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COOPERATIVE FEDERALISM AND HEALTHCARE REFORM: THE MEDICARE PART D "CLAWBACK" EXAMPLE

ELIZABETH A. WEEKS*

I. INTRODUCTION

In spring 2006, several states petitioned the United States Supreme Court to hear a challenge under its original jurisdiction to one piece of the new Medicare Part D prescription drug law.¹ Before Part D implementation, individuals who qualified for both Medicare and Medicaid received their prescription drug coverage through state Medicaid programs.² Part D requires these dually eligible beneficiaries to enroll in the new federal Medicare program instead of state Medicaid programs for drug coverage.³ This legislation gave the federal government control over prescription drug coverage for dually eligible beneficiaries but requires states perpetually to pay most of the cost of those beneficiaries' drugs.⁴

The "phased-down state contribution," or "clawback," is a unique example of cooperative federalism.⁵ The federal government claimed credit

* Associate Professor, University of Kansas School of Law. This Article would not have been possible without the other authors, editors, organizers of and signatories to the Professors' Amicus Brief in *Texas v. Leavitt*: Nicole Huberfeld, Ted Marmor, Steve Calandrillo, Molly Wood, Mark Walters, Carla Cox, Christopher Murgica, Sean Jordan, Adam Aston, and Bill Davis. I am also indebted to Rick Levy, Rob Glicksman, Steve McAllister, Steve Ware, Mike Wells, Jack Preis, and Frank Thompson for comments on earlier drafts of the Brief and this Article and to my research assistants, Laura Ward, Neal Johnson, and Eunice Lee for their tireless assistance.

1. See generally Motion for Leave to File Bill of Complaint, Supporting Brief, and Bill of Complaint, *Texas v. Leavitt*, 126 S.Ct. 2915 (2006) (mem.) (No. 135) [hereinafter States' Brief]. The Petitioner States were Texas, Kentucky, Maine, Missouri, and New Jersey.

2. See Daniel A. Cody, *Trouble on the Horizon? Medicare Part D and Dual Eligibles*, 18 HEALTH LAWYER 27, 27 (2005).

3. *Id.*

4. *Id.* at 28.

5. See Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and "Dual Sovereignty" Doesn't*, 96 MICH. L. REV. 813, 815, 815 n.2 (1998) (citing "voluminous literature" on "cooperative federalism" and suggesting that this approach to policymaking "offers us a vision of independent governments working together to implement federal policy"); see also Joshua D. Sarnoff, *Cooperative Federalism*,

for expanding Medicare to cover prescription drugs and retained administrative and budgetary control over the new program.⁶ States, meanwhile, were left footing the bill for the federal programs but were denied any control, discretion, or ability to respond to constituents' concerns about their state budget appropriations for the new program's cost.⁷ In effect, the clawback requires states to allocate an undeterminable amount of their state budgets to fund a fully federal program. In challenging the clawback, the States' U.S. Supreme Court Petition raised various constitutional arguments, including intergovernmental tax immunity, anti-commandeering, and the Guarantee Clause.⁸ The States also asserted grounds on which the Court should take the unusual step of exercising original jurisdiction to resolve the dispute.⁹ Specifically, the States urged that the potentially staggering and immediate state budgetary impact of the clawback necessitated a speedy and final resolution of the issues.¹⁰

The 2007 Saint Louis University Health Law Symposium offered a unique opportunity to examine a wide range of issues raised by the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act (the MMA).¹¹ The MMA effected the largest expansion of Medicare since the program began, including, most notably, outpatient prescription drug coverage.¹² Some contributions to this Symposium provided broad policy perspectives on the landmark legislation and its effect on beneficiaries, providers, taxpayers, insurers, and the public. This Article, by contrast, offers a focused examination of a relatively minor, and perhaps largely overlooked, funding provision. The clawback is significant, nonetheless, because it represents a unique approach to shared responsibility between

the Delegation of Federal Power, and the Constitution, 39 ARIZ. L. REV. 205, 205 (1997) (describing "cooperative federalism" and Congress's historical reliance on states "to implement the goals and controls of federal policy"); *Symposium on Cooperative Federalism: Foreword*, 23 IOWA L. REV. 455, 456 (1938) (discussing recent "experimentation in federalism" through legislation "characterized by the participation of several governments in cooperative legislative or administrative action").

6. See Press Release, John Lynch, Governor of N.H., Governor Announces New Hampshire Joins Other States in Challenging Medicare "Clawback" Provision (Mar. 3, 2006), at www.nh.gov/governor/news/2006/030306clawback.htm (last visited Nov. 3, 2007).

7. William G. Weissert & Edward A. Miller, *Punishing the Pioneers: The Medicare Modernization Act and State Pharmacy Assistance Programs*, 35 PUBLIUS 115, 139-40 (2005).

8. States' Brief, *supra* note 1, at 5-20.

9. *Id.* at 5.

10. *Id.* at 21.

11. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, (codified at 42 U.S.C. § 1395 (Supp. IV 2004)).

12. Rick Mayes, *Medicare and America's Healthcare System in Transition: From the Death of Managed Care to the Medicare Modernization Act of 2003 and Beyond*, 38 J. HEALTH L. 391, 393 (2005).

the federal and state governments but lacks the hallmarks of cooperative and consensual federalism.¹³ It was highly objectionable to many states, spawning constitutional U.S. Supreme Court litigation.¹⁴ I, together with several other health law professors and practitioners, submitted an amicus brief in support of the States' Petition.¹⁵ Although the Supreme Court declined to hear the States' challenge to this unprecedented funding mechanism,¹⁶ the clawback remains constitutionally suspect and presents important questions for cooperative state-federal health reform.

II. PART D OF THE MMA

In 2003, Congress enacted the MMA,¹⁷ adding, for the first time since the program began in 1965, coverage for outpatient prescription drugs.¹⁸ The absence of outpatient prescription drug coverage under Medicare was a relic of the political and medical climate in which the program was envisioned.¹⁹ Medicare was originally intended to cover catastrophic, rather than routine, healthcare costs, much like a true insurance plan.²⁰ The program's core components, Part A for hospital services and Part B for physician services, were based roughly on the early Blue Cross and Blue Shield plans, which did not cover prescription drugs.²¹ In addition, pharmaceutical research and the importance of pharmacotherapy in disease treatment were relatively rudimentary when Medicare began.²² The lack of

13. See generally Sarnoff, *supra* note 5 (discussing cooperative federalism).

14. States' Brief, *supra* note 1.

15. Brief of Professors and Practitioners of Health Law as Amici Curiae in Support of Plaintiffs, *Texas v. Leavitt*, 126 S. Ct. 2915 (2006) (mem.) (No. 135) [hereinafter Professors' Brief].

16. *Texas v. Leavitt*, 126 S.Ct. 2915 (2006) (mem.).

17. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, (codified at 42 U.S.C. § 1395 (Supp. IV 2004)).

18. See Thomas R. Barker, *The Low-Income Subsidy in the New Medicare Drug Benefit*, 1 J. HEALTH & BIOMEDICAL L. 49, 50-52 (2005) (summarizing historical Medicare drug coverage); Susan A. Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will it be Good Medicine for U.S. Health Policy?*, 14 ELDER L.J. 237, 241 (2006) (noting historical lack of outpatient drug benefit).

19. See RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 10-15, 371-72 (1997) (describing historical background and political compromises required for passage of Medicare program).

20. See Thomas R. Oliver et al., *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283, 290-91 (2004) (discussing the initial Democratic and Republican proposals for a senior health insurance plan and the ultimate adoption of Medicare, which provided hospital insurance and supplementary medical insurance).

21. Channick, *supra* note 18, at 241 n.18; ROSENBLATT ET AL., *supra* note 19, at 14-15.

22. See Shannon Cadres, *The Citizens Health Prescription: Coping with Rising Drug Costs*, 18 NEW ENG. J. PUB. POL'Y 49, 51 (2002) (noting that Medicare's lack of outpatient

Medicare coverage for outpatient drugs became increasingly conspicuous as drug therapy became an essential intervention and the standard of care for many diseases and chronic conditions.²³ Moreover, most other insurers, including many private health insurance and managed care plans as well as Medicaid, the government indigent healthcare program, covered prescription drugs.²⁴ Finally, with much fanfare, Congress extended Medicare coverage to prescription drugs under Medicare Part D.²⁵

A little-noticed and last-minute addition to the Part D federal drug plan requires states to pay a portion of the costs of the new benefit.²⁶ This provision, dubbed the “phased-down state contribution” in the statute, and commonly referred to as the clawback, demands state payments for a federal benefit.²⁷ If a state fails to remit the required clawback amount, the federal government will automatically offset the amount demanded, plus interest, against the federal dollars otherwise due to the state under the Medicaid program.²⁸

The combination of the Part D clawback and automatic offset effects an unprecedented change in the core funding and administrative structures of two distinct government programs: Medicare and Medicaid. Medicare, since its enactment, has been a fully federal program.²⁹ Because of the Part D clawback, a substantial portion of the program now is funded by state contributions.³⁰ The clawback also alters Medicaid, a government welfare

drug coverage “went virtually unnoticed” in 1965, “when prescription drugs were a relatively small part of overall healthcare costs not typically covered by private insurance plans”).

23. See *id.* at 51-52 (quoting a Massachusetts pharmaceutical industry source as stating that “[p]harmaceuticals are about 10 percent of healthcare spending, but they are probably about 70 percent of the cure”).

24. See Oliver et al., *supra* note 20, at 285, 291, & 293 (noting that Medicare’s omission of a drug benefit “prompted the development of other sources of coverage,” including Medicaid and private insurance).

