from DRA of 2005. 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. She queried (like the United States Brief), “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?” Ginsburg’s also observed that nothing would stop Congress from simply

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259 Id.
260 Id.
261 Id. at 2635.
262 Id. at 2636.
263 Id. at 2639.
264 Id. (referring to 42 U.S.C. § 1304).
265 Id. (quoting *NFIB*, 132 S. Ct. at 2606 (Roberts, C.J., plurality opinion)).
266 Id.
267 Id. at 2636, note 20 (citing 42 U.S.C. § 1396u–7 (defining “benchmark coverage” or “benchmark equivalent coverage”) and 42 U.S.C. § 1396a(k) (allowing states to offer the same level of coverage to newly eligible beneficiaries under the ACA).
268 Id.
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.”

Regarding the contract analogy, Justice Ginsburg concluded that case law requires only that “conditions on federal funds be unambiguously clear at the time a State receives and uses the money.” That moment would begin in 2014, giving states more than three years to understand what was required of them. 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. Relying on Bowen v. Public Agencies Opposed to Social Security Entrapment, 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.

Justice Ginsburg expressed serious concern about the Court’s failure to “fix the outermost line” of the “point at which pressure turns into compulsion.” She noted 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, the effect of the lead plaintiff refusing the spending condition, or the combined effect of all plaintiff states refusing the spending conditions. Echoing the United States’ argument, Ginsburg worried that “political judgments that defy judicial calculation” will become the business of courts.

Ginsburg was joined only by Justice Sotomayor in finding the Medicaid expansion constitutional. Seven Justices signed two opinions holding the Medicaid expansion to be unconstitutionally coercive. The ACA was saved only on severability grounds. Justice Ginsburg agreed that Section 1303 and judicial precedent require the Court to “conserve, not destroy” the statute’s purpose. Here, Congress’s objective was to increase access to health care for the poor by increasing state funding. That objective is furthered by permitting states to accept Medicaid expansion funds, without facing potential withdrawal of federal funds under Section 1396c.
3. The Joint Dissent

The remaining four Justices filed a joint dissent signed by order of seniority. Justices Scalia, Kennedy, Thomas, and Alito joined no part of the Court’s opinion despite substantially agreeing with the coercion holding. The joint dissent would have held the Medicaid expansion unconstitutional on broader grounds and refused to sever the application of Section 1396c. According to the joint dissent, the constitutional flaws in the Medicaid expansion required striking down the entire ACA.

The joint dissent noted that “the 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. Left unchecked, however, such a power “would present a grave threat to the system of federalism” and allows 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.” The joint dissent shared the political accountability concern in the states’ Brief regarding the ability of federal officials to “remain insulated from the electoral ramifications of their decision.” In order to protect the “unique role of the States in our system,” 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 at which the spending power becomes coercive. The joint dissent suggested that freedom “as a matter of law” to accept or decline the Medicaid expansion was insufficient to render use of the spending power constitutional as it ignored the “practical matter” of whether states can effectively create an alternative.

To the joint dissent, “there can be no doubt” that the Medicaid expansion was unconstitutional. The states have independent power to tax and spend and could theoretically create a new healthcare program, but “the sheer size” of Medicaid means

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280 Id. at 2642 (Scalia, Kennedy, Thomas, and Alito, J., dissenting).
281 Id. at 2667 (“We should not accept the Government’s invitation to attempt to solve a 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 (regarding nonseverability of the rest of the ACA from the individual mandate and Medicaid expansion).
282 Id. at 2668 (describing severability inquiry as “whether the now-truncated statute will operate in the manner Congress intended” and “if Congress would have enacted [the provisions] standing alone and without the unconstitutional portion”).
283 Id. at 2658.
284 Id. at 2659 (citing Justice O’Connor’s dissent in Dole, at 217 (quoting Butler, 297 U.S., at 78)).
285 Id. at 2660 (quoting New York, 505 U.S. at 169).
286 Id. (quoting Davis v. Monroe County Bd. of Ed., 526 U.S. 629, 685 (1999) (Kennedy, J., dissenting)).
287 Id. at 2661.
288 Id.
that states would have to contribute up to “an additional 33% of all . . . state expenditures to fund an equivalent state program.”\textsuperscript{289} The dissent also suggested that states that opt out of Medicaid could also face the loss of TANF funds, which program is premised on state participation in Medicaid.\textsuperscript{290} 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.\textsuperscript{291}

Finally, the anticipated success of the inducement was a strike against it. The joint dissent agreed with the states’ argument that no one expected the states to refuse the Medicaid expansion.\textsuperscript{292} 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.”\textsuperscript{293} To the joint dissent, the exceedingly generous federal match was therefore further evidence of coercion.\textsuperscript{294}

On the question whether Medicaid expansion operates as unconstitutional coercion, seven Justices agreed. But the joint dissent and the Chief Justice parted ways not only on the scope of coercion, but also on the issue of remedy and severability. The joint dissent disagreed with the Court’s approach of severing the Medicaid expansion from the rest of the ACA for several reasons. First, the dissent maintained that “the ACA depends on States’ having no choice” as many individuals cannot afford insurance outside of Medicaid.\textsuperscript{295} 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. The joint dissent warned that the Court should not create this “divisive dynamic” but should leave such a design to “conscious congressional choice.”\textsuperscript{296} Third, the joint dissent agreed that the severability clause in Section 1303\textsuperscript{297} required the unconstitutional provision (that is, the Secretary’s authority under Section 1396c to withhold federal funding to noncompliant states\textsuperscript{298}) to be severed from the rest of the Act. But Section 1303 did not authorize the Court to rewrite the statute to prevent the ACA from being unconstitutionally coercive.\textsuperscript{299} The Court’s

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\item \textsuperscript{289} Id. at 2663 (citing Arizona as an example, noting that 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 billion”).
\item \textsuperscript{290} Id. (citing 42 U.S.C. § 602(a)(3)).
\item \textsuperscript{291} Id. (citing 42 U.S.C. § 1395dd) (using the old name of the statute).
\item \textsuperscript{292} Id. at 2664.
\item \textsuperscript{293} Id. at 2665 (giving examples of federal health insurance exchanges, as alternative to state-based exchanges, and option to cover lawful permanent residents either through state Medicaid programs or federal insurance subsidies).
\item \textsuperscript{294} Id. at 2666.
\item \textsuperscript{295} Id. at 2667.
\item \textsuperscript{296} Id.
\item \textsuperscript{297} 42 U.S.C. § 1303 (“separability” in the statutory text).
\item \textsuperscript{298} 132 S. Ct. at 2667 (regarding 42 U.S.C. § 1396c).
\item \textsuperscript{299} Id.
severance of the Medicaid expansion from the rest of the ACA “make[s] a new law” rather than “enforc[ing] an old one.”

IV. Coercion and Constitutional Confusion

Seven Justices in NFIB declared the Medicaid expansion unconstitutionally coercive. The Court has now decisively determined, through a three Justice plurality and a four Justice joint dissent, 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.

The courthouse doors have now been thrown open to invite challengers to explore the contours of the coercion doctrine. Therefore, in this Part, we give some shape to this new judicially enforceable concept. We begin by placing NFIB in context as a continuation of the Rehnquist Court’s Federalism Revolution. Next, we explore three key coercion questions. First is the Court’s reliance on, and potential modifications to, the Dole test. This includes whether Congress gave clear notice of the condition as well as the degree of relatedness between the program and the condition. Second, we consider the nature of coercion as it may be interpreted from this case, including how coercion is quantified, the tenacious theory of political accountability, and the concept of “coercion in fact.” Finally, we investigate the question of severability for future conditional spending challenges.

