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The Strange Politics of Medicaid Expansion, 47 J. Marshall L. Rev. 947 (2014)

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THE STRANGE POLITICS OF MEDICAID EXPANSION

STEVEN D. SCHWINN*

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I. INTRODUCTION

Even before the ink was dry on President Obama’s signature on the Patient Protection and Affordable Care Act, or “PPACA,” Florida and twelve other states sued in the United States District Court for the Northern District of Florida to stop the Act.¹ Thirteen more states, several individuals, and the National Federation of Independent Businesses later joined the suit.² States brought cases in other federal courts, too, all lodging similar challenges against the Act.

The plaintiffs’ principal argument was that PPACA’s individual coverage provision, the so-called “individual mandate,” exceeded Congress’s powers. The minimum coverage provision required most individuals to maintain a minimum level of health insurance by a certain time.³ It was designed to help achieve the Act’s goals of universal health insurance coverage and keeping health-care costs in check.⁴ But plaintiffs claimed that Congress

*Associate Professor, The John Marshall Law School. I would like to thank Professor Kathryn J. Kennedy for organizing and inviting me to participate in this symposium. I would also like to thank my fellow symposium participants, who provided valuable feedback on the ideas and arguments presented here. Finally, I would like to thank the staff of the JOHN MARSHALL LAW REVIEW for its outstanding work on this piece. All errors, of course, are my own.

1. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2580 (2012).

2. *Id.*

3. The Act also contained a requirement that certain employers provide minimum coverage for their employees. 26 U.S.C. § 4980H.

4. The universal coverage requirement complemented two other insurance regulations in the PPACA, the “guaranteed issue” provision and the “community rating” provision. The “guaranteed issue” prohibits health

lacked power to force individuals into a market (the health insurance market), or to require them to purchase something (like health insurance) that they did not want.⁵

The plaintiffs also challenged another provision in the Act: Medicaid expansion.⁶ Medicaid expansion was designed to provide Medicaid coverage for a greater number of individuals, in particular, individuals who earned up to 138 percent of the federal poverty line.⁷ Like the individual coverage provision, Medicaid expansion helped serve the Act's goals of universal health insurance coverage and keeping health-care costs in check. But plaintiffs claimed that Congress lacked authority to enact the provision.

In particular, plaintiffs argued that Congress could not condition a state's entire federal Medicaid budget on a state's adoption of the expansion. Plaintiffs argued that the sheer size of the states' Medicaid programs, and the generous size of the promised federal contribution to Medicaid expansion, made Medicaid expansion all but compulsory for the states. Therefore, they said, Congress lacked authority to so compel the states to act.⁸

Balking states also claimed that they did not want to expand Medicaid. They argued that Medicaid expansion would be too costly for them, despite the very generous promised federal contribution. They also claimed that the federal government's efforts to expand Medicaid would require a substantial commitment of federal funds (which would require the federal government to tax citizens, which would leave citizens less money to pay state taxes, which would ultimately frustrate the states' abilities to achieve their own policy goals, whatever those goals may be).

The states' arguments against the PPACA were novel. As to the individual coverage provision, the Supreme Court had never defined a limit on congressional authority based on a person's participation, or not, in a particular market. As to Medicaid expansion, the Court had never defined a limit on congressional authority to condition federal funding based on the size of a pre-

insurers from denying coverage to individuals with pre-existing conditions. 42 U.S.C. § 300gg-1. The "community rating" provision requires health insurers to base health insurance rates on four factors (including self-only or family enrollment plans, geographic area, tobacco use, and age), but not on health factors. 42 U.S.C. § 300gg. Those provisions would have driven insurance companies out of the market without the additional revenue they would collect from newly enrolled individuals under the universal coverage requirement.

5. Brief of State Respondents on the Minimum Coverage Provision, *National Federation of Independent Business v. Sebelius* (No. 11-398) at 15-24 (Feb. 6, 2012).

6. See *infra* notes 20 and accompanying text.

7. *Id.*

8. *Id.*

existing program or the generosity of the federal contribution.

The states' positions were, and are, also surprising, especially with regard to Medicaid expansion. That is because Medicaid expansion amounts to a remarkably generous gift from the federal government to the states. Expansion would extend health insurance coverage to a wide swath of Americans, and it would cost the states very little, potentially even yielding a net savings. Maybe most surprising: the states that stand to gain the most are the loudest objectors.⁹ These states now say that they will decline to expand Medicaid.

Why? Objecting states argue Medicaid expansion will cost them and their citizens too much money. But the studies belie this. Most studies, before and after the Supreme Court ruled on the states' challenge in *National Federation of Independent Businesses v. Sebelius* (“*NFIB*”),¹⁰ concluded that Medicaid expansion would cost the states very little and could yield substantial cost savings.¹¹

So with all its benefits and few, if any, drawbacks, why do states continue to balk at Medicaid expansion? One reason is raw politics. From its inception, the PPACA has been a political lightning rod, dividing Democrats (who largely support it) and Republicans (who largely oppose it). Medicaid expansion is a particularly explosive and politically controversial component of the PPACA.¹² The fact that raw politics can drive opposition to policy is hardly news. But the political opposition to Medicaid expansion is different, because it comes at such a high cost to the state itself. A state's refusal to participate in Medicaid expansion means that many of the state's poorest citizens will go without insurance coverage, that the state itself will decline a remarkably generous federal gift, and that the state will forego all attendant economic benefits. In short, opposing states forego significant policy gains in order to score a modest political point.

Another reason is that the opposition to Medicaid expansion is just one piece of a larger effort to dismantle the PPACA. After opponents failed to overturn the Act in the Supreme Court and in Congress, they now attack the Act piecemeal in the states and the courts. For example, some states have declined to join state health insurance exchanges. This undermines the PPACA's attempts to expand health insurance coverage and keep costs in check by creating single point-of-purchase marketplaces where consumers

9. See, e.g., *Obamacare Facts: Dispelling the Myths*, available at <http://obamacarefacts.com/obamacares-medicaid-expansion.php> (last visited Apr. 7, 2014).

10. *NFIB*, 132 S. Ct. at 2566.

11. For example, every state that opted out of Medicaid expansion has a Republican governor. *Obamacare Facts: Dispelling the Myths*, *supra* note 9.

12. See, e.g., *id.* (explaining that some states with Republican governors, however, have opted in to Medicaid expansion).

can compare and select policies. Opponents have challenged the PPACA's so-called "employer mandate" in the lower courts. Additionally, opponents have challenged particular health insurance coverage requirements (the so-called contraception mandate) in the lower courts and now in the Supreme Court. These piece-by-piece challenges seek to pick off only portions of the PPACA. But because the Act depends on near universal coverage to succeed, these piece-by-piece challenges threaten to significantly undermine the entire Act, or even kill it—a death by a thousand cuts.

Opponents first sought to overturn Medicaid expansion entirely, in *NFIB*. Having failed in that effort, and having failed to overturn the PPACA in Congress, they declined to expand Medicaid in many states. In the wake, when all is said and done, opponents will have left substantial federal dollars on the table, they will have left a significant number of poor people uninsured, they will have foregone the economic policy benefits of increased federal grants and broader health insurance coverage, and they will have left behind bad constitutional law. This is a singularly high price to pay for politics. It is strange politics, indeed.

This paper first outlines the Medicaid program, Medicaid expansion in the PPACA, and the Court's ruling on Medicaid expansion in *NFIB*. It next explores the impacts of the opposition to Medicaid expansion. In particular, it details the substantial federal resources that opposing states will leave on the table, the health insurance coverage that states stand to deny to their poor citizens, and the constitutional law that opposing states left in *NFIB*.