25. See generally The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified at 42 U.S.C. § 1395 (Supp. IV 2004)).

26. Louise M. Slaughter, *Medicare Part D – The Product of a Broken Process*, 354 NEW ENG. J. MED. 2314, 2314-15 (2006) (describing conference committee deliberations and the 3:00 a.m. vote, including a provision requiring “[s]tates, already overburdened by health care costs, . . . to partially fund Part D”).

27. See 42 U.S.C. § 1396u-5(c)(1)(A) (Supp. IV 2004); Channick, *supra* note 18, at 245-46 (“The MMA contains a provision, colloquially known as the ‘clawback,’ that essentially requires the states to subsidize a benefit granted to Medicare beneficiaries by federal legislation, administered by federal agencies, and operated by private-sector entities.”); Cody, *supra* note 2, at 28 (describing clawback).

28. 42 U.S.C. § 1396u-5(c)(1)(C).

29. See Judith Feder et al., *Long-Term Care in the United States: An Overview*, 19 HEALTH AFF. 40, 48 (2000).

30. See Cody, *supra* note 2, at 28.

program that gives federal financial support to states that voluntarily establish and administer their own programs, as long as the programs comply with certain federal requirements.³¹ The effect of the clawback and automatic offset penalty is that states must comply with an onerous, new condition on federal Medicaid dollars. Specifically, they must perpetually fund a portion of Medicare, a distinct and separate federal program that is wholly out of states' fiscal, administrative, and legislative control, in order to receive the full federal Medicaid contribution.

A. Overview of the Medicare and Medicaid Programs

Medicare is a fully federal program that provides health insurance to elderly, disabled, and end-stage renal disease patients.³² Medicare covers hospital services under Part A³³ and physician services under Part B.³⁴ The new Part D adds coverage for outpatient prescription drugs,³⁵ which the program never before covered.³⁶ Medicare is funded from mandatory payroll taxes, federal general revenue, and beneficiary-paid premiums and deductibles.³⁷ States, traditionally, have had no fiscal responsibility for or administration over the federal Medicare program.³⁸

Congress enacted Medicaid at the same time as Medicare, intending Medicaid to be a welfare program to provide healthcare to the needy, including individuals impoverished by staggeringly high medical expenses.³⁹ Medicaid is a joint state-federal program that accords states considerable

31. Kenneth R. Wiggins, *Medicaid and the Enforceable Right to Receive Medical Assistance: The Need for a Definition of "Medical Assistance"*, 47 WM. & MARY L. REV. 1487, 1489-90 (2006).

32. See U.S. Dep't of Health & Human Servs., Medicare: Medicare Eligibility Tool (2007), at www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment#TabTop (last visited Oct. 20, 2007).

33. 42 U.S.C. §§ 1395c to i-5 (2000).

34. *Id.* §§ 1395j to w-4.

35. *Id.* §§ 1395w-101 to w-152 (Supp. IV 2004).

36. See Weissert & Miller, *supra* note 7, at 134 n.50 (describing the new Medicare Part D, original Parts A and B, and Part C managed care model).

37. See 42 U.S.C. §§ 1395e, 1395s (2000); *id.* § 1395r (Supp. IV 2004); *id.* § 401 (Supp. IV 2004).

38. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 374-75 (1982) (discussing the original structure of Medicare and the federal government's fiscal responsibilities).

39. See *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); Channick, *supra* note 18, at 273 (describing history of Medicaid); Sara Rosenbaum et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMEDICAL L. 1, 7-8 (2004) (characterizing Medicaid as "an 'afterthought' to Medicare, and a 'relegation' to states of responsibility for insuring the poor").

discretion over eligibility requirements and program benefits.⁴⁰ The federal Medicaid statute requires states to cover certain beneficiaries and services, but states can expand eligibility and services beyond the federal requirements.⁴¹ Eligibility, which also varies by state, is generally based on income and/or medical condition or other “categorical” eligibility requirements.⁴² As long as states comply with certain broad federal requirements, they receive federal matching dollars to support their state Medicaid programs.⁴³ Each dollar a state spends on federally approved Medicaid programs, whether required or optional, is matched by federal funds on a percentage basis determined by the state’s relative poverty.⁴⁴ At the time the MMA was passed, all states operated Medicaid programs and provided some level of outpatient prescription drug coverage, even though the federal Medicaid statute does not require states to provide that benefit.⁴⁵

Medicare eligibility is tied to Social Security pension eligibility and is based on statutorily defined requirements of prior employment or current disability.⁴⁶ Medicare eligibility and benefits are not based on income.⁴⁷ In other words, Medicare does not means test; rich and poor beneficiaries qualify on the same terms and receive the same benefits. It was never

40. See Rosenbaum et al., *supra* note 39, at 7-8 (noting that “Medicaid is the largest surviving public means-tested legal entitlement” and “entitles states to open-ended federal financial assistance for the cost of dozens of classes of federally recognized health services furnished to eligible and enrolled persons”).

41. See Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 857 (1990) (noting that “[b]ecause states have great flexibility . . . the Medicaid program is really 50 very different programs serving different populations and providing different benefits”).

42. See *Gray Panthers*, 453 U.S. at 37 (describing “categorically” and “medically” needy beneficiaries); Kinney, *supra* note 41, at 865-68 (describing Medicaid eligibility); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL’Y 5, 12-13 (2006) (describing Medicaid eligibility and coverage); Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 17-19 (2001) (same).

43. See 42 U.S.C. § 1396b (2000) (regarding payments to states).

44. 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”).

45. See Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. REV. 441, 445 (2008) (noting that “states historically have covered drug expenses for dual eligibles through Medicaid”); Weissert & Miller, *supra* note 7, at 118 (“Although it is an optional benefit, all states have elected to provide at least some level of pharmaceutical coverage under Medicaid.”); Richard Cauchi, *State’s Rx for Medicare Gaps*, ST. LEGISLATURES, Mar. 2006, at 28,28 (describing states’ programs to fill prescription drug gap in federal Medicare program).

46. See 42 U.S.C. § 426(a)-(b) (2000).

47. See *id.*

intended as a welfare program for needy people, but rather, as a pension and health insurance program for workers.⁴⁸ The MMA, however, changed Medicare's fundamental parity notion by adding lower-end means testing for Part D drug plan subsidies and upper-end means testing for Part B physician service premiums.⁴⁹ For the first time since the program's enactment, poor Medicare beneficiaries may be eligible for additional government support while wealthy beneficiaries may pay more than others for the care that they receive.

Under the MMA, Medicare beneficiaries may also receive different outpatient prescription drug coverage, depending on which plan they elect.⁵⁰ The Bush administration's idea was for private health plans to compete for program beneficiaries as a way of promoting cost containment and quality through market principles.⁵¹ To succeed in offering choices and promoting competition among plans, the new program had to attract a number of private health plans to participate.⁵² To make the program attractive to private health plans, the administration had to enroll a sufficient volume of beneficiaries.⁵³

48. See Channick, *supra* note 18, at 258-59 (noting that prior to Medicare, it was uncommon for employers to set up health insurance for retired workers, and Medicare was thus "intended to ensure access to health insurance for the retired elderly who have few other options.")

49. Timothy S. Jost, *The Most Important Health Care Legislation of the Millenium (So Far): The Medicare Modernization Act*, 5 YALE J. HEALTH POL'Y L. & ETHICS 437, 445 (2005).

50. See Barker, *supra* note 18, at 54 (describing unique Part D benefit delivery through private insurers, unlike traditional Medicare delivery through federal agency).

51. See Channick, *supra* note 18, at 243 n.28 (describing private market underpinnings of Part D benefit); Robert Dodge, *Bush's Free-Market Medicare Plan Draws Fire from Democrats: Drug Benefits, HMO and PPO Proposals Offered*, DALLAS MORNING NEWS, March 5, 2003, at 4A (describing a competitive model in which "beneficiaries force providers to offer their best coverage at the lowest prices with competing plans" and noting the Democrats' questioning of the Administration's suggestion that free-market forces will contain costs); Christopher Snowbeck, *Medicare Drug Plan Brings More Choices: Health-Care Competition Gets Hot as Prescription Program Gets Set to Begin*, PITTSBURG POST-GAZETTE, June 23, 2005, at E1 (describing private plans' strategies to attract seniors to new Part D plans).

52. See Robert Pear, *In Medicare Debate, Massaging the Facts*, N.Y. TIMES, May 23, 2006, at A21 ("The number of prescription drug plans – 40 or more in most states – has far exceeded expectations. Premiums are lower than expected, partly because insurers obtained larger discounts in negotiations with drug manufacturers."). *But see* William M. Welch, *Medicare Measure Becomes Law Today*, USA TODAY, Dec. 8, 2003, at 14A (noting that plan "relies on untested assumptions that private insurers will step in to provide subsidized policies").

53. See generally Peter B. Bach & Mark B. McClellan, *The First Months of the Prescription-Drug Benefit – A CMS Update*, 354 NEW ENG. J. MED. 2312 (2006) (summarizing plan choices and enrollment numbers, including dual-eligibles, and noting that "[o]f the [forty-two] million beneficiaries eligible for drug coverage, more than [thirty-one] million were enrolled in a plan by early May 2006").