A. Continuing the Federalism Revolution

The spending power was notably excluded from the Rehnquist Court’s Federalism Revolution, which otherwise recognized a Tenth Amendment limit on various exercises of federal power. Justices and commentators interested in advancing the  

300 Id. (quoting Trade-Mark Cases, 100 U.S. 82, 99 (1879)).  
301 132 S. Ct. at 2606. 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 ‘enough 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. (citations omitted). At oral arguments, Justice Alito proffered a question about coercion in the context of federal education programs. Transcript, supra note 122, at 45:12-47:18.  
303 See, e.g., Davis v. Monroe County Bd. of Educ., 526 U.S. 629 (1999) (Kennedy, J., dissenting) (in which Justice Kennedy discussed 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, 10102-03 (1998). It seems from her dissent in South Dakota v. Dole that Justice O’Connor would have taken the Dole
Federalism Revolution found the exclusion of the spending power to be a fissure in the project, as the dissent in *Davis v. Monroe County Board of Education* observed. The Rehnquist Court bypassed several opportunities to recognize a Tenth Amendment limit in direct Spending Clause challenges such as *Dole* and *New York v. U.S.*, and in other cases such as *Pierce County v. Guillen*, a commerce power case that also presented a spending power issue in the lower court. Accordingly, the Roberts Court’s keenness to test a step farther by fortifying the germaneness element. *South Dakota v. Dole*, 483 U.S. 203, 212-18 (1987) (O’Connor, J., dissenting).

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305 See *Davis v. Monroe County Bd. of Educ.*, 526 U.S. 629 (1999) (Kennedy, J., dissenting). Justice Kennedy’s dissent, joined by Chief Justice Rehnquist, Justice Scalia, and Justice 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.” ” *South Dakota v. Dole*, 483 U.S. 203, 207 (1987) (quoting United States v. Butler, 297 U.S. 1, 66 (1936)). 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. 483 U.S., at 207. 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.” 526 U.S. at 654-55 (emphasis added) (parallel cites omitted).

306 *South Dakota v. Dole*, 483 U.S. 203, 210 (1987) (“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 Service Comm’n, 330 U.S. 127 (1947))).

307 *New York v. United States*, 505 U.S. 144 (1992). The majority approved of federal spending as an appropriate method of influencing state policymaking. *Id.* at 166-67. 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. …[thus] not inconsistent with the Tenth Amendment.” *Id.* at 173.

308 537 U.S. 129 (2003) (holding that federal regulation of information about highway failures collected by states for federal funding purposes was a proper exercise of commerce authority).

309 *Guillen v. Pierce County*, 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).
revisit federalism through the vehicle of Medicaid in NFIB was not surprising. As a former clerk of then-Justice Rehnquist, Chief Justice Roberts’ jurisprudential ideas understandably may have been honed 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 recently hinted at desire to revisit conditional spending doctrine as well as federalism protections for the states. For example, Justice Kennedy’s concurrence in U.S. 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.” Justice Kennedy was clearly asserting that the Tenth Amendment should be a judicially enforced limiting principle on the spending power, just has he had written it should be on the Commerce Clause in cases such as Lopez and Morrison. 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….”

Likewise, the Court’s 2011 decision in Bond v. United States was rich with federalism observations that were harbingers of NFIB. Bond could have been a brief decision (see Justice Ginsburg’s two-page concurrence) that a criminal defendant can always defend herself based upon the constitutionality of the law under which she is charged. But because Ms. Bond defended herself by asserting a Tenth Amendment issue, Justice Kennedy wrote pages about the nature and value of federalism and the role of divided government in protecting individuals. Bond contains language that was echoed in the States’ Brief and that is reiterated in NFIB.

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312 United States v. Morrison, 529 U.S. 598 (2000) (Kennedy in the majority voting to strike down portions of the Violence against Women Act as violating the Tenth Amendment).
315 Bond, 131 S.Ct. at 2367 (Ginsburg, J., concurring).
316 Id. at 2364-66 .
317 States’ Brief, supra note 194, at 24-25.
318 See, e.g., NFIB, 132 S. Ct. at 2578 (“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.’”) (citing Bond) (internal citations omitted); NFIB, 132 S. Ct. at 2602 (“‘freedom is enhanced by the creation of two governments, not one.’”) (citing Bond) (internal citations omitted).
In addition, Justice Alito crafted his 2006 opinion in *Arlington Central School District Board of Education v. Murphy* 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. 319 *Arlington* was also indicative of things to come, as the clear statement rule that the Court introduced there was a step toward greater judicial limits on congressional spending power.

*NFIB* advances the Federalism Revolution as the first decision by any federal court to hold Spending Clause legislation to be unconstitutionally coercive. For proponents of broad federal power, it is tempting to conclude that the decision is *sui generis* and limited to its particular facts, but the decision suggests 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 been the definitive test for determining whether conditions placed on federal spending are constitutional. 320 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.’”

Unfortunately, the manner in which the plurality addressed the four-part *Dole* test is both unclear and disorganized. The *NFIB* opinions relied heavily, but indirectly, on the elements of the *Dole* test, despite those elements not having been argued or briefed below. Judge Vinson cited the *Dole* test and noted that “[t]he plaintiffs do not appear to dispute that the Act meets these restrictions.” 322 The Eleventh Circuit also noted the concession, with a footnote distinguishing the plaintiffs’ claims from the germaneness requirement under *Dole*. 323 At oral arguments, the Solicitor General said the Medicaid expansion “complies with all of the limits set forth in this Court’s decision in *Dole*, and

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319 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 parents who successfully challenge inadequate plans for the children with attorneys’ fees. At issue in the case was whether such fees also included reimbursing expert (non-attorney) fees. The Court held that expert fees could not be reimbursed because the state did not have clear notice of this funding requirement. *See Arlington Central Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291 (2006).


321 *NFIB*, 132 S. Ct. at 2634 (Ginsburg, J. concurring in part and dissenting in part) (quoting *Dole*).

322 *Florida*, 716 F. Supp. 2d at 1157.

323 *Florida*, 648 F.3d at 1263, n.63.
the States do not contend otherwise.” 324 Justice Ginsburg noted similarly in her opinion.325

And yet, elements of the Dole test feature prominently in the plurality opinion,326 though they are not named 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. With irony that the Court perhaps did not intend, the first such part was “clear notice.”

a. Clear Notice

When exercising authority under the Spending Clause, Congress must clearly express any conditions it attaches to federal funds.327 The Court first articulated this legislative clear statement rule in Pennhurst State School and Hospital v. Halderman,328 authored by then-Justice Rehnquist, who later incorporated it into the second element of the Dole test as an “unambiguous conditions” requirement.329 This requirement was later tightened by Justice Alito’s majority opinion in Arlington, which announced that “clear” notice is required, not mere unambiguity or “adequate” notice.330 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.331

The clear notice requirement is closely linked with the Court analogizing spending legislation as “much in the nature of a contract.”332 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

325 NFIB, 132 S. Ct. at 2634, n.18 (Ginsburg, J., concurring in part and dissenting in part).
326 Id. This issue was discussed at oral arguments as well. Transcript, supra note 122, at 41:25, 42:11,16,22; 43:1,7; 44:21.
328 Id. at 25. Pennhurst involved the requirements of the Developmentally Disabled Assistance and Bill of Rights Act (the “Act”), in particular § 6010 of the Act (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 moneys must be “unambiguous” so that States may “exercise their choice knowingly, cognizant of the consequences” of their choice to comply with federally imposed conditions. Id. at 17. Because states could not have known the particular provision at issue to be a requirement, the Court refused to enforce it against them retroactively.
329 Huberfeld, Clear Notice, supra note 14, at 446-52 (describing the progression from Pennhurst to Dole).
331 Arlington, 548 U.S. at 296, 304.
332 Pennhurst State Sch. & Hosp. v. Halderman, 451 U. S. 1, 17 (1981); see also Brief Amicus Curiae of James F. Blumstein on Behalf of Petitioners (No. 11-400) (further developing the contract analogy for the Medicaid coercion argument).
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.” Arguably the goal of this requirement is informed choice, not second-guessing the wisdom of the state’s decision.