II. MEDICAID EXPANSION AND NATIONAL FEDERATION OF INDEPENDENT BUSINESSES

Congress enacted the Medicaid program in 1965.¹³ Medicaid is a jointly-funded, federal-state, cooperative-federalism program that provides medical care to pregnant women, children, needy families, the blind, the elderly, and the disabled.¹⁴ Under the program, the federal government provides federal funds to states on the condition that they satisfy certain federal criteria.¹⁵ Those criteria set the qualifications of program participants, the services available to program participants, and the costs of those services.¹⁶ States contribute their own funds and administer their own Medicaid programs.¹⁷ Despite the federal criteria, states retain

13. 42 U.S.C. § 1396a et seq.

14. 42 U.S.C. § 1396a(a)(10).

15. See, e.g., *NFIB*, 132 S. Ct. at 2581-82 (2012) (describing the Medicaid program).

16. See, e.g., *id.* (describing the Medicaid program).

17. See, e.g., *id.* (describing the Medicaid program).

substantial flexibility in setting the rules for their own programs.¹⁸

Nothing in federal law requires states to participate in Medicaid; it is a purely voluntary program.¹⁹ Indeed, when Congress first enacted the Medicaid program, only twenty-six states signed up within the first year.²⁰ Over time, however, the federal funds became sufficiently attractive, and the health-care needs in the states became sufficiently acute, that more and more states joined the program. By 1972, forty-nine states plus the District of Columbia signed up, and by 1982, every state had elected to participate in Medicaid.²¹ It is easy to see why. Medicaid comprises 20 percent of the average state total budget,²² and the federal contribution rate generally falls between 50 percent and 83 percent of a state's total Medicaid expenditures, generally averaging 57 percent, depending on the state's per capita income.²³ On average, the federal government contributes 10 percent of a state's total budget in Medicaid funds.²⁴

The basic Medicaid program is the same today as it was in 1965. But over time, Congress added certain requirements, expanded eligibility, and expanded benefits.²⁵ Congress put the states on notice when it enacted the Medicaid Act that it might make changes like these to the Medicaid program. In particular, Congress expressly reserved the "right to alter, amend, or repeal any provision of the Act."²⁶ Moreover, federal regulations require each state to amend its plan "whenever necessary to reflect . . . [c]hanges in Federal law."²⁷

Thus, in 1972, Congress created Supplemental Security Income for the Aged, Blind, and Disabled ("SSI").²⁸ SSI replaced a former federal Medicaid requirement that participating states

18. See, e.g., *id.* (describing the Medicaid program).

19. See, e.g., *id.* (describing the Medicaid program).

20. *A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED 2 (Aug. 2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8349.pdf>. Thirty-seven states signed up within two years. *Id.*

21. *Id.* at 2.

22. *NFIB*, 132 S. Ct. at 2604-05.

23. *State Expenditure Report 2010 (Fiscal 2009-2011)*, NATIONAL ASS'N OF STATE BUDGET OFFICERS 11, Table 5 (2011) available at www.nasbo.org/sites/default/files/2010%20State%20Expenditure%20Report_0.pdf.

24. *NFIB*, 132 S. Ct. at 2583.

25. See generally *A Historical Review*, *supra* note 20 (describing the history of the Medicaid program); *Medicaid: A Timeline of Key Developments*, THE KAISER FAMILY FOUNDATION, available at <http://kaiserfamilyfoundation.files.wordpress.com/2008/04/5-02-13-medicare-timeline.pdf> (last visited Apr. 18, 2014); *History*, CMS.GOV, available at www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/history/ (last visited Apr. 18, 2014).

26. 42 U.S.C. § 1304.

27. 42 C.F.R. § 430.12(c)(1)(i).

28. Pub. L. No. 92-603, 86 Stat. 1465 (1972).

provide medical assistance to individuals receiving welfare benefits under four federal programs administered by the states: Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled.²⁹ Under SSI, the federal government displaced the states and assumed responsibility for funding payments and setting standards of need. The effect was to expand Medicaid eligibility in some states to those who were not previously eligible under state-set standards.³⁰

Beginning in the 1980s, Congress expanded Medicaid eligibility to certain individuals who were not receiving federal welfare. In 1989, Congress extended eligibility to pregnant women and children under age six, with household incomes up to 133 percent of the federal poverty line.³¹ In 1990, Congress extended eligibility to children aged six through eighteen with household income up to 100 percent of the federal poverty line.³²

Every state accepted these changes and elected to continue to participate in the expanded Medicaid program. However, many low-income individuals remained ineligible. For example, adults under age 65 who do not care for dependent children or are not pregnant or disabled are generally ineligible, regardless of income.³³ Parents who care for dependent children may be eligible, but standards vary by state, with the median eligibility cap of 37 percent of the federal poverty line for unemployed parents and 63 percent of the federal poverty line for parents with earnings.³⁴ The Secretary of Health and Human Services (“Secretary”) may authorize states to engage in “demonstration projects” that deviate from federal Medicaid requirements and expand eligibility and provide additional funds to states to cover parents with higher

29. *Id.*

30. The 1972 changes gave states a second option. That option, the “209(b) option,” allowed states to maintain their existing basic Medicaid eligibility standards (keyed to their federal welfare eligibility standards) so long as they adopted a “spend-down” provision that made eligible those individuals whose incomes otherwise met the SSI standard, but were too high to meet the state’s existing basic Medicaid eligibility standard, when an individual used his or her income above the basic Medicaid eligibility standard for medical care. Social Security Act of 1972 Section 209(b), Pub. L. No. 92-603 (Oct. 30, 1972). The upshot of this provision, too, was to expand Medicaid eligibility in some states.

31. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2258 (1989).

32. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4601, 104 Stat. 1388-166 (1990).

33. See 42 U.S.C. § 1396(d) (listing categories of individuals who are eligible).

34. *Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED 2 fig. 4 (Jan. 2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8272.pdf>.

incomes.³⁵ However, a vast number of low-income individuals still remain ineligible.

The Secretary enforces state compliance with the federal Medicaid requirements. In particular, the Medicaid Act authorizes the Secretary to withhold all “further [Medicaid] payments . . . to the State” if he or she determines that the state is out of compliance with any Medicaid requirement.³⁶ This allows, but does not require, the Secretary to withhold all federal Medicaid funding for a state that fails to comply with a particular requirement. It also allows the Secretary to withhold just a portion of the federal Medicaid funding related to a state’s compliance failure, or to withhold nothing at all.

Congress sought to address the gaping need for medical coverage for low-income individuals in 2010, when it enacted the PPACA.³⁷ In particular, the Act required state programs to provide Medicaid coverage to adults with incomes up to 133 percent of the federal poverty line.³⁸ (With the 5 percent set-aside, this meant that participating states had to provide Medicaid coverage to adults with incomes up to 138 percent of the federal poverty line).³⁹ Like earlier changes to the Medicaid program, states stood to lose their entire federal Medicaid funding, or the portion of it dedicated to the Medicaid expansion, if they declined to meet this new condition.⁴⁰ Again, this was subject to the Secretary’s discretion.⁴¹ But unlike earlier changes to the Medicaid program, Medicaid expansion under the PPACA came with a significant boon for the states: the federal government would pay 100 percent of the expansion through 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.⁴² (Recall that the federal Medicaid contribution before the Medicaid expansion in the PPACA generally fell between 50 percent and 83 percent of a state’s total Medicaid expenditures).⁴³ The very generous federal contribution rate amounted to a free gift to the states, at least until 2016, and ensured that states would consider it too good to pass up. Indeed,

35. 42 U.S.C. § 1315.

36. 42 U.S.C. § 1396c.

37. Pub. L. No. 111-148, 124 Stat. 119 (2010).

38. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

39. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

40. See 42 U.S.C. § 1396c (authorizing the Secretary to withdraw federal Medicaid funding for a state that fails to comply with a Medicaid requirement).