Part D enrollment is optional for most Medicare beneficiaries.⁵⁴ Those who elect to enroll pay a premium and can choose from a variety of plans, including a government-provided option.⁵⁵ For some Medicare beneficiaries, however, Part D enrollment is not optional. Beneficiaries who meet both Medicare and Medicaid eligibility requirements, called dual eligibles, must enroll in Part D.⁵⁶ As discussed above, before the MMA all states covered outpatient drugs under their Medicaid plans. But Part D mandated that all dually eligible beneficiaries switch from their existing state Medicaid drug plans to the new federal Part D drug plans.⁵⁷ The justification for the clawback, it seems, is that states would not be in any different position since they were already paying those drug costs. Now they would just pay the federal government, rather than their Medicaid pharmaceutical providers, the same amount; nothing gained and nothing lost.⁵⁸ From the federal government's perspective, pulling all dual-eligibles into Part D would increase the beneficiary rolls and attract plans to compete for the enrollees' drug plan dollars.⁵⁹

B. *The Clawback's Impact*

The reality of the mandated switch is that the federal government took administrative control of the new drug benefit for dually eligible beneficiaries while leaving the states with the burden of paying for the drugs. The MMA clawback is an unprecedented funding mechanism that requires states to perpetually pay the bulk of dually eligibles' drug costs.⁶⁰ The amount of

54. Cody, *supra* note 2, at 27.

55. See *id.*

56. *Id.* (estimating that 7.5 million Medicaid beneficiaries are dually eligible and account for 40% of all Medicaid spending); see also *Rehab. Ass'n. of Va., Inc. v. Kozlowski*, 42 F.3d 1444, 1447 (4th Cir. 1994) ("The Medicaid and Medicare statutes intersect for coverage of the population of the disabled or people 65 or over (eligible for Medicare) who are also poor (eligible for Medicaid). These people are called dual eligibles or crossovers."); Channick, *supra* note 18, at 245 (discussing mandatory enrollment for dual eligibles); Huberfeld, *supra* note 45 (describing mandatory enrollment for dual eligibles).

57. Channick, *supra* note 18, at 245.

58. See Huberfeld, *supra* note 45 (describing the clawback).

59. See Channick, *supra* note 18, at 243 n.28 (discussing the administration's beliefs about involving private insurers in Medicare); see also KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., DUAL ELIGIBLES: MEDICAID'S ROLE FOR LOW-INCOME MEDICARE BENEFICIARIES (July 2005), available at [www.kff.org/medicaid/upload/4091-04%20final\(v2\).pdf](http://www.kff.org/medicaid/upload/4091-04%20final(v2).pdf) (last visited Nov. 3, 2007) (discussing the number of dual eligibles and why Medicare beneficiaries need Medicaid).

60. See Weissert & Miller, *supra* note 7, at 136 (describing the "clawback" and suggesting that a "major source of financing for the new plan is 'clawback' payments imposed on the states by the MMA").

each state's contribution to the federal benefit is based on states' historical spending on Medicaid prescription drugs.⁶¹

In eleventh-hour amendments to the MMA, intended to address the Part D budget overrun,⁶² Congress required states to pay 90% of dually eligible beneficiaries' drug costs in 2006, the program's first year.⁶³ The state contribution "phases down" to 75% for the year 2015 and will remain at that level permanently.⁶⁴ While states' primary fiscal responsibility for drug costs phases down, it never phases out. Furthermore, despite their funding responsibility, states have no administrative control over the federal prescription drug formulary, Medicare eligibility, clawback calculation and assessment, or any other aspect of Medicare program administration.⁶⁵ In addition, the MMA provides no method for states to review, appeal, or object to the clawback amount. If states fail or refuse to pay, the MMA authorizes the payment due to be extracted through an automatic offset against federal Medicaid funds to which states are otherwise entitled.⁶⁶ The automatic offset effectively means that states cannot choose whether to participate in the cooperative funding approach to Part D. The clawback operates as a mandatory, permanent excise on states to support a federal public benefits program.

III. THE STATES' CHALLENGE

Concerned about the potentially enormous budgetary impact of the clawback and its distortion of state and federal powers, several states sought

61. *Id.*; see also Cody, *supra* note 2, at 28 (some states estimated that they would pay more under the Part D clawback than historical Medicaid drug costs); Channick, *supra* note 18, at 275 (noting that CBO estimated states' contribution toward MMA in the first five years at \$50 billion, or 13% of program costs).

62. The Bush Administration promised that Part D could be enacted for \$400 billion. In 2005, the White House released budget figures estimating that Part D will cost more than \$1.2 trillion in the next decade. Ceci Connolly & Mike Allen, *Medicare Drug Benefit May Cost \$1.2 Trillion; Estimate Dwarfs Bush's Original Price Tag*, WASH. POST, Feb. 9, 2005, at A1; see also Channick, *supra* note 18, at 238 (noting that Senator Edward Kennedy "freely admitted that the \$400 billion is merely a down payment on the cost of providing a prescription drug benefit to Medicare beneficiaries"); Dodge, *supra* note 51 (noting that many healthcare analysts "questioned whether the \$400 billion for prescription drugs and free-market forces would be enough, predicting Congress would have to find other ways to contain Medicare costs").

63. 42 U.S.C. § 1396u-5(c)(5) (Supp. IV 2004); see also Weissert & Miller, *supra* note 7, at 136 (discussing the initial and future percentages of costs that states are responsible for under the clawback).

64. 42 U.S.C. § 1396u-5(c)(5).

65. See Weissert & Miller, *supra* note 7, at 140.

66. 42 U.S.C. § 1396u-5(c)(1)(C) (Supp. IV 2004).

to have the clawback struck down on constitutional grounds.⁶⁷ Given the utter unpredictability of the payment demand, with first payments coming due in October 2006 and no means to appeal the amount demanded, the five Petitioner States—Texas, Kentucky, Maine, Missouri, and New Jersey—decided to seek immediate review of the clawback in the U.S. Supreme Court.⁶⁸ Several other states—Arizona, Alaska, Connecticut, Kansas, Mississippi, New Hampshire, Ohio, Oklahoma, South Carolina, and Vermont—filed a supporting amicus brief,⁶⁹ essentially reiterating the Petitioner States' arguments.

A. *Original Jurisdiction*

The States' Petition presented one jurisdictional and three substantive arguments. As a threshold matter, the States had to establish grounds for the Court to exercise original jurisdiction, an exceptional practice by the Court⁷⁰ and arguably strategic error by a petitioner. But the States' stakes were utterly unpredictable and potentially staggering. The clawback formula, its calculation, and payment demand are completely within federal control and the statute provides no method of appeal or challenge to the payment demand. Accordingly, it seemed imperative to leapfrog lower court litigation and challenge the clawback definitively in the Supreme Court before the first payments were calculated and due on October 15, 2006.

The two grounds for Supreme Court original jurisdiction that the States had to establish were the "seriousness and dignity" of the States' interest⁷¹ and the lack of an adequate alternative forum.⁷² The States argued that the clawback raises serious constitutional questions regarding federal intrusion into essential state functions, namely, the budgetary process.⁷³ They urged

67. Channick, *supra* note 18, at 276-77 (describing States' litigation); Cauchi, *supra* note 45, at 30 (quoting Wyoming State Senator Charles Scott, "Don't underestimate the degree of resentment that the 'clawback' has wrought. It's wide and it's deep, and I think it's going to cause widespread litigation."); Huberfeld, *supra* note 45, at 483-86 (describing States' litigation and summarizing arguments).

68. States' Brief, *supra* note 1, at 20-27.

69. Brief of the States of Arizona, Alaska, Connecticut, Kansas, Mississippi, New Hampshire, Ohio, Oklahoma, South Carolina, and Vermont as Amici Curiae in Support of Plaintiffs, Texas v. Leavitt, 126 S.Ct. 2915 (2006) (mem.) (No. 135) [hereinafter States' Amicus Brief].

70. U.S. CONST. art. III, § 2; see, e.g., South Carolina v. Regan, 465 U.S. 367, 370, 382 (1984) (exercising original jurisdiction to review constitutionality of Internal Revenue Code provision limiting exemption for interest earned on some state bonds).

71. Illinois v. City of Milwaukee, 406 U.S. 91, 93 (1972); see also Mississippi v. Louisiana, 506 U.S. 73, 77 (1992).

72. United States v. Nevada, 412 U.S. 534, 538 (1973); see also Mississippi, 506 U.S. at 77.

73. States' Brief, *supra* note 1, at 11-14.

that the clawback could impose a staggering budgetary impact on states and the statute provides no way to appeal the payment demand.⁷⁴ Furthermore, no adequate alternative forum existed that could provide timely, final resolution of the issue, especially because the clawback was already in operation and payments were quickly coming due.⁷⁵

B. Substantive Arguments

In addition to the jurisdictional argument, the States presented three constitutional grounds for striking down the clawback: violation of intergovernmental tax immunity, violation of state sovereignty by commandeering state regulatory powers for federal functions, and violation of the Guarantee Clause. Essentially, each of the constitutional claims is grounded in federalism and the Framers' structural protections to prevent the federal government from encroaching on state sovereignty.

1. Intergovernmental Tax Immunity

The intergovernmental tax immunity doctrine provides that the federal government cannot tax states qua states.⁷⁶ For this argument, the States relied on *New York v. United States*,⁷⁷ involving a state's challenge to a federal tax on sales of spring water. The rationale for the intergovernmental tax immunity doctrine is that requiring states to pay taxes to the federal government interferes with a core state function and state sovereignty.⁷⁸ Just as the federal government cannot tax states, states cannot tax instrumentalities of the federal government.⁷⁹ The doctrine derives from *McCulloch v. Maryland*, which famously recognized that "the power to tax involves the power to destroy."⁸⁰ Applying this doctrine to the clawback, the Petitioner States argued that setting state budgets is a core state function that is violated by requiring states to remit an undeterminable amount to the federal government each year.⁸¹ In *New York*, the Court ruled that

74. *Id.*

75. *Id.* at 21, 23-25.