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. It now appears that clear notice and coercion are linked. 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 such a long-standing program as Medicaid cannot possibly have clear notice of a meaningful new condition on the funding for that program, despite Congress’s express reservation of the right to amend, revise, and thereby, implicitly, to impose new conditions on the program. If so, then Congress apparently could never significantly change the terms of cooperative federalism programs. It is hard to believe this was the Court’s intended effect. Future Congresses could certainly repeal Medicaid entirely, as Justice Ginsburg noted.

The reasoning of the plurality and the joint dissent 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 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. In *Pennhurst*, the Court cautioned “[t]hough Congress’ power to legislate under the spending power is broad, it does not include surprising participating States with post acceptance or ‘retroactive’ conditions.” 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. Here, states have several years to decide whether to agree to the conditions before agreeing to Medicaid participation.

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333 *Id.* at 25.
334 *NFIB*, 132 S. Ct. at 2636 (Ginsburg, J., concurring in part and dissenting in part)
335 *Id.* at 2636.
337 *Pennhurst*, 451 U.S. at 24-25.
The lack of notice in *Arlington* is similarly distinguishable from the present case.\(^{338}\) 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 briefing, much ink was spilled over whether Congress gave clear notice in 1965, but surely this is the wrong question. The original 1965 Medicaid statute provided: “The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress.”\(^{339}\) 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 are there. 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 since an explicit provision permitting unilateral amendment is hardly a contract.

When discussing the question of clear notice, it is important to remember that the Court did not rule any provision of the ACA to be unconstitutional. The only federal law affected by *NFIB* is Section 1396c which authorized the Secretary to limit federal funds for noncompliance. But Section 1396c was not added by the ACA; it also has been part of the Medicaid Act since 1965. And surely Congress could cut off future funds to states through legislation repealing, no longer funding, or otherwise amending the Medicaid Act. The Court’s decision is therefore tantamount to saying that congressionally authorized administrative remedies are unconstitutionally coercive, but direct congressional action would be permissible. Of course, the Tenth Amendment gives no textual hint of this rule, nor does the Court elucidate any precedent or theory supporting this approach.

The Court also displayed muddled thinking about the purpose of the clear notice requirement. If some states accept the conditions on a federal offer, and others reject them, does that suggest that the rejecting states have a better understanding of the implications of the conditions, or did they merely made different political choices? Clear notice is a procedural, not a substantive rule. The requirement does not ask normatively whether states should accept the offer, only whether they have all the facts they need to ensure a deliberative process. But here, the Court has effectively chosen the view advanced in the States’ Brief rather than deferring to the statute as written and to congressional expertise. As we discuss further below, the Court’s lack of legislative deference also characterizes its relatedness discussion but runs contrary to its severability analysis.

\(^{338}\) *Arlington*, 548 U.S. at 296 (noting that a state must have clear notice of conditions and not learn of them post-hoc through piecemeal litigation).

\(^{339}\) 42 U.S.C. § 1304.
b. Relatedness

The linchpin of the plurality is the artificial distinction 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. Until now, the Court had not enforced “relatedness” in this context. But after NFIB, we will undoubtedly see many cases applying this new concept, especially to determine exactly how “related” the condition must be to the existing program.340

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, structured as a permanent mechanism for protecting states.341 This is far from the truth. As we described in Part III, in 1965 Medicaid was limited to covering the “deserving” poor,342 but that was the historical path created by the Elizabethan Poor Laws. The limited categories of Medicaid eligibility were not a mechanism for protecting states from onerous federal conditions.

Chief Justice Roberts’ suggestion that individuals below 133% FPL are not “the neediest among us” was egregiously incorrect.343 As Justice Ginsburg described, the expansion income levels are quite modest,344 especially given the lack of protection from medical bankruptcy.345 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. 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 insists on a hearing. 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,” extending eligibility by eliminating the categorical characterizations of poverty was

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340 Kenneth R. Thomas, Cong. Research Serv. THE CONSTITUTIONALITY OF FEDERAL GRANT CONDITIONS AFTER NATIONAL FEDERATION OF INDEPENDENT BUSINESS v. SEBELIUS. July 17, 2012. As the Congressional Research Service described it, this transformation created an entirely new category for constitutional condition cases.
341 NFIB, 132 S. Ct. at 2636 (Ginsburg, J., concurring in part and dissenting in part).
342 Huberfeld, Federalizing Medicaid, supra note 14, at 436-49 (2011) (providing a history of Medicaid to explain why the program has persistently carried the limitation on the deserving poor and a focus on states’ rights).
343 NFIB, 132 S. Ct. at 2636 (Ginsburg, J., concurring in part and dissenting in part).
344 Id.
entirely consistent with federal control of a program that exists to mainstream the poor into the healthcare system.\textsuperscript{346} The Court rejected the idea that Congress could “style” the “new” expansion as part of “old” Medicaid simply by calling it so.\textsuperscript{347} But the Medicaid expansion is not merely an issue of style. It is a modernization of the Medicaid program compatible with prior expansions.\textsuperscript{348}

The characterization of “new Medicaid” is dangerous because it essentially denies Congress authority to set the parameters of its conditional funding 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 seemed to misunderstand that eligibility for a federal program is a key element of “preserv[ing] control over the use of federal funds.”\textsuperscript{349} If eligibility for federal funding is beyond the federal government’s control, then \textit{NFIB} truly opens the floodgates for litigation and eliminates any reliance on the coverage promised by those programs.

With respect to relatedness, the views of the joint dissent and the Roberts plurality merge, suggesting a line of argument likely to garner the support of seven justices in future litigation. A majority of the Justices appear willing to look behind 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 \textit{Dole} dissent, which similarly would have given prominence to germaneness under the \textit{Dole} test, will now surely operate in future coercion analyses.\textsuperscript{350}

\textsuperscript{346} \textit{Id.} at 2639.
\textsuperscript{347} \textit{Id.} at 2605-06 (Roberts, C.J.); \textit{id.} at 2635 (Ginsburg, J., concurring in part and dissenting in part).
\textsuperscript{348} The essential health benefits package is also not new, it was introduced as an element of flexibility for states in the Deficit Reduction Act of 2005. [cite] How ironic that the states now point to it as coercion, when it was originally written to benefit them and provide them more flexibility.
\textsuperscript{349} \textit{NFIB}, 132 S. Ct. at 2603 (Roberts, C.J.).
\textsuperscript{350} South Dakota v. Dole, 483 U.S. at 213-18 (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 \textit{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.” \textit{Id.} at 215-16 (citations omitted).
Based on its assessment of the Medicaid expansion as a “new” program, the plurality wrote, “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 change.”\textsuperscript{351} For the plurality, “old” Medicaid was an “other significant independent grant” which could not be conditioned on states agreeing to accept “new” Medicaid conditions. The suggested line of attack for future challenges is that conditions unrelated to the program for which funding is offered should be deemed non-germane thus coercive, depending on the amount and percentage of funding at stake.\textsuperscript{352}

Both the plurality and the joint dissent were opaque in their application of the four \textit{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.\textsuperscript{353} \textit{NFIB} carves new ground, first, by giving teeth to \textit{Dole}’s germaneness limit, and, second, by injecting two \textit{Dole} factors, germaneness and clear notice, into the coercion doctrine. 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 \textit{NFIB}. Two examples follow.