41. *Id.*

42. 42 U.S.C. § 1396d. Moreover, the federal government will pay 90% of the state administrative expenses associated with upgrading information systems for making eligibility determinations through 2015. 76 Fed. Reg. 21,950 (Apr. 19, 2011). The federal government ordinarily pays 50% of most state administrative expenses. 42 U.S.C. § 1396b(a)(2)-(5) and (7).

43. *Fiscal Year 2010 State Expenditure Report*, *supra* note 23, at 11, Table 5.

that was Congress's expectation.

Medicaid expansion was a significant part of the PPACA's goal of achieving universal health insurance coverage,⁴⁴ but it was not the only part. Another key provision of the Act, the so-called "universal coverage" provision or the "individual mandate," required uninsured individuals to purchase health insurance or pay a tax penalty.⁴⁵ Yet another provision required most employers to provide health insurance to their employees.⁴⁶ Finally, the nondiscrimination and "community rating" provisions prohibited insurers from denying coverage for individuals with pre-existing health conditions and kept insurance rates in check.⁴⁷ Together, these provisions of the PPACA were designed to ensure universal, or near-universal, insurance coverage at affordable prices.⁴⁸

The Congressional Budget Office ("CBO"), projected in March 2011 that Medicaid expansion would increase Medicaid enrollment by about 17 million individuals, while costing states very little as a portion of their total budgets. In particular, the CBO estimated that Medicaid expansion would increase state Medicaid spending by roughly \$60 billion between 2012 and 2021.⁴⁹ Federal spending was projected to increase by \$627 billion over the same period.⁵⁰ The Center for Budget and Policy Priorities estimated that increased state spending would have been just 2.8 percent more than what states would have spent on Medicaid without the expansion.⁵¹

But some states contested the expansion, among other aspects of the PPACA. On the day the President signed the Act, thirteen states filed suit.⁵² They were later joined by thirteen more states, individuals and the National Federation of Independent Businesses.⁵³ The plaintiffs alleged, among other things, that Congress lacked the power to enact the Medicaid expansion

44. *NFIB*, 132 S. Ct. at 2580.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Statement of Douglas W. Elmendorf, Director, before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives*, CONGRESSIONAL BUDGET OFFICE 26 (Mar. 30, 2011), available at www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf. This estimate was different than the one the CBO provided the year before—\$20 billion between 2010 and 2019. *Id.* "The difference between those two estimates mostly reflects the different time periods they cover." *Id.*

50. *Id.* at 25.

51. January Angeles, *How Health Reform's Medicaid Expansion Will Impact State Budgets*, CENTER ON BUDGET AND POLICY PRIORITIES 1 (July 25, 2012), available at www.cbpp.org/files/7-12-12health.pdf.

52. *NFIB*, 132 S. Ct. at 2580.

53. *Id.*

portion of the PPACA.⁵⁴ In particular, they argued that Medicaid expansion was “coercive” upon the states and that Congress violated principles of federalism when it conditioned the whole of a state’s federal Medicaid allotment on that state’s compliance with Medicaid expansion.⁵⁵

The states fashioned their argument based on the limits on congressional authority to set conditions on federal spending under the Spending Clause. That Clause grants Congress the power “to pay the Debts and provide for the . . . general Welfare of the United States.”⁵⁶ It means that Congress can spend money for the general welfare; it also means that Congress can set conditions on receipt of that money.⁵⁷ Therefore, when Congress grants money to the states, it can set conditions that “encourage a State to regulate in a particular way [and] influenc[e] a State’s policy choices.”⁵⁸ In this way, Congress can effect policies indirectly (through the states), even if it might lack authority to effect them directly (through an enumerated power in Article 1, Section 8).⁵⁹

The leading case applying these principles is *South Dakota v. Dole*.⁶⁰ In *Dole*, South Dakota challenged a federal statute that conditioned its receipt of a portion of federal highway funds on its adoption of a minimum drinking age.⁶¹ In particular, the federal statute directed the Secretary of Transportation to withhold 5 percent of federal highway funds otherwise allocable to a state “in which the purchase or public possession . . . of any alcoholic beverage by a person who is less than twenty-one years of age is lawful.”⁶² South Dakota, which allowed anyone over nineteen years of age to purchase beer containing up to 3.2 percent alcohol, challenged the law, arguing that it exceeded congressional authority under the Spending Clause and violated the Twenty-First Amendment.⁶³

The Supreme Court rejected the challenge and upheld the law, applying a four-part test for conditional spending under the

54. *Id.* at 2581-82.

55. *Id.*

56. U.S. CONST., Art. I, Sec. 8, cl. 1.

57. *See, e.g.*, *Coll. Sav. Bank v. Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 686 (1999) (explaining that there are conditions attached to federal funding).

58. *New York v. United States*, 505 U.S. 144, 166 (1992).

59. *See, e.g.*, *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980) (recognizing congressional authority “to further broad policy objectives by conditioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives”); *see generally* *United States v. Butler*, 297 U.S. 1, 66 (1936) (holding that “the power of Congress to authorize expenditure of public moneys for public purposes is not limited by the direct grants of legislative power found in the Constitution.”).

60. *S. Dakota v. Dole*, 483 U.S. 203, 206 (1987).

61. *Id.*

62. 23 U.S.C. § 158.

63. *Dole*, 483 U.S. at 205.

Spending Clause.⁶⁴ First, the Court noted that federal highway funds served “the general welfare.”⁶⁵ Next, the Court said that the program conditioned the receipt of federal funds “unambiguously . . . enable[ing] the States to exercise their choice knowingly, cognizant of the consequences of their participation.”⁶⁶ Third, the Court wrote that the condition (the 21-year-old drinking age) was sufficiently related to the federal interest in the federal highway program.⁶⁷ Finally, the Court held that the condition did not violate an “independent constitutional bar.”⁶⁸ The Court held that the condition did not violate the Twenty-First Amendment, because it was an indirect regulation on the drinking age.⁶⁹ More importantly, the Court held that the condition did not violate state sovereignty under the Tenth Amendment (or some invisible radiation of the Tenth Amendment), because it was not unduly coercive:

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.’ Here, however, Congress has directed only that a State desiring to establish a minimum drinking age lower than 21 lose a relatively small percentage of certain federal highway funds. Petitioner contends that the coercive nature of this program is evident from the degree of success it has achieved. We cannot conclude, however, that a conditional grant of federal money of this sort is unconstitutional simply by reason of its success in achieving the congressional objective.

Here Congress has offered relatively mild encouragement to the States to enact higher minimum drinking ages than they would otherwise choose. But the enactment of such laws remains the prerogative of the States not merely in theory but in fact. Even if Congress might lack the power to impose a national minimum drinking age directly, we conclude that encouragement to the state action found in [the federal statute] is a valid use of the spending power.⁷⁰

64. *See id.* at 208 (noting that South Dakota did not dispute the first three prongs of the test).

65. *Id.* at 207. The Court reiterated that this is a highly deferential standard—that “[i]n considering whether a particular expenditure is intended to serve general public purposes, courts should defer substantially to the judgment of Congress.” *Id.* (citing *Helvering v. Davis*, 301 U.S. 619, 640, 645 (1937)).

66. *Dole*, 483 U.S. at 207 (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)).

67. *Dole*, 483 U.S. at 207 (citing *Massachusetts v. U. S.*, 435 U.S. 444, 461 (1978)). The Court concluded that the condition promoted highway safety (by reducing drinking and driving), one of the objectives of the federal highway program. *Dole*, 483 U.S. at 208-209.

68. *Id.* at 209 (quoting *Lawrence Cnty. v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 269-70 (1985)).

69. *Dole*, 483 U.S. at 206, 208-209.