76. See *Metcalf & Eddy v. Mitchell*, 269 U.S. 514, 521 (1926) ("[T]he very nature of our constitutional system of dual sovereign governments is such as impliedly to prohibit the federal government from taxing the instrumentalities of a state government . . .").

77. 326 U.S. 572 (1946).

78. *Id.* at 586-87; see also *Metcalf & Eddy*, 269 U.S. at 523.

79. *Metcalf & Eddy*, 269 U.S. at 521.

80. 17 U.S. 316, 431 (1819) (prohibiting the State of Maryland from taxing a branch of the Bank of the United States); see also *Collector v. Day*, 78 U.S. 113, 127 (1870) (recognizing that states should enjoy the same immunity from federal taxation that federal government enjoys from state taxation), *overruled on other grounds by Graves v. New York ex rel. O'Keefe*, 306 U.S. 466 (1939).

81. States' Brief, *supra* note 1, at 12, 21.

intergovernmental tax immunity did not apply because the tax was imposed on the state acting in proprietary capacity, like any other merchant selling spring water.⁸² Although perhaps not resting entirely on the proprietary versus non-proprietary distinction, *New York* makes clear, at the very least, that the federal government may not tax a state as a state.⁸³

Here, the States argued the clawback does nothing more than impose a direct tax on states as states, thus it violates the intergovernmental tax immunity doctrine.⁸⁴ Under the proprietary function distinction, it could hardly be suggested that states were operating as business entities in administering Medicaid programs and thus properly subject to federal taxation.⁸⁵ Public benefits programs are core state functions, not proprietary operations. More particularly, the clawback interferes with states' ability to govern and leaves them no choice but to allocate a portion of their budgets to a federal program.⁸⁶ Budget setting is a core state function that requires states to allocate necessarily scarce resources among a variety of programs and residents' needs.⁸⁷ The clawback interferes with state sovereignty by removing a substantial portion of the budget from states' control and annually exposing them to an unpredictable federal tax, the amount of which could change without notice or opportunity for objection or review. The States noted that, as of their Supreme Court Petition filing date, the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS) had already "sent up to three different notices to the States, repeatedly altering the clawback amounts the States must pay in 2006."⁸⁸

The States argued that with the automatic offset penalty the clawback operates as a mandatory, unconditional tax, not a conditional offer of federal funds for Medicaid, thereby distinguishing this case from *South Dakota v. Dole*,⁸⁹ which upheld a federal statute that conditioned receipt of

82. 326 U.S. at 581; see also *Ohio v. Helvering*, 292 U.S. 360 (1934) (upholding federal license tax on sale of liquor where state had monopoly on sale of liquor), *abrogated by Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985); *Helvering v. Powers*, 293 U.S. 214 (1934) (upholding federal income tax as applied to employees of state-owned railway), *abrogated by Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985).

83. 326 U.S. at 582.

84. States' Brief, *supra* note 1, at 5, 21.

85. See BLACK'S LAW DICTIONARY 1256 (8th ed. 2004) (defining proprietary function to be "[a] municipality's conduct that is performed for the profit or benefit of the municipality, rather than for the benefit of the general public"). See generally *New York*, 326 U.S. at 572 (discussing the federal government's ability to tax a state depending what capacity it is acting in).

86. See Weissert & Miller, *supra* note 7, at 136-38.

87. States' Brief, *supra* note 1, at 21.

88. *Id.* at 12 n.6.

89. 483 U.S. 203, 206-08 (1987).

federal highway funds on states enacting a specified minimum drinking age. According to the States, the clawback does not require states to enact any laws or implement a particular regulatory regime.⁹⁰ The States argued that nothing in the language of the clawback is conditional or optional. Instead, the statute merely demands that states pay a specified amount of funds to the federal government.⁹¹ In order to extract the payment, the federal government can automatically offset the amount due against states' Federal Medical Assistance Percentages (FMAP).⁹² Accordingly the States' Brief characterized the clawback as a direct, unconstitutional tax on states, rather than a condition on receipt of federal funds.⁹³ The States urged the Court to review the case to examine the present scope of the intergovernmental tax immunity doctrine, which has not been squarely addressed or clarified since *New York* in 1946.

2. Anti-Commandeering

The States' anti-commandeering argument suggested that the clawback operates as the federal government's attempt to commandeer state regulatory powers to carry out a federal program.⁹⁴ Specifically, state appropriations powers and state budgetary mechanisms were enlisted to fund a federal program.⁹⁵ The States relied on two key cases that prohibit the federal government from commandeering states. First, in *New York v. United States*,⁹⁶ federal legislation required states to regulate radioactive waste according to the federal scheme or, if they refused, to "take title" to producers' low-level radioactive waste, including liability and disposal costs imposed by federal law.⁹⁷ The Court held that giving states a choice between two unconstitutional choices was "no choice at all."⁹⁸ States were effectively compelled to enforce the federal regulations or face liability under them. The legislation was struck down as being in violation of the anti-commandeering principle.⁹⁹ Similarly, in *Printz v. United States*,¹⁰⁰ the federal Brady Handgun Act was held to commandeer state executive officials

90. States' Brief, *supra* note 1, at 14-16.

91. *Id.* at i, 2.

92. 42 U.S.C. §1396u-5(c)(1)(C) (Supp. IV 2004).

93. States' Brief, *supra* note 1, at 15 n.10 (arguing unconstitutional condition, in the alternative, because provision failed to give unambiguous notice of condition, thereby impairing states' ability to knowingly accept or refuse conditions).

94. *Id.* at 18.

95. *Id.*

96. 505 U.S. 144 (1992).

97. *Id.* at 174-75.

98. *Id.* at 176.

99. *Id.* at 176, 188.

100. 521 U.S. 898, 933 (1997).

to perform background checks on gun purchasers. States had no choice about carrying out the federal law enforcement function, so the Court struck that provision of the legislation.¹⁰¹

The rationale for the anti-commandeering doctrine is that compelling state governments to enforce a federal regulatory scheme undermines political accountability.¹⁰² The federal government takes credit for enacting legislation, yet is shielded from constituents' objections to the law's implementation or enforcement.¹⁰³ In the context of Part D, such tension is readily apparent. The federal government took credit for radically expanding Medicare benefits but placed a substantial funding responsibility on states and insulated federal lawmakers from taxpayers' complaints about the program's price tag, which already far exceeded the administration's estimates.

3. Guarantee Clause

The States' third substantive argument came under the Guarantee Clause. The Constitution guarantees to every state a republican form of government.¹⁰⁴ This guarantee is violated if states cannot exercise their state powers and discretion. The Court has consistently and repeatedly acknowledged the Guarantee Clause's protection of state sovereignty and separate governance.¹⁰⁵ The States argued that the clawback violates the Guarantee Clause by "hijacking the States' budgetary processes."¹⁰⁶ The clawback effectively subjects states' budgets to the discretion of federal authorities, namely HHS and CMS, by statutorily empowering them to command a substantial and unpredictable portion of state budgets.

C. Professors' Amicus Brief

To buttress the States' constitutional arguments and encourage the Supreme Court to exercise its original jurisdiction to review the clawback, two amici filed supporting briefs. First, ten states that did not participate as petitioners filed a supporting brief, essentially restating the arguments

101. *Id.* at 935.

102. *Id.* at 930.

103. *Id.*

104. U.S. CONST. art. IV, § 4 ("The United States shall guarantee to every State in this Union a Republican Form of Government . . .").

105. See *Alden v. Maine*, 527 U.S. 706, 752 (1999) (recognizing state's right "to order the processes of its own governance"); *Fed. Energy Regulatory Comm'n v. Mississippi*, 456 U.S. 742, 761 (1982) (noting that "power to make decisions and to set policy" is central to state sovereignty); *Lane County v. Oregon*, 74 U.S. 71, 76 (1868) (noting that each state is "endowed with all the functions essential to separate and independent existence").

106. States' Brief, *supra* note 1, at 20.

described above.¹⁰⁷ Second, a group of health law professors and practitioners filed the *Brief of Professors and Practitioners of Health Law as Amici Curiae in Support of Plaintiffs*.¹⁰⁸ Working with attorneys from the Texas Solicitor General's office and Jackson Walker L.L.P. in Austin, Texas, I drafted and circulated the Professors' Brief.

The objective of the Professors' Brief was not to reargue the substantive and jurisdictional grounds in the States' Brief. Instead, we aimed to suggest prudential or policy rationales for striking down the clawback and exercising original jurisdiction by providing the Court with a fuller description of the Medicare and Medicaid programs' design and operation. Our goal was to show that the clawback threatens both Congress's initial design for the programs and beneficiaries' access to essential healthcare. Accordingly, we urged the Court to strike down the clawback by exercising original jurisdiction and not wait for the issue to percolate up from the lower courts.

We asserted two main prudential arguments. First, we demonstrated that the clawback arrangement for funding the cost of dually eligible beneficiaries' drugs disrupts the design, structure, and guarantee of both the Medicare and Medicaid programs.¹⁰⁹ Second, we identified particular flaws in the formula for calculating the clawback amount to highlight the unpredictable and potentially detrimental impact that the payment would have on states' budgets and Medicaid operation.¹¹⁰

1. Program Design and Operation

Medicare has always been a fully federal program with uniform eligibility and benefits nationwide.¹¹¹ By design, Medicare is distinctly not a welfare program.¹¹² Any citizen with the requisite work history or disabling condition qualifies, without regard to income.¹¹³ With minor exceptions, implemented by the MMA, all beneficiaries receive the same level of benefits at the same price, even if they have other means or benefits at their disposal.¹¹⁴ Tied to Social Security benefits, which operate as a federal pension, Medicare is essentially a federal healthcare program for retired and disabled workers.¹¹⁵

107. See generally States' Amicus Brief, *supra* note 69.

108. See generally Professors' Brief, *supra* note 15.

109. *Id.* at 6-7.