First, in \textit{Kansas v. United States}, Kansas challenged conditions imposed on states that accepted federal funds under TANF and related programs after the 1996 welfare reform.\textsuperscript{354} Federal law required states to adopt uniform national child support laws and procedures, including the Uniform Interstate Family Support Act.\textsuperscript{355} Congress required all fifty states to adopt this specific legal text or else suffer loss of all TANF funds.\textsuperscript{356}

\textsuperscript{351} \textit{NFIB}, 132 S. Ct. at 2604.
\textsuperscript{352} Because the majority in \textit{Dole} had found the conditions sufficiently related to spending for the general welfare, the third prong was dispensed. \textit{Dole}, 483 U.S. at 211.
\textsuperscript{353} Justice Ginsburg acknowledged “federalism-based limits” on Congress’s power to spend, \textit{NFIB}, 132 S. Ct. at 2634 (Ginsburg, J., concurring in part and dissenting in part), but she rejected the plurality’s assessment that the states lacked notice of the Medicaid expansion as constitutionally significant. \textit{Id}. at 2634-35. Further, Justice Ginsburg distinguished germaneness concerns in \textit{Dole} from the expansion funding in \textit{NFIB}, a clear reference to the plurality’s nod to Justice O’Connor’s dissent, which Justice Ginsburg did not cite. Justice Ginsburg noted the condition on the spending is for the program, Medicaid, and not for anything else; therefore, the \textit{Dole} coercion concerns were not viable. \textit{Id}. at 2630.
\textsuperscript{354} 214 F.3d 1196 (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. \textit{See}, e.g., Douglas J. Besharov, \textit{End Welfare Lite As We Know It}, N.Y. TIMES, Opinion (Aug. 15, 2006) (describing the many changes attributed the workfare law and noting the impact of a strong economy on reducing welfare roles).
\textsuperscript{355} \textit{Kansas}, 214 F.3d at 1198.
\textsuperscript{356} \textit{Id}. 
States were also subjected to a “maintenance-of-effort” (MOE) provision akin to that found in many amendments to the SSA. Although not articulating “relatedness” as a constitutional test, the Tenth Circuit had little trouble finding an acceptable level of relationship between the funding and the condition. The two were “clearly related,” based on the program’s goals, legislative history, and the “interrelationship” between welfare and child support. Arguably, TANF and the Uniform Interstate Family Support Act appear to be less related than “old” and “new” Medicaid; accordingly, the Roberts plurality may reopen a 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, but this is precisely the type of evidence the Chief Justice slighted in his NFIB opinion.

Second, in Schweiker v. Oklahoma, thirteen states challenged the 1976 SSA amendments on coercion grounds. 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. 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.

NFIB clashes with Schweiker v. Oklahoma on at least two grounds. First, whether the threat of the loss of all Medicaid funds was coercive, and, second, whether Medicaid and SSI were related programs for this purpose. More examples exist and are likely to

357 Id. at 1197.
358 Id. at 1200 (internal citation).
359 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.””)
360 NFIB, 132 S. Ct. at 2605, n.13 (“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.”)
362 Id. at 409.
363 Id. (internal citations omitted).
364 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.” Id.)
arise in the near future; indeed, at oral arguments Justice Alito suggested that federal taxes for education might be vulnerable to coercion challenges.365

Thus, it appears that germaneness is no longer a silent element of the Dole test. The undergirding of relatedness was key to the plurality’s determination that the Medicaid expansion is unconstitutionally coercive, but the degree of connectedness between germaneness and coercion remains to be seen.

2. Failure to Define Coercion

In the absence of case law applying and defining the coercion doctrine, the states instead asked the Court to “fashion” a coercion doctrine.366 And “fashion” the Court did, though the rules for unconstitutional coercion in exercises of spending power have pointedly not been supplied. 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 acknowledgment was open-ended and could have been interpreted to mean either that Congress offered states too much money or that Congress threatened to take away too much money.367 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….”368 The conclusion 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. Indirectly, however, the amount offered seems relevant to the Court’s coercion analysis inasmuch as the overall size of a federal program, including both federal spending and federal grants to states, were part of the Court’s 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.369

365 Transcript, supra note 122, at 45–46.
366 States’ Brief, supra note 194, at 28 (“it is incumbent on this Court to fashion judicially enforceable outer limits on the 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)).
367 Dole, 483 U.S. at 211.
368 NFIB, 132 S. Ct. at 2607. The continuation of the thought was: “What Congress is not free to do is penalize States that choose not to participate in that new [Medicaid] program by taking away their existing funding.” Id.
369 The plurality wrote as if this were clear from Dole, but the interpretation is clearer than its source. NFIB, 132 S. Ct. at 2604 (“By ‘financial inducement’ the Court meant the threat of
Chief Justice Roberts’s opinion echoed a point he made during oral arguments, that 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.”

The Court’s quantitative analysis was not limited to the portion or totality of Medicaid funding at issue, in the abstract, but that amount 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. 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.

_NFIB_’s coercion analysis suggested that some subset of federal laws may now be unconstitutionally coercive, but the quantitative analysis was heavily fact-dependent. We know that offering a large sum of money is a permissible exercise of the spending power. But threatening to take away a large sum or a large percentage of 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 a list, or examples, of offers that would be prohibited but simply declared that if the states have “no choice” then Congress has acted impermissibly. This “choice” language comes dangerously close to Justice Stewart’s “I know it when I see it,” and 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 noted. For instance, based on the plurality, one might think that if the federal funding constitutes more than ten percent of a state’s budget (i.e., 50% federal funding of a typical state’s 20% budget for Medicaid), it must be coercive.\footnote{Slip op. at 52.} By way of contrast, the plurality noted that the federal funds being offered in \textit{Dole} “constituted less than half of one percent of South Dakota’s budget at that time.”\footnote{132 S. Ct. at 2505.} Alternatively, the CBO estimated that state spending to comply with the Medicaid expansion would represent less than a 3% increase over the amount states would spend absent the expansion.\footnote{See January Angeles, How Health Reform’s Medicaid Expansion Will Impact State Budgets, Center on Budget and Policy Priorities, July 25, 2012, available at http://www.cbpp.org/cms/index.cfm?fa=view&id=3801.} Moreover, even that amount was likely overstated, when offset against other expected state and local savings in health care spending for the uninsured under the ACA.\footnote{Id. at 2664 (Scalia, Kennedy, Thomas, Alito, J.J., dissenting); 132 S. Ct. at 2657 & n.7.} The CBO figures, which the Court did not cite, underscore the lack of certainty with a quantitative approach to defining coercion.

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 programs\footnote{Id. at 2657.} and the percentage of total state expenditures that amount would represent.\footnote{Id. at 2657.} The dissent concluded, “the annual Medicaid subsidy is equal to more than one-fifth of the State’s expenditures” and incorporated that figure into its coercion analysis.\footnote{Id. at 2657.} Further, the dissent noted that amount would be in addition to the federal taxes that state citizens have to pay to support Medicaid programs in other states.\footnote{Id.} The analysis has a quantitative veneer, but neither Congress nor a lower court could know from either the plurality or the joint dissent which numbers actually point to unconstitutional coercion.

b. Qualitative Coercion: Political Accountability

Another way of articulating \textit{NFIB}’s coercion discussion is to consider the federalism value of political accountability. The coercion discussion was a striking continuation of the Federalism Revolution; citing \textit{New York} and \textit{Printz}, the plurality wrote, “Permitting the Federal Government to force the States to implement a federal movie at issue was not). \textit{Id.} He seemed to recognize that this standard was unworkable upon joining the dissent in \textit{Miller v. California}, 413 U.S. 15, 37 (1973) (Douglas, J., dissenting).
program would threaten the political accountability key to our federal system."\textsuperscript{385} The Court stated 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.\textsuperscript{386} But when there is no choice, the federal government accomplishes its policy objectives, without being held politically accountable.\textsuperscript{387}

Political accountability has been a remarkably consistent and central concept in decisions limiting congressional authority under the Tenth Amendment.\textsuperscript{388} Neither the phrase “political accountability” nor prior decisions advancing that theme provide a framework for understanding how future coercion claims might play out.\textsuperscript{389} It is not a coherent federalism principle, and it creates no cognizable rule for lower federal courts, let alone Congress, to follow.\textsuperscript{387} 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 political one.\textsuperscript{391} 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.