70. *Id.* at 211-12 (quoting *Charles C. Steward Mach. Co. v. Davis*, 301

The Court had never (before *NFIB*) found a Spending Clause condition that passed the point at which “pressure turns into compulsion”⁷¹ therefore violating state sovereignty under this fourth prong of the *Dole* test. The Court did identify other federalism limits on congressional authority, however. Most notably, the Court in *New York v. United States*, held that Congress cannot commandeer a state by directly requiring it to enact or enforce federal policy.⁷² The Court extended this anti-commandeering principle to state officers in *Printz v. United States*.⁷³ But the Court had never found that an indirect Spending Clause condition violated state sovereignty by compelling a state to comply with a federal condition.

Still, that was exactly what the states argued in challenging Medicaid expansion under the PPACA. They claimed that Medicaid expansion was coercive because it was so generous (who could say no?), and because they stood to lose so much if they declined to participate.⁷⁴ They argued that they had become enmeshed in the federal Medicaid program over time and had acceded to its expansions, and that this latest expansion cynically leveraged their earlier participation by tying their entire federal Medicaid funding to it.⁷⁵ In short, they claimed that Medicaid expansion was an offer that they simply could not refuse.⁷⁶

The Supreme Court agreed. Chief Justice Roberts, in a plurality opinion joined by Justices Breyer and Kagan,⁷⁷ wrote that the threat of a state losing its entire pre-existing federal Medicaid grant was “economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.”⁷⁸

U.S. 548, 590 (1937)).

71. *Davis*, 301 U.S. at 590.

72. *New York*, 505 U.S. at 144.

73. *Printz v. United States*, 521 U.S. 898, 925 (1997).

74. *NFIB*, 132 S. Ct. at 2601-04.

75. *Id.*

76. They also claimed, remarkably, that it intruded on state sovereignty, because the federal government would have to pay for it by taxing citizens, thus leaving less for the states to tax. (Because citizens only have so much money, the states claimed, the greater federal taxation squeezes out states’ ability to tax). Brief of State Petitioners on Medicaid, State of Florida, et al. v. United States Department of Health and Human Services, et al., (No. 11-400) at 43–48 (Jan. 10, 2012); Transcript of Oral Argument at 5–9 State of Florida, et al. v. United States Department of Health and Human Services, et al. (No. 11-400).

77. *NFIB*, 132 S. Ct. at 2656-68. Chief Justice Roberts’s plurality opinion on Medicaid expansion is the opinion of the Court on that issue. *Id.* Justices Scalia, Kennedy, Thomas, and Alito, writing together in the joint dissent, argued that Medicaid expansion was unconstitutional in whole, and could not be “saved” by allowing states to reject it and still retain pre-existing federal Medicaid funds. *Id.* Justice Ginsburg, writing for herself and Justice Sotomayor, argued that Medicaid expansion was constitutional as written. *Id.*

78. *Id.* at 2574.

In this case, 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 in health care coverage thus stands to lose not merely ‘a relatively small percentage’ of its existing Medicaid funding, but *all* of it. Medicaid spending accounts for over 20 percent of the average State’s total budget, with federal funds covering 50 to 83 percent of those costs. The Federal Government estimates that it will pay out approximately \$3.3 trillion between 2010 and 2019 in order to cover the costs of *pre-expansion* Medicaid. In addition, the States have developed intricate statutory and administrative regimes over the course of many decades to implement their objectives under existing Medicaid.⁷⁹

Moreover, Chief Justice Roberts wrote that Medicaid expansion was “not properly viewed as a modification of the existing Medicaid program.”⁸⁰ Instead, it was an entirely new program:

The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health coverage.⁸¹

As a result, Chief Justice Roberts concluded that the Secretary could not withdraw a state’s entire pre-existing federal Medicaid grant for failure to comply with the expansion.⁸² But he also wrote that the Secretary could withhold or withdraw federal funds available for the expansion for any state that declined to participate.⁸³ In other words, the federal government could decline to provide a state with the new funds for Medicaid expansion if that state declined to expand its Medicaid program; but the federal government could not take away all of a state’s federal Medicaid funds simply because the state declined to participate in Medicaid expansion.

As a result, some states did decline to expand Medicaid.⁸⁴ But

79. *Id.* at 2604 (citations omitted).

80. *Id.* at 2605.

81. *Id.* at 2605-06.

82. *Id.* at 2607.

83. *Id.*

84. See *Status of State Action on the Medicaid Expansion Decision, 2014*, THE HENRY J. KAISER FAMILY FOUNDATION, available at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (last visited Apr. 18, 2014) (tracking the states’ positions on Medicaid expansion); *Interactive: A State-by-State Look at How the*

they did so at tremendous cost to themselves and to their citizens. The next section explores the implications of the refusal of these states to expand Medicaid, and of the Supreme Court's ruling in *NFIB*.

III. THE STRANGE POLITICS OF MEDICAID EXPANSION

This section explores the costs of states' opposition to Medicaid expansion, both in the *NFIB* case itself and in refusing to expand Medicaid in the wake of *NFIB*. In particular, this section examines the significant federal resources that opposing states will leave on the table, the significant number of poor citizens that they will leave uninsured, and the damage they have done to constitutional law through their opposition in *NFIB*. The section illustrates the singular costs that opponents of Medicaid expansion are willing to incur in order to score a very modest political point.

First, a note about sources. Several organizations have done outstanding work analyzing the likely effects of Medicaid expansion, both before the PPACA passed and after. These include, among others: The Henry J. Kaiser Family Foundation,⁸⁵ The Urban Institute,⁸⁶ and the Center on Budget and Policy Priorities.⁸⁷ The CBO has also issued several reports on Medicaid expansion.⁸⁸ The analysis below draws on some, but by no means all, of this work. For more, see the web pages cited in the immediately preceding footnotes.

Moreover, the analysis principally draws on sources and data available before Congress passed the PPACA and before the Court ruled in *NFIB*. That is because state officials complained about expanding Medicaid before Congress passed the PPACA and before the Court ruled in *NFIB*. In fact, that was the whole point of the states' suit challenging Medicaid expansion in *NFIB*. They balked, presumably, knowing the implications and impacts detailed in these sources, leading to strange politics even before the Court ruled in *NFIB*. That being said, this analysis also relies on some sources and data available *after* the Court ruled in *NFIB*, because state officials made decisions and declarations about their intentions to expand Medicaid *after* the Court ruled in *NFIB*. They

Uninsured Fare Under the ACA, THE HENRY J. KAISER FAMILY FOUNDATION, available at <http://kff.org/interactive/uninsured-gap/> (last visited Apr. 18, 2014).

85. *Medicaid: The Affordable Care Act and Recent Section 1115 Medicaid Demonstration Waivers*, THE HENRY J. KAISER FAMILY FOUNDATION, available at <http://kff.org/medicaid/> (last visited Apr. 18, 2014).

86. *Medicaid*, THE URBAN INSTITUTE, available at www.urban.org/health/medicaid.cfm (last visited Apr. 18, 2014).

87. *Medicaid*, THE CENTER ON BUDGET AND POLICY PRIORITIES, available at www.cbpp.org/research/?fa=topic&id=72 (last visited Apr. 18, 2014).

88. *Medicaid and CHIP*, CONGRESSIONAL BUDGET OFFICE, available at www.cbo.gov/topics/health-care/medicaid-and-chip (last visited Apr. 18, 2014).

also made these decisions, presumably, with the knowledge of the implications and impacts detailed in these sources, leading to strange politics after the Court ruled in *NFIB*.