110. *Id.* at 8-10.

111. *Id.* at 4; *Rehab. Ass'n of Va. v. Kozlowski*, 42 F.3d 1444, 1463 (4th Cir. 1994).

112. See Professors' Brief, *supra* note 15, at 4 (pointing out that "[p]rogram eligibility is based on age or disability, rather than financial need").

113. *Id.*

114. *But see* Jost, *supra* note 49 (discussing MMA's addition of upper-level means-testing for Part B and Part D drug benefit subsidies for low-income beneficiaries).

115. See Kinney, *supra* note 41, at 856 (noting that Medicare was based on a "social insurance model . . . financed through a separate wage tax, and bases eligibility on

Medicaid, by contrast, is a state welfare program for low-income residents.¹¹⁶ Eligibility traditionally was tied to eligibility for the state welfare programs (Aid to Families with Dependent Children (AFDC) and, later, Temporary Assistance for Needy Families (TANF)).¹¹⁷ The federal government established Medicaid but left states to implement and operate the program according to their own designs. Medicaid is a traditional “conditional funding” program—states that choose to participate in the program must comply with broad federal requirements in order to receive federal funding support.¹¹⁸

The clawback alters the fundamental design of both the Medicare and Medicaid programs. Medicare is no longer a fully federal program because a substantial portion of the Part D benefit is funded directly by state budgets.¹¹⁹ Medicaid is no longer a voluntary, conditional funding program. States must remit the clawback amount or suffer automatic loss of otherwise due FMAP.¹²⁰ Another way of viewing the clawback, not argued in the States’ Petition, is that it operates as a new, burdensome condition on Medicaid participation, of which states had no notice and no opportunity to decline. Under both views, the clawback fundamentally alters Medicaid’s cooperative state-federal design.

Medicaid was included in the same legislation that created Social Security, the federal pension program, and Medicare.¹²¹ Unlike Medicare, which is fully federal, Medicaid is a “cooperative endeavor in which the Federal Government provides financial assistance to participating States to

beneficiary contributions during working years”); see also Robert F. Rich & William D. White, *Federalism and Health Care Policy*, 1998 U. ILL. L. REV. 861, 872 (1998) (“With the enactment of Medicare in 1965, the federal government assumed responsibility for acute care of the elderly.”).

116. See Kinney, *supra* note 41, at 856 (“Congress adopted the welfare model for the Medicaid program’s basic design.”).

117. *Id.* at 864; see also Bowen Garrett & John Holahan, *Health Insurance Coverage After Welfare*, 19 HEALTH AFF. 175, 175 (2000).

118. See Kinney, *supra* note 41, at 856 (noting that “Medicaid is jointly . . . financed by state and federal general revenues, and bases eligibility on a means test.”); Rich & White, *supra* note 115 (noting that Medicaid was enacted at the same time as Medicare, “as a partnership with the states. The program provided resources for cost sharing to induce states to participate,” with a “range of voluntary options” but “terms of participation were determined in Washington.”); Rosenbaum, *supra* note 42, at 10 (“Medicaid followed the tradition of federal grant-in-aid programs, enacted pursuant to Congress’s spending clause powers, which condition the receipt of federal funds by states that elect to participate on compliance with a series of structural and operational conditions of participation.”).

119. See Channick, *supra* note 18, at 245-46.

120. 42 U.S.C. § 1396u-5(c)(1)(C) (Supp. IV 2004).

121. See Rosenbaum, *supra* note 42, at 8-9.

aid them in furnishing health care to needy persons.”¹²² Medicaid is a true welfare program in that eligibility is based on financial need, rather than age or disability.¹²³ Financial contribution by both the states and the federal government is the “cornerstone of Medicaid.”¹²⁴ Medicaid participation is voluntary, but once a state chooses to participate, it must administer its program in a manner consistent with the Medicaid Act’s requirements.¹²⁵ Participating states must submit plans to federal authorities for approval.¹²⁶ Each state’s plan must meet statutory requirements, including covering broad categories of mandatory services and serving “categorically needy” and certain “medically needy” beneficiaries.¹²⁷ States’ Medicaid plans may also extend optional benefits to other categories of beneficiaries and services.¹²⁸ Prescription drugs are one such optional benefit.¹²⁹

Within the broad federal requirements, states have considerable discretion over coverage, eligibility, enrollment, and administration of their own Medicaid programs.¹³⁰ Each state receives federal matching dollars on a percentage basis for all money its Medicaid program spends on both required and optional services. The FMAP, which ranges from 50% to 83%, is based on the state’s relative wealth, with the poorest states receiving the highest matching percentage.¹³¹ The matching grants are intended to create an incentive for states to spend generously on their state Medicaid plans by offering federal support for each dollar spent.¹³² The FMAP applies

122. *Harris v. McRae*, 448 U.S. 297, 308 (1980); see also *Bowen v. Massachusetts*, 487 U.S. 879, 883 (1988).

123. Individuals who are both poor and either disabled or elderly qualify for both Medicaid and Medicare and, thus, are termed dual-eligibles. See *Rehab. Ass’n of Va. v. Kozlowski*, 42 F.3d 1444, 1463-64 (4th Cir. 1994) (Niemeyer, J., concurring in part, dissenting in part) (providing overview of both programs and dual-eligibles).

124. *McRae*, 448 U.S. at 308.

125. See 42 U.S.C. § 1396a(b) (2000); *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502 (1990); *McRae*, 448 U.S. at 301-02.

126. 42 C.F.R. § 430.10 (2007); *Va. Hosp. Ass’n*, 496 U.S. at 502.

127. See 42 U.S.C. § 1396a(10)(A).

128. See generally 42 U.S.C. § 1396a; 42 C.F.R. § 440 (2007).

129. See 42 U.S.C. § 1396d(a)(12) (2000); 42 C.F.R. §§ 440.120(a) (listing prescribed drugs), 440.225 (designating optional services).

130. See *Bowen v. Massachusetts*, 487 U.S. 879, 883 (1988) (noting that, “[s]ubject to the federal standards . . . , each participating State must develop its own program describing conditions of eligibility and covered services”).

131. See 42 U.S.C. §§ 1396b, 1396d(b) (defining “federal medical assistance percentage” (FMAP)); 42 C.F.R. §§ 433.10 (rates of federal financial participation (FFP)), 434.70 (2007) (conditions for FFP).

132. See Frank R. Strong, *Cooperative Federalism*, 23 IOWA L. REV. 459, 479-82 (1938) (introducing symposium on “cooperative federalism” and describing various programs under which Congress provided grants to states to encourage them to expand their activity). But see Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*,

equally to beneficiaries and services that federal legislation requires states to cover as well as expanded categories of beneficiaries and optional benefits, including prescription drug coverage.¹³³

Because states may choose not to participate in conditional funding programs, cases involving such programs are distinguishable from the commandeering cases cited in the Petitioner States' Brief. The Court has held that the federal government may constitutionally exercise its spending power to enact legislation that creates incentives for state regulatory programs, i.e., place conditions on federal funds to support them, as long as the encouragement does not end up commandeering.¹³⁴

Medicaid fits the conditional funding model, as the Court has repeatedly recognized.¹³⁵ States are free to opt out of Medicaid and set up their own state health or welfare plans or provide nothing at all, but they will not receive federal funding. States that choose to participate but fail to comply with federal requirements may be denied federal financial assistance or disqualified from participation in the Medicaid program.¹³⁶ The clawback and automatic offset penalty alter this model significantly. States now face a new, unexpected condition on Medicaid participation. If they fail to comply with the mandatory clawback, they lose FMAP dollars otherwise due.¹³⁷ Given the unpredictable budgetary impact of the clawback, especially in the first year of the new Part D benefit, there may be states that simply cannot afford the demand under current budgets. Perversely, the poorest states stand to lose the most under the clawback offset because the federal matching percentage is based on the states' relative wealth.¹³⁸ Since its enactment, the Medicaid program has made great strides in improving

28 CONN. L. REV. 115, 120 (1995) (suggesting that dollar-for-dollar matching grants, instead of block grants, give states an improper incentive to "create 'luxury' health insurance programs").

133. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID PROGRAM—GENERAL INFORMATION, TECHNICAL SUMMARY, at http://cms.hhs.gov/medicaidGeninfo/03_TechnicalSummary.asp (last visited Nov. 10, 2007).

134. See *South Dakota v. Dole*, 483 U.S. 203, 210-12 (1987) (federal legislation that conditioned highway funds on states' implementation of a minimum drinking age of twenty-one did not violate spending power, as states could freely opt out). Several states, notably, Louisiana, for many years turned down the offer of highway funds and tolerated the potholes, recognizing a better fiscal benefit in tourism income from younger drinkers.

135. See *Harris v. McRae*, 448 U.S. 297, 301 (1980) (characterizing Medicaid as a cooperative endeavor by which federal government created incentive for states to provide healthcare to poor residents by offering federal financial assistance).

136. See 42 U.S.C. § 1396c (2000).

137. See 42 U.S.C. § 1396u-5(c)(1)(C) (Supp. IV 2004).

138. See 42 C.F.R. § 433.10(b) (2007).

healthcare access for low-income and medically vulnerable individuals.¹³⁹ Accordingly, the clawback and automatic offset penalty undermine the very essence of the Medicaid program.