\textsuperscript{385} \textit{NFIB}, 132 S. Ct. at 2602-03 (citing New York v. United States, 505 U.S. 144, 169 (1992), and referencing Printz v. United States, 521 U.S. 898 (1997), though no cite was provided). Quoting \textit{New York}, the Court continued: “Where 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.” \textit{Id.}

\textsuperscript{386} 132 S. Ct. at 2602-03 ; \textit{id.} at 2660 (Scalia, Kennedy, Thomas, Alito, JJ., dissenting).

\textsuperscript{387} \textit{id.} at 2603.

\textsuperscript{388} U.S. CONST. amend. X. Curiously, the plurality did not cite the Tenth Amendment except in introducing 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.” Slip. op. at 49. This almost sounds like Roberts is unwilling to mediate between the federal government and the states except in certain circumstances.

\textsuperscript{389} \textit{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 PURPA should have been held unconstitutional in part). Foreshadowing \textit{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.” \textit{Id.} at 787.

\textsuperscript{390} For a deconstruction of judicially enforced federalism, see MALCOLM M. FEELEY & EDWARD RUBIN, FEDERALISM: POLITICAL IDENTITY AND TRAGIC COMPROMISE, 139-43 (2008).

\textsuperscript{391} Political accountability has been described as the “answerability” of representatives to the represented, D. Bruce La Pierre, \textit{Political Accountability in the National Political Process – The Alternative to Judicial Review of Federalism Issues}, 80 Nw. U. L. Rev. 557, 640 (1985), and 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, \textit{State Autonomy Implications for Congressional Conditional Spending}, 24 Okla. City U. L. Rev. 349, 355 (1999).
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.”

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” that would occur if citizens in opting-out states paid federal taxes to support Medicaid expansion for citizens in opting-in states. 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. The point was raised in the context of coercion, 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. He insisted it would be, for one reason: federal taxes are raised from a state’s own citizens. 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. The linking of taxation and benefit also suggests a political accountability theme, but the United States wisely did not go there. First, the states ignored the existence of the Sixteenth Amendment, which facilitated the federal income tax. Second, 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.

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392 NFIB, 132 S. Ct. at 2633, n.17 (Ginsburg, J. concurring in part and dissenting in part).
393 Id. at 2667 (Scalia, Kennedy, Thomas, Alito, JJ., dissenting); see also id. at 2657.
394 States’ Brief, supra note 194, at 43.
395 Id.; State’s Reply Brief, at 1-2.
396 Transcript, supra note 122, at 3-6. Justice Alito questioned General Verrilli on similar grounds. Id. at 45-47.
397 Transcript, supra note 122, at 3-6, especially page 3:20 and page 5:22.
398 Transcript, supra note 122, 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.
399 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 said “no.” Transcript, supra note 122, at 6:21-7:7.
400 At oral arguments, Justice Sotomayor noted that lead plaintiff Florida 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, supra note 122, at 36:12-13.
own taxation policy choices, but this is not what “political accountability” generally means in the federalism context.

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 dissent questioned the long-settled decision in *Butler*, interpreting the Spending Clause as a separate source of federal authority but grudgingly accepted the Hamiltonian view as settled law.\(^{401}\) 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 federalism principles.\(^{402}\) The *NFIB* dissent’s reliance on a prior dissent amounts to double dicta—a non-binding opinion citing another non-binding opinion. But it provides insight into the direction the Court may take under 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.”\(^{403}\) The dissent seems to have satisfied itself by declaring that a law must be “coercive in fact” (as opposed to in theory). But the distinction between fact and theory is meaningless if coercion remains undefined.\(^{404}\) 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 co-opts the States’ political processes must be declared unconstitutional.”\(^{405}\)

The greatest irony of the dissent’s “coercion in fact” is how badly wrong it got the facts on Medicaid.\(^{406}\) Despite that fundamental misunderstanding of the program, the joint dissent suggests a preference for case-by-case resolution of coercion cases; 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

\(^{401}\) *NFIB*, 132 S. Ct. at 2657-58 (Scalia, Kennedy, Thomas, Alito, J.J., dissenting) (citing United States v. Butler, 297 U.S. at 65 (1937)).

\(^{402}\) See *id.* at 2659 (citing *Davis v. Monroe County Bd. of Educ.*, 526 U.S. 629, 654 (1999) (Kennedy, J. dissenting).

\(^{403}\) *Id.* at 2660.

\(^{404}\) *Id.* at 2661.

\(^{405}\) *Id.*

\(^{406}\) See infra Part II. The joint dissent reiterated its non-rule, writing: “Whether federal spending legislation crosses the line from enticement to coercion is often difficult to 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, J.J., dissenting).
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; we saw this conflict in the amicus briefs submitted on the Medicaid expansion.\footnote{See, e.g., Brief of the States of Oregon, Vermont, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Mexico, and New York, and the Governor of Washington as Amici Curiae in Support of Respondents, Florida v. Department of Health and Human Servs. (No. 11-400) (explaining the benefit of the Medicaid expansion to the states and representing differences of opinion within some states).} But seven members of the Court were unwilling to wait for an as-applied challenge, 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 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 Section 1396c and Medicaid. For example, in \textit{West Virginia v. U.S. Department of Health & Human Services},\footnote{West Virginia v. U.S. Department of Health & Human Services, 289 F.3d 281 (4th Cir. 2002).} the state challenged new cost recovery provisions in Medicaid, claiming: “thirty years later… Congress changed the rules of the game ….”\footnote{\textit{Id.} at 287.} The state asserted that loss of Medicaid funds would have caused West Virginia’s healthcare system to “effectively collapse.”\footnote{\textit{Id.}} But the Fourth Circuit found no unconstitutional coercion. The key point was Section 1396c, which grants \textit{discretion} to the Secretary for dealing with state noncompliance with federal Medicaid rules by withholding all, or some unspecified portion, of federal funding.\footnote{42 U.S.C. § 1396c (quoted in \textit{West Virginia}, 289 F.3d at 292).} In the view of the Fourth Circuit, “[t]his small difference in language makes all the difference in our analysis.”\footnote{\textit{West Virginia}, 289 F.3d at 292.} Because the federal government had not threatened to withhold all funding the penalty was merely “hypothetical,” leading the Court to conclude that West Virginia was “mounting a facial challenge to the constitutionality” of the statute.\footnote{\textit{Id.}}

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. \textit{NFIB} provides no greater clarity, having now applied the coercion doctrine to a set of facts, than \textit{Butler} and \textit{Dole}, which flagged but declined to apply it. Both the Roberts plurality and the joint dissent expressly declined to articulate any sort of test, instead merely providing nomenclature: the “anticoercion
rule. The dissent’s formula was simply: “if 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.” 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.”