A. Medicaid Expansion Is a Boon to States

The federal government will bear, on average, nearly 93 percent of the costs of Medicaid expansion over its first nine years.⁸⁹ The federal government will pay 100 percent of the expansion through 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and permanently thereafter.⁹⁰ As compared to the pre-existing federal contribution to states' Medicaid programs—generally between 50 percent and 83 percent of a state's total Medicaid expenditures⁹¹—this is an exceptionally generous gift to the states from the federal government.⁹²

Moreover, Medicaid expansion adds little to what states would have spent on their Medicaid programs over this same period without the expansion.⁹³ The CBO estimated that Medicaid expansion will cost states just 2.8 percent more than the amount they would have spent on Medicaid from 2014 to 2022 in the absence of health reform.⁹⁴ The Urban Institute estimated that Medicaid expansion would cost states just 1.4 percent more than the amount they would have spent from 2014 to 2019 without expansion, and 2.9 percent if participation turns out to be higher than expected.⁹⁵ The Lewin Group estimated that total state

89. Angeles, *supra* note 51, at 1.

90. 42 U.S.C. § 1396d(y). Moreover, the federal government will pay 90% of the state administrative expenses associated with upgrading information systems for making eligibility determinations through 2015. Medicaid Program, 76 Fed. Reg. 21,950 (Apr. 19, 2011). The federal government ordinarily pays 50% of most state administrative expenses. 42 U.S.C. § 1396b(a)(2)-(5), (7).

91. *NFIB*, 132 S. Ct. at 2604.

92. Edwin Park and Matt Broaddus, *Correcting Seven Myths About Medicaid*, CENTER FOR BUDGET AND POLICY PRIORITIES 3 (updated Apr. 10, 2014), available at www.cbpp.org/files/9-24-13health.pdf.

93. For a recent study that surveys 32 prior studies on the impact of Medicaid expansion on states' economies, see *The Role of Medicaid in State Economies and the ACA* THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, (Nov. 2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf> (providing a recent study that surveys thirty-two prior studies on the impact of Medicaid expansion on states' economies).

94. Angeles, *supra* note 51, at 1, 4, 8-9.

95. John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED (May 2010), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>.

Medicaid spending under the expansion would increase by \$17.4 billion, or, on average, 1.1 percent.⁹⁶

Additionally, Medicaid expansion stands to reduce states' costs for uncompensated care and other health-care services they provide for low-income individuals. These costs are significant. For example, in 2008 state and local governments incurred \$8.6 billion in care for hospital care for the uninsured.⁹⁷ State and local governments also incur substantial costs in care for the uninsured through state mental health agencies.⁹⁸ Under Medicaid expansion, states could cut costs of uncompensated care and related state- and local-funded programs.⁹⁹

For a number of states the reduction of costs under Medicaid expansion could offset all or most of the costs of Medicaid expansion.¹⁰⁰ Results from Massachusetts, the only state to experiment with this kind of program, support this. Massachusetts's legislation, which was enacted in 2006, was the model for the PPACA.¹⁰¹ The program included expanded Medicaid coverage, a requirement that most large employers provide health insurance, a requirement for individuals to purchase health insurance, and subsidies to help low- and moderate-income residents to purchase insurance.¹⁰² As a result, the percentage of uninsured in Massachusetts dropped from 5.7 percent in 2007,¹⁰³ the year of implementation, to 1.9 percent in

96. John Sheils, Kathy Kuhmerker, et al., *The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending*, THE LEWIN GROUP (Dec. 9, 2010), available at www.lewin.com/~media/Lewin/Site_Sections/Publications/Lewin_Impact_of_Medicaid_Expansions_on_State_Spending.pdf.

97. Jack Hadley, John Holahan, et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, 27 HEALTH AFFAIRS 399, 406 (Aug. 25, 2008), available at <http://content.healthaffairs.org/content/27/5/w399.full.pdf>.

98. *Fiscal Year 2009 State Mental Health Revenue and Expenditure Study Results*, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS RESEARCH INSTITUTE, INC. (Sept. 2011), available at www.nri-inc.org/projects/Profiles/RevExp2009/RESummary2009.pdf.

99. See *Quick Take: Key Considerations in Evaluating the ACA Medicaid Expansion for States*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (Apr. 18, 2013), available at [http://kff.org/medicaid/fact-sheet/key-considerations-in-evaluating-the-aca-medicaid-expansion-for-states-2/\(finding-that "\[s\]tates are also likely to see savings or offsets to costs from the Medicaid coverage expansion from: reduced state spending for uncompensated care . . . or reduced spending for programs that service indigent populations \(such as state funded mental health or substance abuse programs.\)"](http://kff.org/medicaid/fact-sheet/key-considerations-in-evaluating-the-aca-medicaid-expansion-for-states-2/(finding-that-%5B%5Ds%5Dtates-are-also-likely-to-see-savings-or-offsets-to-costs-from-the-Medicaid-coverage-expansion-from:-reduced-state-spending-for-uncompensated-care...-or-reduced-spending-for-programs-that-service-indigent-populations-(such-as-state-funded-mental-health-or-substance-abuse-programs.%5D)))

100. *Angeles*, *supra* note 51, at 5.

101. *Id.*

102. *Id.*

103. *Massachusetts Household Survey on Health Insurance Status, 2007*, MASSACHUSETTS DIVISION OF HEALTH CARE FINANCE AND POLICY 3, available at www.mass.gov/chia/docs/r/pubs/10/mhis-report-12-2010.pdf (last visited Apr. 18, 2014).

2010.¹⁰⁴ After Massachusetts enacted the program, state spending on uncompensated care decreased significantly. Indeed, in 2008, the first year after implementation, state spending on uncompensated care dropped substantially under the prior year's payments.¹⁰⁵

Finally, Medicaid expansion will likely boost states' economies in other ways. For example, Medicaid expansion is projected to increase state economic output, gross state product, and state and local revenues, and, in general, "have a noticeable and sustained increase in state economic activity."¹⁰⁶ Medicaid expansion is also projected to increase employment and even salaries and earnings.¹⁰⁷

Opponents argue that Medicaid expansion will cost states money. Opponents allege that states will incur significant new expenses for covering individuals who already qualify under pre-existing rules, and that the federal government will pay only its pre-existing rate for those individuals, and not the higher rate for newly eligible individuals.

But estimates of state costs already account for newly enrolled individuals who already qualify under pre-existing rules. That is, the federal share of Medicaid expansion averages 93 percent between 2014 and 2022, and states face an increase of only 2.8 percent, on average, *even accounting for the enrollment of already-qualified individuals*. Moreover, other provisions of the PPACA, like the universal coverage requirement and procedures to simplify Medicaid enrollment, will increase Medicaid enrollment by individuals who qualify already.¹⁰⁸ That means that some of the costs states will incur are associated with increased enrollment by already-qualified individuals and cannot be attributed to Medicaid expansion.¹⁰⁹

Finally, studies supporting vastly increased state costs dramatically overstate those costs. As summarized by the Center for Budget and Policy Priorities, those studies suffer from flawed assumptions and other errors.¹¹⁰ For example, those studies make assumptions about participation rates that are not supported by

104. *Massachusetts Household Survey on Health Insurance Status: Results from the 2008–2010 Surveys*, MASSACHUSETTS DIVISION OF HEALTH CARE FINANCE AND POLICY 9 (Dec. 2010), available at www.mass.gov/chia/docs/r/pubs/10/mhis-report-12-2010.pdf.

105. *2009 Annual Report: Health Safety Net*, MASSACHUSETTS DIVISION OF HEALTH CARE FINANCE AND POLICY 5 (Dec. 2009), available at www.mass.gov/chia/provider/health-safety-net/health-safety-net-reports.html.