2. The Clawback Formula

The second line of argument in the Professors' Brief highlighted flaws in the clawback formula's operation. The formula for calculating states' clawback payment is specified in the MMA statute and detailed in HHS implementing regulations.¹⁴⁰ The formula itself is not constitutionally objectionable or grounds for striking down the clawback. But we hoped to support the States' substantive arguments and enhance the Court's understanding of the budgetary impact, violation of state sovereignty, and threat to beneficiaries' healthcare by explaining the inherent flaws and unfairness in the formula and its unusual legislative history.

The MMA requires states to make monthly payments to federal authorities, calculated annually as the states' historical spending on prescription drugs in the base year (2003) multiplied by the number of dual eligibles in the current year, multiplied by the "phased down state contribution," which begins at 90% in year 1 (2006) and phases down to 75% in year 2015 and thereafter.¹⁴¹ Thus, the formula has three components: (1) State per capita expenditures for prescription drug coverage for dual-eligibles; (2) the number of enrolled dual-eligibles; and (3) phased-down percentage, as specified in the Act.¹⁴² We demonstrated flaws with each element of the formula.

(a) Using 2003 as the Base Year

First, the historical spending and 2003 base year permanently insert unfairness and anomalies into the formula. The figure is the amount that the state spent, per capita, on dual eligibles' Medicaid prescription drug costs in 2003.¹⁴³ The base-year amount is trended forward, based on an inflation factor and other adjustments that the HHS Secretary exclusively controls.¹⁴⁴ The problem with the base year is that it may reflect a one-time

139. See Marc L. Berk & Claudia L. Schur, *Access to Care: How Much Difference Does Medicaid Make?*, 17 HEALTH AFF. 169, 170, 176-78 (1998).

140. See 42 U.S.C. § 1396u-5(c)(1)(A); 42 C.F.R. §§ 423.908, 423.910 (2007).

141. 42 U.S.C. § 1396u-5; see also *Implementation of the New Medicare Drug Benefit: Hearing Before the S. Comm. on Finance*, 109th Cong. 34 (2006) (testimony of Mark B. McClellan, Administrator, Centers for Medicare and Medicaid Services) (explaining that the clawback was intended "to account for a portion of the costs that states had previously paid for Medicare beneficiaries who are also in Medicaid").

142. See 42 U.S.C. § 1396u-5(c)(1)(A); 42 C.F.R. § 423.10.

143. See 42 U.S.C. § 1396u-5(c)(3)(A).

144. See 42 U.S.C. § 1396u-5(c)(3)(B).

aberration in state Medicaid drug spending in year 2003. For example, states may have temporarily expanded drug spending in that year or subsequently implemented successful cost-containment strategies that would never be captured in the clawback formula.¹⁴⁵ In addition, states are perpetually denied the fiscal benefit of recent reforms to improve Medicaid efficiency or contain costs during the time that they bore full responsibility for prescription drug coverage. Meanwhile, the federal government garners a windfall to the extent that states reduced Medicaid spending after 2003 until Part D was implemented.

Moreover, the base-year figure penalizes states that were historically more generous. Prescription drug coverage is an optional service under Medicaid that all states were providing when the MMA was enacted.¹⁴⁶ As an optional benefit, states had full discretion over the scope of coverage provided. But now, states that historically provided more generous coverage than other states perpetually will be required to pick up a larger share of the federal tab for Medicare Part D, without regard to their relative wealth, financial resources, Medicaid enrollment, or current Medicaid spending. States that provided generously in 2003 but were forced to cut benefits due to budgetary or other pressures will be on the hook continuously for the higher spending amount. In other words, the clawback translates states' past generous spending on state Medicaid programs into mandatory generous support for a federal program.

The inflation factor is also problematic because it is based not on state-specific drug costs reflected in states' individualized Medicaid drug formularies. Starting from each state's 2003 base-year spending level, the amount is trended forward, theoretically to reflect rising prescription drug costs over time.¹⁴⁷ Recall that prescription drug coverage is optional under Medicaid; accordingly, states may vary widely in the variety and number of

145. Forty-six out of fifty states implemented some type of Medicaid pharmacy cost-savings reforms during 2003; forty-four took action in 2004, but these efforts will not be reflected in the amount states are required to pay to the federal government. APRIL GRADY & CHRISTINE SCOTT, CONG. RESEARCH SERV., IMPLICATIONS OF THE MEDICARE PRESCRIPTION DRUG BENEFIT FOR STATE BUDGETS CRS-3 n.4 (2004) (citing VERNON SMITH ET AL., THE HENRY J. KAISER FAMILY FOUND., STATES RESPOND TO FISCAL PRESSURE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2003 AND 2004, RESULTS FROM A 50-STATE SURVEY apps. B-E, available at <http://kff.org/medicaid/upload/States-Respond-to-Fiscal-Pressure-State-Medicaid-Spending-Growth-and-Cost-Containment.pdf> (last visited Oct. 23, 2007)).

146. Weissert & Miller, *supra* note 7, at 118.

147. See 42 U.S.C. § 1396u-5(c)(2)(A)(ii); 42 C.F.R. § 423.902 (2007) (defining "[a]pplicable growth factor," based on "National Total Drug National Health Expenditure projections" for 2004-2006).

drugs they choose to cover.¹⁴⁸ The clawback base year is trended forward for inflation, however, based on nationwide per capita drug costs under all formularies.¹⁴⁹ Various factors (e.g., regional practice preferences and marketing, drug plan formularies, relative bargaining strength and price negotiations, cost-containment laws and incentives) could produce differences in prescription drug costs increases across states and regions.¹⁵⁰ The amounts that private insurers' prescription drug coverage or patients' out-of-pocket spending on prescription drugs differ from and exceed states' Medicaid spending levels will be inserted into the clawback formula, inflating the amount that states are required to pay to the federal program. Beginning in 2007, the growth factor will be tied to Medicare Part D spending.¹⁵¹ Like the 2003 base year, the nationwide inflation factor could result in grossly inaccurate estimates of states' actual drug spending.

(b) Dually Eligible Beneficiary Enrollment

We also pointed out that using the current-year dually eligible beneficiary enrollment factor is problematic because states are largely at the mercy of the federal government's efforts to increase enrollment in the new Part D program. Part D was designed to promote quality and contain costs by relying on competitive market incentives, with private insurers offering competing drug plans that beneficiaries could select among based on ease of enrollment, premiums, deductibles, service, coverage, quality, and other factors.¹⁵² The success of the competitive model depended on the federal government's ability to create a sufficiently large market demand for drug plans so that multiple insurers would choose to enter the market.¹⁵³ Requiring dual eligibles to enroll in Part D plans, instead of state Medicaid drug plans, was one approach to increasing the customer base.¹⁵⁴ In addition, the availability of the new Medicare drug benefit and the federal government's promotion efforts were expected to create an incentive for previously unenrolled but eligible Medicare beneficiaries to enroll in the

148. See *supra* notes 125-135 and accompanying text (describing Medicaid conditional funding and optional services).

149. See 42 U.S.C. § 1396u-5(c)(2)(A); 42 C.F.R. §§ 423.902, 423.910(b) (defining elements of formula).

150. See GRADY & SCOTT, *supra* note 145, at CRS-3. *But see* Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4422 (Jan. 28, 2005) (declining to adopt state-specific inflation factors because that approach would be "imprecise and would introduce new reporting requirements").

151. See 42 U.S.C. § 1396u-5(c)(4).

152. See Channick, *supra* note 18, at 267-69.

153. *Id.* at 269-70.

154. See Cody, *supra* note 2.

program.¹⁵⁵ Many new enrollees might discover, in the sign-up process, that they also qualified for state Medicaid benefits. The so-called woodwork effect could dramatically increase dual-eligible enrollment, escalating states' direct Medicaid costs and clawback liability over time.¹⁵⁶

We certainly did not argue that encouraging unenrolled, eligible beneficiaries to sign up for Medicare and Medicaid was an undesirable, much less unconstitutional, feature of Part D implementation. But we did want to point out that the new Part D's attraction and federal efforts to "shake the trees" could dramatically increase state Medicaid rolls and, thereby, state funding pressures, with little room for states to contain the costs of increased enrollment. States that cannot balance the clawback's added costs and dual-eligible rolls may be forced to discontinue or limit certain optional eligibility categories or more rigorously screen enrollment applications to maintain existing rolls. One way states could contain budget pressures would be to restrict eligibility, for example, by raising the income level or other substantive requirements, to the extent states have discretion under the federal Medicaid statute.¹⁵⁷ Another approach would be to restrict coverage or benefits under state Medicaid plans, again, to the extent the federal requirements allow.¹⁵⁸

However, both approaches are problematic. First, restricting enrollment and eliminating previously covered services threatens beneficiaries' entitlement to Medicaid and potentially exposes states to Section 1983 litigation for violating beneficiaries' due process or other constitutional rights.¹⁵⁹ Aside from potential constitutional challenges, a policy problem

155. Professors' Brief, *supra* note 15, at 15.

156. *Id.*

157. *Id.* at 3, 9-10.

158. See Cody, *supra* note 2, at 29 (highlighting adverse incentives on states to decrease enrollment and services as result of clawback, and noting that "[s]everal states . . . have recently announced plans to reduce or eliminate Medicaid coverage for certain individuals, including dual eligibles"); Weissert & Miller, *supra* note 7, at 136 (noting that "[s]tates will also face tough choices in deciding how generous to be in supplementing Medicare's limited national coverage" and "fear that decisions to extend supplemental benefits will doom them to having to subsidize coverage in perpetuity if the national government ever decides to expand its own benefits").