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,” continuing the bizarre comparisons to “dragooning” that began with Printz. Both phrases are inappropriately incendiary. Historically, “dragoons” were French monarchist cavalry units who destroyed Huguenot churches and closed Protestant schools following the revocation of the Edict of Nantes in October 1685. Dragoons destroyed religious freedom and drove hundreds of thousands of religious dissenters from France, without democratic legitimacy or due process of law. Comparing the Medicaid expansion to “dragooning” demonstrates either an ignorance of history 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 to coldly “shoot” unless the state/victim complies. 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. No court below had found the Medicaid expansion to be unconstitutional, so there was no prior opinion deciding the remedy issue. Even when the Court granted certiorari, the Question Presented on severability focused exclusively on the Minimum Coverage Provision.

The first substantive discussion of Medicaid severability appeared in a single paragraph in the United States’ Brief filed on February 10, 2012, followed by more
robust discussion by *amici* in the briefs filed a week later. The Court ultimately adopted these points as their formal decision on Medicaid severability. By contrast, the States’ Brief and the States’ Reply Brief had little to say on the subject, other than a passing mention in a footnote. 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.

Clement was amenable to the suggestion, agreeing that his clients would be “certainly happy” with that result. Five Justices, including Justice Ginsburg, 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 may be anomalous but creates a host of unintended consequences for Medicaid and ACA implementation. First, we offer some preliminary thoughts on the effect of severability after a finding of unconstitutional coercion under the spending power. Second, we describe just two of the implementation challenges that the Court’s decision creates, though more will arise.

In many respects, the narrow remedy adopted by five justices reflects the particular context of the *NFIB* case, which was a path breaking case with significant political baggage. That context may have compelled the majority to choose a more conciliatory path when it came to the remedy. One commentator has gone so far as to call this decision a “*Marbury* for our time.” Chief Justice Roberts explicitly based his severability analysis, in part, on his political judgment of what Congress wanted, asserting that “[w]e are confident that Congress would have wanted to preserve the rest of the Act.”

The basis for this confidence is unclear and notably conflicts with the plurality’s lack of deference to Congress elsewhere in the opinion. The compulsion to

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422 Health Law Brief, supra note 14, at 29-41; NHeLP Brief; CAP Brief.
423 States’ Brief, supra note 194, at 54 n. 18 (11-400).
424 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, supra note 122, at 84-85.
425 Id.
427 *NFIB*, 132 S. Ct. at 2608.
preserve the ACA, it seems, was more a perception of political will than a judicial finding.

Other severability factors are internal to the facts of the case, rather than political, and contain broader legal context. For example, the plurality relied on Section 1303, the severability clause present in the Social Security Act since 1935.\textsuperscript{428} We do not know whether Section 1303 was determinative or merely helpful. Moreover, Congress cannot possibly have foreseen the need for a severability clause as a remedy for successful coercion challenges to the spending power. But it is not difficult to foresee decisions like \textit{U.S. v. Morrison} in the near future, where the Court holds Congress to a legislative drafting standard that could not have been known at the time a law was written.\textsuperscript{429}

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 (Section 1396c) was part of the “old” Medicaid Act. But as a matter of statutory interpretation, it defies reason to deem the Medicaid expansion part of the Medicaid Act for the statutory severability question but not for purposes of the constitutionality of the expansion. This result is more baffling considering the plurality expressly deferred to Congress, via Section 1303, an “old” Medicaid provision, in narrowly applying the severability remedy.\textsuperscript{430} But earlier in its opinion, the plurality declined to defer to Congress on the question whether the Medicaid expansion was simply an amendment of the Medicaid Act.\textsuperscript{431} The equivocal deference to congressional findings\textsuperscript{432} also appears in the plurality’s earlier assertion that “every reasonable construction must be resorted to, in order to save a statute from unconstitutionality.”\textsuperscript{433} With regard to upholding the minimum coverage provision, Roberts’ majority was willing to “[g]rant[] the Act the full measure of deference owed to federal statutes…,” but somehow that deference was not granted to Congress’s creation of the Medicaid expansion.\textsuperscript{434} Notably, the joint dissent also refused to defer to Congress’s legislative expertise.\textsuperscript{435}

\textsuperscript{428} 42 U.S.C. § 1303.
\textsuperscript{429} 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 \textit{United States v. Lopez}, which was decided after VAWA was passed).
\textsuperscript{430} See \textit{NFIB}, 132 S. Ct. at 2607 (“Our ‘touchstone for a decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature.’” (citing Ayotte v. Planned Parenthood of Northern New Eng., 546 U.S. 320, 330 (2006))).
\textsuperscript{431} See \textit{NFIB}, 132 S. Ct. 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.”).
\textsuperscript{432} See \textit{NFIB}, 132 S. Ct. at 2640-41 (Ginsburg, J., concurring in part and dissenting in part) (noting the plurality’s strange lack of deference for the congressional determination that the Medicaid expansion is in fact part of the Medicaid program).
\textsuperscript{433} \textit{NFIB}, 132 S. Ct. at 2594 (citing Hooper v. California, 155 U.S. 648, 657 (1895)).
\textsuperscript{434} \textit{NFIB}, 132 S. Ct. at 2579. In setting forth first principles, the Court wrote:

“Our permissive reading of these powers is explained in part by a general reticence to invalidate the acts of the Nation’s elected leaders. “Proper respect for a co-ordinate
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 Commerce Clause issue, those cases and analyses did not figure prominently in the Roberts Spending Clause plurality. We do not know if this was a conscious choice to fashion new standards in this discreet area.

Second, in the Health Law Brief, we suggested a federalism rationale for a narrow view of severability should the Court find unconstitutional coercion. Each state has different financial circumstances, so a federal spending program deemed coercive in Mississippi could be perfectly acceptable in Massachusetts. As we noted above, that approach seems consistent with the preferred coercion-in-fact approach. Put another way, why insist that all 50 states have been coerced when only 26 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 of or objection to the federal program. The Red State Option might be federalism’s preferred remedy as opposed to mere political expediency.

Third, perhaps the narrow remedy 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 clarifying that the Secretary had not

branch of the government” requires that we strike down an Act of Congress only if “the lack of constitutional authority to pass [the] act in question is clearly demonstrated.”

Id. (citing United States v. Harris, 106 U.S. 629, 635 (1883)). Later, the Chief Justice wrote: “The States contend that the expansion is really a new program …. 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.” Id. at 2605.

The joint dissent’s facts and analysis read like a doomsday worst-case scenario, which helps to explain the joint dissents’ coercion conclusion. Presenting the law in its least-flattering, most likely to fail light cannot be consistent with the Court’s proclaimed interest in deference to Congress’s expertise in lawmaking. See NFIB, 132 S. Ct. at 2594 (citing Hooper v. California, 155 U.S. 648, 657 (1895)).


Health Law Brief, supra note 14, at 38–41.

See e.g., Brief of the States of Oregon, Vermont, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Mexico, and New York, and the Governor of Washington as Amici Curiae in Support of Respondents, Florida v. Department of Health and Human Servs. (No. 11-400) (explaining the benefit of the Medicaid expansion to the states and representing differences of opinion within some states).

See supra Part IV.B.2.c.
threatened to withhold all Medicaid funding from any litigant state.\textsuperscript{440} Instead, at oral argument the Chief Justice focused on the worst-case hypothetical (i.e., the Secretary merely threatening to cut off all Medicaid funds) while General Verrilli did little to dissuade him.\textsuperscript{441} Justice Breyer tried to throw the Solicitor General a bone, noting the Secretary’s administrative discretion under Section 1396c and the Administrative Procedure Act, but Verrilli did not pick it up.\textsuperscript{442} Perhaps Justice Breyer was looking for a commitment that the Secretary would never actually cut off all existing Medicaid funds, given the strong institutional commitment to delivering health insurance and healthcare to Americans in need. Alternatively, Justice Breyer suggested at oral arguments the Administrative Procedure Act might cabin the Secretary’s discretion and provide an avenue for judicial review.\textsuperscript{443} Justice Scalia teased Justice Breyer about the suggestion,\textsuperscript{444} and no mention of these ideas appear in the decision.