106. *The Role of Medicaid in State Economies*, *supra* note 93, at 4

107. *Id.*

108. Angeles, *supra* note 51, at 2.

109. *Id.*

110. See *id.* at 7-8 (summarizing overstatements and mistaken assumptions in studies and by policy-makers in Mississippi, Nebraska, Indiana, and Florida).

experience with participation rates in various means-tested programs.¹¹¹ Some of those studies assume that under Medicaid expansion 100 percent of eligible individuals will sign up for Medicaid.¹¹² But other means-tested programs have much lower participation rates, between 43 percent and 86 percent.¹¹³ Even Medicare achieves only a 96 percent participation rate.¹¹⁴ “While a mandate to have health insurance, requirements to establish a simplified and seamless enrollment process, and the publicity and outreach efforts surrounding the expansion should result in increased enrollment, the evidence is overwhelming that the participation rate will not be 100 percent.”¹¹⁵

Those studies also make an unsupported assumption that already-insured individuals who qualify for Medicaid under Medicaid expansion will drop their current coverage and enroll in Medicaid instead.¹¹⁶ In other words, some of these studies assume that Medicaid expansion will “crowd out” private health insurance.¹¹⁷ Some of these studies assume that 35 percent to 45 percent of new Medicaid enrollees would be individuals who dropped their private insurance in order to enroll in Medicaid.¹¹⁸ But studies of state expansions of Medicaid for children show that only between 10 percent and 20 percent of new Medicaid enrollees previously had private health insurance.¹¹⁹

111. *Id.* at 7.

112. *Id.* (citing Dahlia Remler and Sherry Glied, *What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs*, 93 AM. J. PUBLIC HEALTH 67-74 (Jan. 2003)).

113. Angeles, *supra* note 51, at 7 (citing Remler and Glied, *supra* note 106).

114. Angeles, *supra* note 51, at 7 (citing Remler and Glied, *supra* note 106).

115. Angeles, *supra* note 51, at 7 (citing Sherry Glied, Jacob Hartz, & Genessa Giorgi, *Consider it Done? The Likely Efficacy of Mandates for Health Insurance*, 26 HEALTH AFFAIRS 1612-1621 (Nov/Dec 2007), available at <http://content.healthaffairs.org/content/26/6/1612.full.pdf+html>).

116. Angeles, *supra* note 51, at 7; Park and Broaddus, *supra* note 92, at 4.

117. Angeles, *supra* note 51, at 8; Park and Broaddus, *supra* note 92, at 4.

118. Angeles, *supra* note 51, at 7 (citing January Angeles, *Some Recent Reports Overstate the Effects on State Budgets of the Medicaid Expansion in the Health Reform Law*, CENTER ON BUDGET AND POLICY PRIORITIES (Oct. 21, 2010), available at www.cbpp.org/cms/?fa=view&id=3310).

119. Angeles, *supra* note 51, at 7 (citing Matthew Broaddus and January Angeles, *Medicaid Expansion in Health Reform Not Likely to “Crowd Out” Private Insurance*, CENTER ON BUDGET AND POLICY PRIORITIES (June 22, 2010) available at www.cbpp.org/files/6-22-10health.pdf); Gesture Davidson, Lynn Blewett, and Kathleen Call, *Public program crowd-out of private coverage: What are the issues?*, THE ROBERT WOOD JOHNSON FOUNDATION (June 2004), available at www.shadac.org/files/Crowdout_Brief_Jun04.pdf; Lisa Dubay, *Expansions in Public Insurance and Crowd Out: What the Evidence Says*, THE KAISER FAMILY FOUNDATION (Oct. 2009), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/7763.pdf>; Anne Sommers, Steve Zuckerman, Lisa Dubay, and Genevieve Kenney, *Substitution of SCHIP For Private Coverage: Results from a 2002 Evaluation in Ten States*,

Finally, these studies overstate the costs of newly enrolled individuals under Medicaid expansion.¹²⁰ That is in part because they make cost assumptions based on already-enrolled individuals. Since uninsured people eligible for coverage typically seek insurance when they become ill or develop medical conditions, experts overwhelmingly agree that the average cost per beneficiary of already-eligible people who have not signed up for Medicaid will be lower, not dramatically higher, than the average cost of those the program already serves.¹²¹

Some have argued that the PPACA and Medicaid expansion will result in a redistribution of wealth. But those claims are also wrong or overstated. For example, an Urban Institute analysis of Medicaid expansion concluded that most funding for the PPACA (74.3 percent) comes from “recycling dollars within the health care industry.”¹²² These “recycled dollars” are reimbursement cuts and taxes and fees on health care providers and health insurers—the health-care industry itself.¹²³ These increased costs could partially be offset by the industry’s increased revenue derived from increased insurance coverage and Medicaid expansion under the PPACA.¹²⁴ Other funding for the PPACA comes from tax increases, but those increases are not significantly redistributive,¹²⁵ and the PPACA will not reduce benefits for Medicare enrollees.¹²⁶

In short, the evidence is overwhelming: Medicaid expansion will be a boon to the states; and fears of dramatic cost increases are unsupported. Based on the projected fiscal impacts of Medicaid expansion, states should agree to participate. By declining to expand Medicaid, states will forego substantial economic gains. But more: they will deny health insurance to their low-income citizens.

B. States Stand to Deny Insurance to Low-Income Citizens

Medicaid expansion, if adopted by every state, would cover about 17 million low-income adults and children, most of whom were previously uninsured.¹²⁷ This includes about 3.5 million

26 HEALTH AFFAIRS 529 (March/April 2007)).

120. Angeles, *supra* note 51, at 7.

121. *Id.*

122. Stan Dorn, Bowen Garrett, and John Holahan, *Redistribution Under the ACA Is Modest in Scope*, URBAN INSTITUTE 4-6 (Feb. 2014), available at www.urban.org/UploadedPDF/413023-Redistribution-Under-the-ACA-is-Modest-in-Scope.pdf.

123. *Id.*

124. *Id.* at 4.

125. *Id.* at 4-5.

126. *Id.* at 6-7.

127. *Statement of Douglas W. Elmendorf*, *supra* note 49, at 3. The Urban

individuals with incomes between 100 percent of the federal poverty line and 133 percent of the federal poverty line (or 138 percent, with the 5 percent income disregard).¹²⁸ It also includes about 11.5 million individuals with incomes below the federal poverty line who do not qualify for pre-existing Medicaid in their states.¹²⁹ That is because most states set Medicaid eligibility for adults below the federal poverty line. According to the Urban Institute, “only 18 states provide comprehensive Medicaid coverage to parents at or above 100 percent of [the federal poverty line].”¹³⁰ Indeed, under pre-existing state eligibility standards, a working-poor parent, on average, loses Medicaid eligibility when his or her income reaches just 63 percent of the federal poverty line.¹³¹ On average, an unemployed parent loses eligibility when his or her income reaches just 37 percent of the federal poverty line.¹³² Under pre-existing rules, most states do not provide Medicaid coverage at all to adults without children, no matter how low their income falls.¹³³

In states that decline to expand Medicaid, low-income individuals will go without subsidized health insurance. The PPACA provides subsidies for individuals to purchase health insurance through a new health insurance exchange, but only if their incomes fall between 100 percent and 400 percent of the federal poverty line.¹³⁴ In states where pre-existing Medicaid eligibility is set below 100 percent of the federal poverty line, that means that individuals with incomes too high to qualify for Medicaid, but still below the federal poverty line, will not qualify for Medicaid and will not qualify for a federal subsidy. Nationwide, there are 11.5 million uninsured people with incomes below the federal poverty line that would be eligible under Medicaid expansion.¹³⁵

Make no mistake about it: these individuals are poor. 133

Institute puts this number at 15.1 million. Genevieve M. Kenney, Stephen Zuckerman, et al., *Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?*, URBAN INSTITUTE 1 (Aug. 2012), available at www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

128. *Id.* at 2.

129. *Id.*

130. *Id.* at 1.

131. *Id.*; Angeles, *supra* note 51, at 2.

132. *Id.* at 3.

133. *Id.* at 2. In contrast, on average, under pre-existing rules, children qualify for Medicaid if their household income falls below 241 percent of the federal poverty line. *Children*, MEDICAID.GOV, available at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Children/Children.html (last visited Apr. 18, 2014).