159. See Professors' Brief, *supra* note 15, at 7-10 (noting that restricting eligibility or limiting services could run awry of Medicaid enrollees' entitlement to a certain level of medical care to which they have become accustomed. Therefore, states that choose these cost containment strategies risk constitutional challenges from program beneficiaries); Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs., 443 F.3d 1005, 1015-16 (8th Cir. 2006); Doe v. Chiles, 136 F.3d 709, 719 (11th Cir. 1998) (holding that plaintiffs had a "federal right to . . . prompt provision of assistance under . . . the Medicaid Act, and that this right is enforceable under section 1983"); see also Barker, *supra* note 18, at 65-67 (discussing cases asserting enforceable entitlement to Medicaid benefits); Rosenbaum et al., *supra* note 39, at

exists with incentivizing states to decrease enrollment, coverage, or services. This incentive directly opposes FMAP's intended incentive for states to spend generously on their Medicaid programs. As one court eloquently noted in considering beneficiaries' Section 1983 challenge, underlying the

statistics, acronyms of agencies and bureaucratic entities, Supreme Court case names and quotes, official governmental reports, periodicity tables, etc. . . . let there be no forgetting the real people to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications . . . for their children, AIDS patients unable to get treatment, [and] elderly persons suffering from chronic conditions like diabetes and heart disease¹⁶⁰

But if states opt to extend Medicaid eligibility, the clawback works against the expansion by adding costs, directly opposing the intention of open-ended federal matching dollars to encourage broader state spending.¹⁶¹

The second component of the formula, counting the number of dual-eligible Medicare Part D enrollees during the month in question, also leaves states at the mercy of federal authorities who have full control and discretion over Medicare enrollment.¹⁶² Unlike with Medicaid, under which states have broad discretion, states have no authority or control over the Medicare enrollment or coverage. For example, if Congress statutorily expands Medicare eligibility, or CMS or other federal authorities ease the Medicare enrollment or application process, states could face corresponding increases in dual-eligible Medicaid enrollment and, accordingly, their clawback obligations.

Furthermore, "the new Part D benefit could have a 'woodwork' effect of encouraging previously unenrolled [but eligible] individuals to sign-up for government health insurance" programs.¹⁶³ Federal enrollment and screening procedures may identify individuals as dually eligible and assist them with referral to and applying for appropriate state Medicaid programs. Much of the touted savings that states anticipate with the federal government assuming the prescription drug costs could largely be lost to increased dual-eligible enrollment.¹⁶⁴

7-8 (describing Medicaid's "three entitlements" to states, providers, and beneficiaries). *But see* Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement*, 22 HEALTH AFF. 145, 147-48 (2003) (characterizing Medicaid as a "weak entitlement").

160. *Salazar v. District of Columbia*, 954 F. Supp. 278, 281 (D.D.C. 1996).

161. See S. REP. NO. 89-404 (1965), as reprinted in 1965 U.S.C.C.A.N. 1934, 1951.

162. See 42 U.S.C. § 1396u-5(c)(2)(A) (Supp. IV 2004).

163. Professors' Brief, *supra* note 15, at 15.

164. See CONG. BUDGET OFFICE, COST ESTIMATE: H.R. 4954—MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002, at 1, 13 (2002) (as ordered reported by the House Committee on Ways and Means) (reducing CBO's initial fifty eight billion dollar estimate of savings to states for the period of 2003-2012, to approximately twelve billion dollars, after

Congress and the courts have previously recognized that changing federal Medicare eligibility could increase Medicaid rolls and place financial pressures on the states.¹⁶⁵ To ease the pressure and prevent states from opting out of Medicaid, Congress gave states alternative implementation options. For example, when Congress added the federal Supplemental Security Income for the Aged, Blind, and Disabled (SSI) program, it also declared that all SSI recipients were entitled to Medicaid.¹⁶⁶ Accordingly, the SSI amendment “threatened to swell the Medicaid rolls and place a large and immediate fiscal burden on participating states.”¹⁶⁷ Congress worried that “states would withdraw from the cooperative Medicaid program rather than expand their Medicaid coverage” proportional to the expanded federal benefit.¹⁶⁸ Therefore, Congress gave states an alternative, the “§ 209(b) option,” to automatically enrolling new SSI recipients in their Medicaid plans. Fifteen states opted to be “§ 209(b) states.”¹⁶⁹ No comparable safety valve or option exists in Part D to help states absorb the “woodwork” effect and increased enrollment resulting from the Part D Medicare expansion. Thus, the possibility of states withdrawing from the Medicaid program under Part D pressures, thereby undermining an essential element of the welfare safety net, remains a very real possibility.

(c) The Phased-Down Percentage

The clawback formula’s third element is the phased-down state percentage, beginning at 90% state funding in 2006 and phasing down to 75% state funding in 2015 and thereafter.¹⁷⁰ Again, it is important to emphasize that the states’ percentage phases down but never out completely. States perpetually will pay for three-quarters of the cost of a federal benefit for dual eligibles’ prescription drugs. The legislative history of the clawback reveals its true intention.

offsets accounting for increased spending on new dual-eligible enrollees and other factors); GRADY & SCOTT, *supra* note 145, at CRS 4-5 (noting potential increase in total state expenditures if Part D screening process identifies additional Medicaid-eligible individuals).

165. See, e.g., *Winter v. Miller*, 676 F.2d 276, 278 (7th Cir. 1982) (noting that “raising benefits and lowering eligibility criteria” for Medicaid could “place a large and immediate fiscal burden on participating states”).

166. *Id.* at 277-78; *Schweiker v. Gray Panthers*, 453 U.S. 34, 38 (1981).

167. *Winter*, 676 F.2d at 278 (describing changes).

168. *Gray Panthers*, 453 U.S. at 38 (describing the program); see also *Cohen v. Quern*, 608 F. Supp. 1324, 1326 (N.D. Ill. 1984). See generally 42 U.S.C. § 1396a(f) (2000) (describing states’ duty to provide medical assistance to SSI recipients).

169. *Gray Panthers*, 453 U.S. at 39-40, 40 n.6; *Winter*, 676 F.2d at 278.

170. 42 U.S.C. § 1396u-5(c)(5)(A) – (J) (Supp. IV 2004).

The clawback was an eleventh-hour addition to the MMA, inserted in an attempt to address Part D's significant budget overrun.¹⁷¹ The clawback did not appear in either the House or Senate bill. Neither bill required dual eligibles to switch drug coverage from state Medicaid plans to the to new Medicare benefit. The Senate bill, in fact, required dual eligibles to continue receiving their prescription drug coverage through state Medicaid plans.¹⁷² The House bill gave these beneficiaries the option to enroll in Part D and remain enrolled in the Medicaid drug plan; Part D would be primary and Medicaid would be "wrap around" coverage.¹⁷³ Under the House version, states would temporarily contribute to the federal benefit for dual enrollees, but the payment obligation phased out over time.¹⁷⁴

The Bush administration, touting the new, expanded Medicare program, affixed a \$400 billion price tag to the Part D benefit.¹⁷⁵ It quickly became clear that \$400 billion was a gross underestimation.¹⁷⁶ Attempting to address the cost overrun, the Conference Committee added three offsets. First, beneficiaries were required to pay monthly premiums for Part D coverage.¹⁷⁷ Second, the Committee factored in the federal savings from the FMAP amount no longer due to states for drug costs.¹⁷⁸ That is, the federal government would no longer have to pay matching dollars to states for dual eligibles' Medicaid drug plans because those beneficiaries would be enrolled in Part D. Third, the Committee added the clawback, permanently requiring states to shoulder a portion of the federal budget for

171. See Channick, *supra* note 18, at 274 (discussing the clawback provision's costs to the states); Weissert & Miller, *supra* note 7, at 133-34 (describing the tumultuous legislative history of the MMA, including an "unprecedented nearly three-hour vote count delay while party leaders twisted arms," and the clawback enactment).

172. THE HENRY J. KAISER FAMILY FOUND., PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: A SIDE-BY-SIDE COMPARISON OF S. 1 AND H.R. 1, AND THE CONFERENCE AGREEMENT 5 (2003), available at www.kff.org/medicare/upload/Prescription-Drug-Coverage-for-Medicare-Beneficiaries-A-Side-bySide-Comparison-of-S-1-and-H-R-1-and-teh-Conference-Agreement-H-R-1.pdf (last visited Nov. 10, 2007).

173. *Id.*

174. *Id.*

175. Connolly & Allen, *supra* note 62; Channick, *supra* note 18, at 238.

176. See Channick, *supra* note 18, at 238 (suggesting that Senator Edward Kennedy (D-Mass.) "freely admitted that the \$400 billion is merely a down payment on the cost of providing a prescription drug benefit to Medicare beneficiaries"); Dodge, *supra* note 51 (noting that many healthcare analysts "questioned whether the \$400 billion for prescription drugs and free-market forces would be enough, predicting Congress would have to find other ways to contain Medicare costs").

177. See THE HENRY J. KAISER FAMILY FOUND., *supra* note 172, at 3.

178. *Id.* at 5.

Part D.¹⁷⁹ The clawback represents the largest offset, fixed as a permanent, primary funding source for the new Part D benefit.¹⁸⁰

Despite statutory language about the states' "phased-down percentage," suggesting that the federal government retains the primary obligation for the benefit, the Conference Committee report reveals the reality of the arrangement. The committee notes speak in terms of "phased-in" federal assumption of "administrative costs," making clear that states have the primary funding obligation.¹⁸¹ Meanwhile, the federal government claims full credit for a generous and unprecedented expansion of Medicare.¹⁸² Moreover, the federal government retains full administrative control for the program at all times even though its responsibility for the so-called administrative costs starts at only 10% and increases to a 25% maximum. With their hands tied, states are unable to exercise any discretion over the Part D benefit, cost, or enrollment levels.¹⁸³ They are required, however, to submit monthly payments, calculated by a formula wholly outside of their control, with no opportunity for review, challenge, or appeal.