In the near future, a federal court may be called upon to decide severability after unconstitutional coercion. If so, we hope the discussion above provides a useful set of warning posts through this novel territory, especially since the Court has left so much of it unmarked.

\textsuperscript{440} See, e.g., Health Law Brief, supra note 14, at 21.

\textsuperscript{441} The discussion:

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, supra note 122, at 54-55.

\textsuperscript{442} The discussion:

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?

Transcript, supra note 122, at 55-56.

\textsuperscript{443} Transcript, supra note 122, at 13-14.

\textsuperscript{444} Transcript, supra note 122, at 62-63.
4. Medicaid After the Healthcare Cases

In this final section, we will briefly explore challenges particular to the future of Medicaid created by the decision in *NFIB*. Even this exceedingly narrow severability opinion left many unanswered questions.445

The severability holding seems straightforward: the Secretary cannot use Section 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?446 This question is surprisingly difficult. The law we commonly refer to as the “Affordable Care Act” was two separate Acts of Congress, the Patient Protection and Affordable Care Act of 2010,447 as amended by the Health Care and Education Reconciliation Act of 2010.448 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 (late amendment to Title II); and Title I.C of Public Law 111-152 (Medicaid amendments made in reconciliation). In the following paragraphs, we sort all of the new Medicaid provision449 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 states; and (3) other Medicaid provisions, for which it is contestable whether they are now optional.

First, most of the new Medicaid provisions were never challenged in *NFIB*. Examples include enhanced reimbursement for primary care doctors in Medicaid,450 changes to the Medicaid drug rebate rules for new formulations of existing drugs,451 and expanding Medicaid coverage starting in 2019 for former foster care children.452 Other

446 We limit this analysis to new provision in Medicaid added by the ACA. States are still responsible to follow pre-ACA requirements such as due process when coverage or care is denied, 42 U.S.C. § 1396a(a)(3). See Jane Perkins, National Health Law Program, FACT SHEET: THE SUPREME COURT’S ACA DECISION & ITS IMPLICATIONS FOR MEDICAID 8 (July 2012) [hereinafter Perkins, FACT SHEET] available at http://www.healthlaw.org/images/stories/ACA_July_2012_Fact_Sheet.pdf.
448 H.R. 4872, Pub. L. 111-152.
449 The Eleventh Circuit opinions provide lists of the Medicaid provisions. See Florida v. HHS, 648 F.3d at 1261 (majority opinion), 1367-68 (Marcus, J., concurring in part and dissenting in part). Most of these provisions are never mentioned as coercive by Chief Justice Roberts in *NFIB*.
451 Health Care and Education Reconciliation Act of 2010, H.R. 4872, § 1206, amending 42 U.S.C. § 1396r-8(c)(2), as added by § 2501(d) of the Patient Protection and Affordable Care Act.
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 5% “income disregard” adjustment to the calculation of “modified adjusted gross income” for income eligibility purposes, and section 2304 (“Clarification of Definition of Medical Assistance”) of the ACA, which was singled out by the states in their brief, until we pointed out textual and factual errors in their selective reading of the statute. The great majority of the new Medicaid provisions fall into this category of provisions unaffected by the Court’s coercion decision.

Second, two new Medicaid provisions were central to Chief Justice Roberts’ analysis: the addition of an eighth mandatory category of adults eligible for Medicaid (otherwise ineligible adults under 133% FPL) and the enhanced federal matching rate, starting at 100% for the first three years. Of the two, only the former bears directly on the coercion holding. Without a doubt, after NFIB, if states fail to extend eligibility to adults under 133% FPL, the Secretary cannot use Section 1396c to cut off existing Medicaid funds. The plurality highlighted the enhanced federal match in support of its characterization of the Medicaid expansion as a “new” program but a 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.

The third category of Medicaid provisions is a roadmap for future litigation. The contestable provisions include: (1) the mandatory expansion of coverage to children under 133% FPL; (2) the “maintenance of effort” (MOE) rules locking in previous

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454 States’ Brief, supra note 194, at 9
455 Health Law Brief, supra note 14, at 36-38.
456 NFIB, 132 S. Ct. at 2601 (Roberts, C.J.); see supra Parts III.B.1, IV.B.1 and citations therein. This provision is found in the opening paragraph of Title II, § 2001(a)(1) of the ACA, amending 42 U.S.C. § 1396a.
457 See supra Part II.D and citations therein. This provision is found in § 2001(a)(3) of the ACA, amending 42 U.S.C. § 1396a.
state expansions while the ACA phases in;\textsuperscript{459} and (3) provisions defining the new “essential health benefits” package for the expansion populations.\textsuperscript{460} It is not entirely clear from \textit{NFIB} whether states may choose to ignore these provisions, either individually or in combination.\textsuperscript{461} We will briefly explore all three.

Modifications to CHIP and Medicaid for children occur in various parts of the Medicaid Act, but they are supported by the catch-all new eighth category of eligibility for everyone under 65 under 133\% FPL. The plurality mentioned these two expansions in the same breath, but the analysis focused almost exclusively on the novelty of the adult expansion not on the modifications to existing categories of poor children.\textsuperscript{462} Under current law, children up to five years old are covered to 133\% FPL. From age six to eighteen, current law mandates eligibility only up to 100\% FPL.\textsuperscript{463} It is unclear whether Chief Justice Roberts believed constitutional significance attaches to celebrating your 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 a “shift in kind.”\textsuperscript{464}

Second, federal law frequently has resorted to mandatory MOE provisions during transition periods.\textsuperscript{465} The issue was briefed\textsuperscript{466} and discussed at oral arguments,\textsuperscript{467} but was not discussed in \textit{NFIB}.\textsuperscript{468} A bill in Congress, the State Flexibility Act, would repeal the MOE requirements under ARRA, CHIP, and the ACA,\textsuperscript{469} but it has not passed. There is little or no basis for a state to conclude the MOE did not apply,\textsuperscript{470} and yet the National Association of Medicaid Directors, in a letter issued shortly after \textit{NFIB} was handed down, asked if states are “still subject to the MOE requirements” and what “penalty is

\[\text{(459) ACA \textsection 2001(b), amending 42 U.S.C. \textsection 1396a(gg).}\]
\[\text{(460) ACA \textsection 2001(a)(2), amending 42 U.S.C. \textsection 1396a(k)(1) and ACA \textsection 2001(c), amending 42 U.S.C. \textsection 1396u-7(b)(5).}\]
\[\text{(462) \textit{NFIB}, 132 S. Ct. at 2581-82, 2601; see also Health Law Brief, supra note 14, at 30-30.}\]
\[\text{(463) See supra Part II.D.}\]
\[\text{(464) \textit{NFIB}, 132 S. Ct. at 2605 (Roberts, C.J.).}\]
\[\text{(465) See supra Part II.D.}\]
\[\text{(466) US Brief, supra note 215, at 30-31; States’ Brief, supra note 194, at 6, 8-9, 45 n.17; Health Law Brief, supra note 14, at 34-36.}\]
\[\text{(467) Transcript, supra note 122, at 51:11, 72:20.}\]
\[\text{(468) There was also no substantive discussion in the Eleventh Circuit decision. See Florida v. HHS, 648 F.3d 1235.}\]
\[\text{(469) H.R. 1683, 112\textsuperscript{th} Cong., 2\textsuperscript{nd} Sess.; S. 868, 112\textsuperscript{th} Cong., 2\textsuperscript{nd} Sess.}\]
there for noncompliance? Notably, the Congressional Research Service concluded that NFIB did not affect the MOE requirement.