134. *Focus on Health Reform*, THE HENRY J. KAISER FAMILY FOUNDATION 1 (July 2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf>.

135. Kenney, Zuckerman, et al., *supra* note 127, at 1.

percent of the federal poverty line for a single individual is \$15,520.10 and for a family of four is \$31,720.50.¹³⁶ Despite Chief Justice Roberts's statement in *NFIB* that Medicaid expansion reaches individuals who are not poor, these individuals are poor. And most of them do not have access to private health insurance.¹³⁷

Medicaid is a dramatic improvement for the uninsured poor. Medicaid produces good health-care results for the poor at lower costs and with lower cost distribution as compared to no insurance.¹³⁸ The reason is simple: individuals with Medicaid use Medicaid-provided primary care services to head off serious health conditions that, for uninsured individuals, end up costing more money than they cannot afford and thus spread the cost throughout the health-care system. For example, a study by the Kaiser Foundation found that in general, Medicaid provides beneficiaries services that are comparable to those in employer-provided health insurance plans, but at significantly lower costs.¹³⁹ A study of Oregon's Medicaid program showed that individuals with Medicaid were 40 percent less likely to suffer a decline in their health in the previous six months than individuals without coverage.¹⁴⁰ They were also more likely to use preventive care, visit a primary care provider regularly, and receive diagnoses of and treatment for depression and diabetes.¹⁴¹ Additionally, they were 40 percent less likely than those without insurance to go into

136. 2014 *Poverty Guidelines: All States (Except Alaska and Hawaii) and D.C.*, MEDICAID.GOV, available at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2014-Federal-Poverty-level-charts.pdf (last visited Apr. 18, 2014).

137. Park and Broaddus, *supra* note 92, at 4.

138. Medicaid may produce particularly good health results for those with chronic conditions. See generally Lisa Clemans-Cope, Sharon K. Long, et al., *The Expansion of Medicaid Coverage under the ACA: Implications for Health Care Access, Use, and Spending for Vulnerable Low-income Adults*, 50 INQUIRY: THE JOURNAL OF HEALTH CARE ORGANIZATION, PROVISION, AND FINANCING, 135, 146 (May 2013), available at <http://inq.sagepub.com/content/50/2/135.full.pdf+html> ("extending Medicaid coverage to low-income uninsured adults with chronic conditions under the ACA offers the potential for significant gains in health care access and increases in health care use, as well as improved protection from high health care costs."). This comes with a significant cost, but "[i]t is expected that these increases in spending would be offset at least in part by reductions in uncompensated care and charity care." *Id.* at abstract.

139. Teresa A. Coughlin, Sharon K. Long, et al., *What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED 1 (May 2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf>.

140. Katherine Baicker, Sarah Taubman, et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713-22 (May 2, 2013).

141. *Id.*

medical debt.¹⁴² Another study found that expansion of Medicaid coverage in Arizona, Maine, and New York reduced mortality by 6.1 percent.¹⁴³

Medicaid expansion will allow states to cover an additional 17 million mostly uninsured poor individuals, including about 11.5 million who are too poor for pre-existing Medicaid but too rich for a federal subsidy to purchase private health insurance on an exchange. Moreover, Medicaid expansion will likely lead to much better health outcomes for these individuals and less personal medical debt. By declining Medicaid expansion, states also decline these substantial benefits to their poor citizens.

C. Objecting States Left Us With Bad Constitutional Law

In addition to the bad policy results when states decline Medicaid expansion, the states' legal challenge to Medicaid expansion in *NFIB* left us with bad constitutional law. The new doctrine limits congressional authority to condition the receipt of federal funds and potentially threatens existing programs. It also bolsters "states' rights" and federalism claims against federal authority.

In particular, the Court's ruling, forced by the states' arguments, marks a new limit on Congress's power to condition the receipt of federal funds under the Spending Clause. The Court drew this new limit at the point where conditions on "new" federal programs (here, Medicaid expansion) threaten the receipt of federal funds under existing programs (the pre-existing Medicaid program). The lynchpin of the Court's analysis is the distinction between Medicaid expansion and pre-existing Medicaid. According to the Court, they are two entirely different programs. The Court explained:

The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance

142. *Id.*

143. Benjamin Sommers, Katherine Baicket, and Arnold Epstein, *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 *NEW ENG. J. MED.* 1025-34 (Sep. 13, 2012).

coverage.¹⁴⁴

Having drawn such a sharp distinction between Medicaid expansion and pre-existing Medicaid, the Court could easily rule that conditions on Medicaid expansion could not threaten states' pre-existing Medicaid funding. After all, it has long been settled that federal funding conditions must relate to the purpose of the underlying funding program.¹⁴⁵ If conditions on one program threaten funding under a separate and distinct program, the conditions must violate this long-settled principle. The Court put it this way:

We have upheld Congress's authority to condition the receipt of funds on the States' complying with restrictions on the use of those funds, because that is the means by which Congress ensures that the funds are spent according to its view of the "general Welfare." Conditions that do not here govern the use of the funds, however, cannot be justified on that basis. When, for example, such conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes.¹⁴⁶

So for the Court, program distinction was one flaw of Medicaid expansion. But there was another. The Court held that Medicaid expansion, by threatening the whole of states' pre-existing federal Medicaid funding, was unduly coercive.¹⁴⁷ In other words, by threatening to take away a state's entire pre-existing federal Medicaid budget, the PPACA forced the states to accept Medicaid expansion. The Court explained it this way:

In this case, the financial 'inducement' Congress has chosen is much more than 'relatively mild encouragement'—it is a gun to the head . . . Medicaid spending accounts for over 20 percent of the average State's total budget, with federal funds covering 50 to 83 percent of those costs. The Federal Government estimates that it will pay out approximately \$3.3 trillion between 2010 and 2019 in order to cover the costs of *pre-expansion* Medicaid. In addition, the States have developed intricate statutory and administrative regimes over the course of many decades to implement their objectives under existing Medicaid. It is easy to see how the *Dole* Court could conclude that the threatened loss of less than half of one percent of South Dakota's budget left the State with a 'prerogative' to reject Congress's desired policy, 'not merely in theory but in fact.' The threatened loss of over 10 percent of a State's overall budget, in contrast, is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.¹⁴⁸

The upshot is that Congress is now limited in conditioning

144. *NFIB*, 132 S. Ct. at 2605-06.

145. *Dole*, 483 U.S. 208-09.

146. *NFIB*, 132 S. Ct. at 2603-04.

147. *Id.* at 2606-07.

148. *Id.* at 2604-05 (citations omitted).

federal spending to the states in two complementary ways. First, under *NFIB*, Congress cannot make an alteration to an already-existing federal program that is conditioned upon the federal funding under the original program, unless the two programs are closely related. Second, Congress cannot place a new condition on an already-existing federal program when the condition is sufficiently generous and the original program is sufficiently large.

But there are significant problems with this new doctrine. To start, the Court does not tell us exactly *how* closely related a pre-existing program and an alteration to that program must be. Medicaid expansion—that is, enrolling individuals up to 138 percent of the federal poverty line—looks like an expansion of the base Medicaid program. After all, pre-existing Medicaid was designed principally to provide health-care coverage for the poor. Medicaid expansion was designed to do this, too. (Individuals up to 138 percent of the federal poverty line are, indeed, quite poor.)¹⁴⁹ Indeed, pre-existing Medicaid in some states already covers individuals at or above the federal poverty line. Yet the Court says that Medicaid expansion “accomplishes a shift in kind, not merely degree.”¹⁵⁰ If Medicaid expansion creates a shift “in kind, not merely degree,” it is not at all clear where that shift occurs in other programs.

Some think that the Court’s ruling could threaten other well-established conditioned-spending programs and tie the hands of Congress in imposing new conditions on pre-existing programs, especially in the area of civil rights. Some are particularly worried about Title IX.¹⁵¹ Title IX of the Education Amendments of 1972 provides that entities that receive federal funding may not discriminate on the basis of sex in education programs and activities.¹⁵² Title IX reaches all operations of an entity receiving federal education funds, including not only the traditional educational programs but also housing, transportation, campus commercial operations (like restaurants and bookstores), and athletics. It “has had a revolutionary effect in opening educational

149. *2014 Poverty Guidelines*, *supra* note 136.

150. *NFIB*, 132 S. Ct. at 2605.

151. Kevin Russell, *Civil rights statutes put at risk by health care decision*, SCOTUSBLOG (Jun. 29, 2012), *available at* www.scotusblog.com/2012/06/civil-rights-statutes-put-at-risk-by-health-care-decision/; Carrie Johnson, *How the Health Care Ruling Might Affect Civil Rights*, NATIONAL PUBLIC RADIO (July 6, 2012), *available at* www.npr.org/2012/07/06/156378347/how-the-health-care-ruling-might-affect-civil-rights.

152. Pub. L. No. 92-318, 86 Stat. 235 (1972), codified at 20 U.S.C. §§ 1681–88. *See Title IX and Sex Discrimination*, ED.GOV., *available at* www2.ed.gov/about/offices/list/ocr/docs/tix_dis.html (last visited Apr. 18, 2014) (providing general information on Title IX); *see also Title IX Info*, *available at* www.titleix.info (last visited Apr. 18, 2014) (providing more background information on Title IX).

opportunities to women and girls over the past forty years.”¹⁵³

Title IX, like Medicaid expansion, was a new condition on substantial and generous pre-existing federal funding programs for education. The opposing states’ position, and ultimately the Court’s ruling in *NFIB*, could work to dismantle Title IX. Justice Ginsburg articulated the concern best in a comment and question at oral argument in *NFIB*:

Most colleges and universities are heavily dependent on the government to fund their research programs and other things, and that has been going on for a long time. And then Title IX passes, and a government official comes around and says to the colleges, you want money for your physics labs and all the other things you get it for, then you have to create an athletic program for girls. And the recipient says, I am being coerced, there is no way in the world I can give up all the funds to run all these labs that we have, I can’t give it up, so I’m being coerced to accept this program that I don’t want . . .

[I]f your theory is any good, why doesn’t it work any time . . . someone receives something that is too good to give up?¹⁵⁴

The same concern could apply to Title VI of the Civil Rights Act of 1964, which prohibits race discrimination “under any program or activity receiving Federal financial assistance,”¹⁵⁵ Section 504 of the Rehabilitation Act of 1973, which prohibits disability discrimination “under any program or activity receiving Federal financial assistance,”¹⁵⁶ or other measures that impose conditions across pre-existing federal spending programs. While there are good arguments why the Court’s ruling in *NFIB* should not threaten these programs,¹⁵⁷ the Court’s ruling understandably causes some concern.

Moreover, everyone seems to agree that Congress could have achieved its desired aim by entirely dismantling the pre-existing Medicaid program one day and re-enacting it with Medicaid expansion the next. It is not at all clear why Medicaid expansion represents a new program in the PPACA (and is therefore unconstitutional as it was written), but would not substantially deviate from the rest of a new Medicaid program if Congress simply enacted it together with a re-enacted pre-existing Medicaid program. In any event, this potential congressional work-around

153. Emily J. Martin, *Title IX and the New Spending Clause*, AMERICAN CONSTITUTION SOCIETY, ISSUE BRIEF 5 (Dec. 2012), available at www.acslaw.org/sites/default/files/Martin_-_Title_IX_and_the_New_Spending_Clause_1.pdf.

154. Transcript of Oral Argument at 21: 18, *National Federation of Independent Business v. Sebelius* (No. 11-393), available at www.supremecourt.gov/oral_arguments/argument_audio.aspx.

155. 42 U.S.C. § 2000d.

156. 29 U.S.C. § 794(a).

157. Samuel R. Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After NFIB*, 101 GEO. L. J. 861 (2013); Martin, *supra* note 153, at 5.

highlights the absurdity of the Court's new test. After all, if the rock-solid principles of federalism at the core of the Court's ruling mean anything, how could Congress so easily bypass them with a simple shell game?

Next, the Court does not tell us exactly how significant a pre-existing program must be before a new condition turns pressure into compulsion. The Court does tell us that the pre-existing Medicaid program plays significant roles in state budgets and administration (and a substantially greater role than the federal highway funds at stake in *Dole*), and that these significant roles make Medicaid expansion look like "a gun to the head" of the states. But it does not tell us when a pre-existing federal program crosses that line. And the grey area is large: states stood only to lose 5 percent of their federal highway funds if they declined the condition upheld in *Dole*; but they stand to lose "over 10 percent of a State's overall budget" if they decline Medicaid expansion. The ruling potentially puts many other federal programs at risk.

The opponents' arguments and the Court's ruling on this point are particularly surprising, given that a number of states announced that they would decline to participate in Medicaid expansion *even before the Court ruled in NFIB*. One might have thought that if Medicaid expansion operated like a "gun to the head" of the states, all states would have had to participate.

The ruling also bolsters "states' rights" and federalism claims against federal authority in the area of federal conditioned spending. It does this by underscoring and expanding federalism principles that animate the Court's jurisprudence on conditioned spending. In particular, the Court wrote that our system of federalism and dual sovereignty, where "States [stand] as independent sovereigns in our federal system," is designed to enhance freedom and promote individual liberty.¹⁵⁸ The Court said that Congress would destroy that balance if it could require states to act in accordance with federal policies.¹⁵⁹ The Court also stated that its doctrine promotes transparency and accountability in governance. It said that when the federal government forces the states to act, the voters cannot tell who to hold to account—their state elected representatives, or their federal elected representatives.¹⁶⁰

But these reasons are inapt in the context of Medicaid expansion. For one, it is not at all clear how freedom and individual liberty are threatened under Medicaid expansion in the PPACA, or how freedom and individual liberty are enhanced by the Court's ruling in *NFIB*. Indeed, if freedom and liberty are at stake at all in Medicaid expansion, it is probably the freedom and

158. *NFIB*, 132 S. Ct. at 2602.

159. *Id.*

160. *Id.* at 2602-03.

liberty of newly eligible Medicaid beneficiaries to receive medical care. If so, and if the Court were concerned with that freedom and liberty, the Court should have upheld Medicaid expansion as written in the PPACA. As to transparency and accountability, these have little relevance in Medicaid expansion. Voters know who to hold to account in a cooperative federalism program like Medicaid, and given all the attention on the PPACA, they know who to hold to account here.

IV. CONCLUSION

States opposing Medicaid expansion do so at an enormous cost. They stand to leave millions of their poor citizens uninsured, they leave substantial federal grants on the table (along with the economic benefits that those grants would bring to them), and they wreak havoc on long-settled constitutional doctrine.

Given these enormous costs, we might expect that opposing states have a good reason to oppose Medicaid expansion. Not so. While they claim that Medicaid expansion would cost them too much money, the studies, both before PPACA enactment and after *NFIB*, belie this. And while opposing Medicaid expansion might be a part of a larger effort to undermine or dismantle the PPACA entirely, a states' rejection of Medicaid expansion comes with enormous opportunity costs in the meantime.

It is no surprise that raw politics can drive bad policy, especially in today's divisive political climate. But states that oppose and decline Medicaid expansion take these raw politics to a whole new level. They essentially shoot themselves, and their poor citizens, in the foot in order to score a modest political point. Time will tell whether this gambit pays off for those states or their decision-makers. (It surely will not pay off for these states' poor citizens, many of whom are left too rich for their state's pre-existing Medicaid program but too poor for a federal subsidy to purchase insurance, now required under the PPACA's individual mandate). In the meantime: this sure seems like strange politics.