Finally, the operation of the “essential health benefits” (EHB) provision in the Medicaid expansion remains an open question. Under the ACA, certain health insurance plans, including Medicaid benchmark and benchmark equivalent plans for the expansion population, must provide at least EHB. The ACA broadly defines ten categories of services that must be included in EHB and delegates rulemaking authority to HHS to further define the set of health services and items in EHB. HHS exercised its discretion to involve states in defining EHB. The Congressional Research Service did not include the EHB on its list of optional Medicaid provisions, but the National Health Law Program did.

Despite that uncertainty, the EHB is an unlikely trigger for a Tenth Amendment challenge. Of all the provisions discussed in this Section of the article, the EHB is by far the most flexible, giving each individual state significant room to follow the characteristics of their local commercial health insurance markets. It would be difficult to find coercion in the EHB’s application to Medicaid, as benchmark and benchmark equivalent coverage are were created to be less restrictive than previous Medicaid 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. But he did not discuss the provision in any detail nor did he explain how a change in the Medicaid benefits package would be “unrelated” to the historical program.


472 CRS, SELECTED ISSUES, supra note 474, at 5-7; Outterson, Red State Option, supra note 23.


474 ACA § 1302(b).

475 CRS, SELECTED ISSUES, supra note 474, at 5-7.


477 CRS, SELECTED ISSUES, supra note 474, at 5-7.

478 See NHeLP, Q&A, supra note 482, at Q.1, p. 1.

479 See Health Law Brief, supra note 14, at 33 and sources cited therein.

480 NFIB, 132 S. Ct. at 2601. This sole mention is described as connected to the individual mandate, which the Court upheld. See also Health Law Brief, supra note 14, at 32.


Directors peppered the Administration with questions, seeking guidance. On July 10, 2012, Secretary Sebelius wrote back to the governors, promising “as much flexibility as we can.” 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 percent of such costs thereafter, or that states have flexibility to design the benefit package for the individuals covered.

The Secretary apparently does not consider the eligibility expansion to children or the EHB to be covered by NFIB. But given the tenor of the questions from states, future controversies seem likely.

The Obama Administration has decided to be even more flexible than the law requires. The level of voluntary flexibility promised has been extraordinary, surprising some observers.

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484 National Association of Medicaid Directors, *supra* note 492.
486 *Id.* (emphasis added) The letter also promises to aggressively protect otherwise eligible adults in opt out states from the individual mandate penalty. *Id.* at 2.
later, or miss the January 2014 deadline, but join when they are ready. It also appears that states will be permitted to expand and contract piecemeal, which is not supported by either the text of the ACA, including the MOE,\(^{489}\) or the Court’s opinion. In effect, the Administration has read *NFIB* as establishing an opening bid, from which states can bargain with the Secretary about the timing, scope, and coverage for Medicaid expansion within their individual states. But this is not a garden-variety expansion of the administrative state; it was created by the Supreme Court through the imprecise language in *NFIB* itself. At least until Congress can revisit the issue, the Court has given the Obama Administration nearly *carte blanche* authority, *de facto* if not *de jure*, to cut Medicaid deals with the states.

The second major implementation wrinkle raised by *NFIB* concerns premium assistance tax credits in the exchanges. For legal residents with incomes exceeding the FPL, the ACA provides tax credits to subsidize the purchase of private health insurance in the Exchanges. The mechanism is Section 36B of the Internal Revenue Code.

The ACA encourages states to create their own exchanges, but failing that, the federal government will create backup federal exchanges for states that fail to do so.\(^{490}\) The tax credits flow 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.\(^{491}\) This was inartful wording, as it has led the Cato Institute to allege that tax credits will not be available in the backup federal exchanges.\(^{492}\) 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 exchanges. A public hearing was held on November 17, 2011 and the regulations were finalized on May 23, 2012.\(^{493}\) It was clearly the intent of Congress for the tax credits to be available to people in all 50 states, including both state and federally operated exchanges.\(^{494}\)

\(^{489}\) *See* Rosenbaum & Westmoreland, *supra* note 504; Rosenbaum & Westmoreland, *supra* note 505; Perkins, *FACT SHEET*, *supra* note 467.

\(^{490}\) **ACA § 1321.**

\(^{491}\) **I.R.C. § 36B(b)(2)(A).**


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 receive full public assistance while less impoverished individuals will 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 boost coverage. In states that exercise their *NFIB* option to not expand adult eligibility to 133% FPL, we have a new health care “donut hole.” The poorest adults will still have Medicaid under current law (in some states, only up to 17% FPL, in others, to 133% FPL and beyond). Slightly less impoverished people will have tax credits in the exchanges (i.e., 100% to 400% FPL). People in the middle will be left out, with neither a government health care program nor government assistance to purchase private health insurance. If Cato’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, if incorrectly, may hold their state elected officials politically accountable for these anomalies. One political goal of the tax credit challenge is to deny coverage to millions of additional people, but to lay the blame for ACA’s failures on the federal tax code rather than state officials. Federalism’s political accountability is thereby turned on its head.

We are skeptical of this tax challenge on substantive and procedural grounds: substantively, the IRS has significant discretion, especially when it is arguably too generous to taxpayers; procedurally, states would not have standing to bring this suit and the Anti-Injunction Act should delay suit until no earlier than 2015. The Congressional Budget Office generally concurs. But for the purposes of this Article, it is sufficient to note that no federalism or coercion issue is present. Section 36B of the Internal Revenue Code is clearly an exercise of the taxing power.

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495 The “old” health care donut hole is the out of pocket payments in Part D, which is addressed over time by the ACA. ACA § 3301.


V. Conclusion

Of the four discrete questions before the Court, the Medicaid expansion offered the greatest potential for destabilization from both a statutory and a constitutional perspective; NFIB is likely to fulfill that promise. For the first time in its history, the Court held federal legislation based upon the spending power to be unconstitutionally coercive. A plurality of the justices (joined for future voting purposes by the dissent) decided that the Medicaid expansion created by the ACA was a “new” program to which Congress could not attach a potential penalty of losing all Medicaid funding for refusing to participate. Thus, the Secretary’s remedy of total funding withdrawal has been taken off the table, based paradoxically on the severability section of the Medicaid Act itself.

In reaching this conclusion, the Roberts Court signaled interest in continuing the Federalism Revolution. Though not named as such, the Court relied on, seemingly modified, and strengthened at least two existing elements of the test for conditional spending articulated in South Dakota v. Dole. The Court relied on clear notice of the condition on Medicaid spending, and it expanded the germaneness concept by distinguishing between “old” and “new” Medicaid. Though the Court has long required Congress to clearly notify the states of the conditions placed on federal spending, this was the first time the Court enforced the relatedness prong of the Dole test. Clear notice and germaneness now appear to be folded into the newly fashioned yet undefined coercion doctrine, which relied on quantitative as well as qualitative analysis to determine that the Medicaid expansion was unconstitutionally coercive.

At the end of the day, this fractured decision created a host of questions by saving the Medicaid expansion through the Red State Option. Not only do we not know how far the severability concept will go in future disputes, but also many questions have been left open pertaining to the implementation of the Medicaid expansion as well as the larger scheme of the ACA. The dockets will no doubt experience the reverberations of these open questions, as well as the Court’s unstated invitation to explore the coercion doctrine further.

Thanks to their success before the Court, the remedy in NFIB will force states to act one way or the other. States are no longer plaintiffs claiming coercion, powerless with a “gun to the head.” They can now make the difficult political choice upon which the lives of some of their most medically fragile, disenfranchised citizens will rely. We are now plunged into Justice Cardozo’s “endless difficulties.”