The House bill's reference to administrative costs and federal phase-in inaccurately implies that states retain primary fiscal and administrative responsibility for the drug benefit.¹⁸⁴ The federal government, in fact, retains full control over the new Part D program, including the authority to increase states' clawback payments or demand additional state contributions through statutory revision if Medicare Part D expenditures

179. See H.R. REP. NO. 108-391, at 509 (2003) (Conf. Rep.).

180. See GRADY & SCOTT, *supra* note 145, at CRS-1-2.

181. See H.R. REP. NO. 108-391, at 509. Even the initial House Report proposal would have phased-out state contribution (or "phased-in" 100% federal assumption of costs, in the proposal's terminology) by 2019, unlike the finally enacted version that requires states permanently to pay 75%. See *id.* at 506, 509.

182. OFFICE OF THE PRESS SEC'Y, THE WHITE HOUSE, FACT SHEET: MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 (Dec. 8, 2003), at www.whitehouse.gov/news/releases/2003/12/20031208-3.html (last visited Nov. 10, 2007) (announcing the MMA and touting that it will "help to create a modern Medicare system, allow for the biggest improvements in senior health care in nearly 40 years, and provide seniors with prescription drug benefits and more choices in health care" and that, "[f]or the first time in Medicare's history, a prescription drug benefit will be offered to all 40 million seniors and disabled Americans"); see also Susan Rose-Ackerman, *Cooperative Federalism and Co-optation*, 92 YALE L.J. 1344, 1346-47 (1983) (describing previous conditional funding statutes and noting that "[s]uch legislation is relatively easy for Congress to pass because legislators can take credit for bold, new initiatives without having to face up to the problem of finding tax money to cover the costs of those programs").

183. For a discussion of accountability and federalism principles that are violated when states are forced to bear the expense of federal programs, see *New York v. United States*, 505 U.S. 144, 168 (1992).

184. See H.R. REP. NO. 108-391, at 506-07.

continue to overrun expectations. The federal government claims full credit for expanding government healthcare benefits, while state authorities neither receive credit for funding nor retain control over the expansive program.

D. The Outcome of the Petition

Despite the States' and Amici's best efforts, the Supreme Court denied certiorari on June 19, 2006, inviting the States to pursue their claims in lower courts.¹⁸⁵ This disposition was not entirely unexpected, given the infrequency of the Court's exercise of original jurisdiction. Perhaps the Petitioner States would have fared better had they pursued the litigation in district court and used the standard appellate process to request Supreme Court review if necessary. At the time the Petition was filed, however, with the first unpredictable, possibly staggering clawback payments coming due, the extraordinary strategy seemed warranted.

Somewhat surprisingly and despite the Court's invitation, no state has brought clawback litigation in lower courts. At least initially, the clawback's budgetary impact on states turned out not to be as great as anticipated.¹⁸⁶ Most states broke even, compared to their previous Medicaid drug costs, and some came out ahead in the first year.¹⁸⁷ Given various features of the clawback formula and the federal government's complete control over its calculation and operation, there is no guarantee that states will avoid a future adverse budgetary impact. But, for now, the Petitioner and Amici States appear to have directed their litigation and regulatory resources elsewhere.

More importantly, the Supreme Court's denial of review and states' lack of follow-up in lower courts leaves the constitutionality of the clawback still very much an open question. Funding a fully federal program with a permanent excise against states is an unprecedented and troubling innovation in the federalist system. It runs awry of traditional notions of the constitutional allocation of power between the federal and state governments. With the recent attention on healthcare reform at both federal and state levels, especially the attempt to identify strategies to defray the

185. *Texas v. Leavitt*, 126 S.Ct. 2915 (2006) (mem.).

186. VERNON SMITH ET AL., THE HENRY J. KAISER FAMILY FOUND., *LOW MEDICAID SPENDING GROWTH AMID REBOUNDED STATE REVENUES: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY STATE FISCAL YEARS 2006 AND 2007*, at 48-49 (2006), available at www.kff.org/medicaid/upload/7569-ES.pdf (last visited Nov. 10, 2007) (compared to the expense of covering drugs for dual eligibles through Medicaid, fifteen states reported their FY 2007 clawback obligation cost more, while fifteen states reported that it actually cost less. Twenty states reported little to no change.)

187. *Id.*

ever-increasing costs,¹⁸⁸ this unique funding arrangement warrants closer scrutiny.

Accordingly, this Article examines some of the constitutional objections that the Court declined to consider, focusing particularly on the federalism grounds. I conclude that the clawback should not survive a constitutional challenge because it effectively commandeers state regulatory authority to carry out a federal program. Alternatively, the clawback operates as a new, retroactive condition on state's voluntary Medicaid participation, exceeding the federal government's spending power to enact conditional funding programs.

IV. FEDERALISM "TURF WAR"

The allocation of power and responsibility between the federal government and the states is constitutionally grounded and was part of the Framers' design to facilitate centralized coordination at the federal level, on the one hand, and diffusion of power and respect for state sovereignty, on the other.¹⁸⁹ Federal powers are enumerated in the Constitution, including the power to tax and spend for the general welfare, the commerce power, national security powers, and the catch-all Necessary and Proper Clause.¹⁹⁰ Most health and welfare legislation at the federal level is enacted under the

188. See *id.* at 24. For example, Pennsylvania Governor Ed Rendell recently introduced the "Prescription for Pennsylvania" plan. Among the various factors expected to reduce the cost of healthcare, the proposal suggests incentivizing hospitals to reduce expensive emergency department procedures for non-emergency health problems, and stopping reimbursements to hospitals for unnecessary care in emergency departments. *State Watch: Pennsylvania Gov. Rendell Announces Proposal to Expand Health Care, Improve Quality, Reduce Costs*, KAISER DAILY HEALTH POLICY REPORT, Jan. 19, 2007, at www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=42367&dr_cat=3 (last visited Nov. 10, 2007); see also Governor's Office of Health Care Reform, *Prescription for Pennsylvania*, at www.ohcr.state.pa.us/prescription-for-pennsylvania/index.html (last visited Nov. 10, 2007).

189. See, e.g., *Printz v. United States*, 521 U.S. 898, 918 (1997) ("It is incontestable that the Constitution established a system of 'dual sovereignty.'"); *South Carolina v. Baker*, 485 U.S. 505, 533 (1988) (O'Connor, J., dissenting) ("If there is any danger, it lies in the tyranny of small decisions—in the prospect that Congress will nibble away at state sovereignty, bit by bit, until someday essentially nothing is left but a gutted shell", quoting Laurence Tribe, *AMERICAN CONSTITUTIONAL LAW* § 5-20, at 381 (2d. ed. 1988)); see also Hills, *supra* note 5, at 816 ("The national government has unique needs in maintaining the supremacy of federal law and an orderly federal system, yet there must be a limit to federal power and a corresponding reservoir of state power if federalism is to have any meaning at all."); Rich & White, *supra* note 115, at 862 (noting historical tension between national and state governments and the "basic principle . . . of division of powers between distinct and coordinate governments").

190. See U.S. CONST. art. I, § 8 (listing the federal powers).

spending or commerce powers.¹⁹¹ Spending power legislation must address matters of national concern and be for the benefit of the general welfare.¹⁹² The Court has limited Congress' ability to legislate social policy under the Commerce Clause to the extent that social problems may not sufficiently impact interstate commerce to justify use of that power.¹⁹³ Spending power challenges to federal welfare legislation, by contrast, have been consistently rejected.¹⁹⁴ Under the Supremacy Clause, if the federal government acts within its constitutionally enumerated powers, its laws are supreme and trump any contrary or inconsistent state laws.¹⁹⁵

Under the Tenth Amendment to the Constitution, all governmental powers not assigned to the federal government are reserved to the states.¹⁹⁶

191. See Carleton B. Chapman & John M. Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROBS. 334, 336, 342 (1970).

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

193. See Richard E. Levy, *Federalism: The Next Generation*, 33 LOY. L.A. L. REV. 1629, 1638-45 (2000). (suggesting that "the Court made clear that the relationship between a regulated activity and interstate commerce must be *substantial*," in his discussion of *United States v. Lopez*, 514 U.S. 549 (1995), and federal Gun-Free School Zones Act); see also Stephen R. McAllister, *Is There a Judicially Enforceable Limit to Congressional Power Under the Commerce Clause?*, 44 U. KAN. L. REV. 217, 225 (1996) (listing examples of federal legislation enacted under Commerce Clause aimed at carjacking, arson, domestic violence, child support, and research animals); Melanie L. Winskie, Note, *Can Federalism Save the Violence Against Women Act?*, 31 GA. L. REV. 985, 1006-12 (1997) (citing cases and analyzing VAWA under Commerce Clause).

194. See Levy, *supra* note 193, at 1656-57, 1656 n.119 (citing lower court cases and discussing *South Dakota v. Dole*, 483 U.S. 203 (1987)).

195. U.S. CONST. art. VI, cl. 2 ("This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."); see also *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 203-04 (1983).

196. U.S. CONST. amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."); see also *Printz v. United States*, 521 U.S. 898, 918-19 (1997) (noting that the states retained "a residuary and inviolable sovereignty" (quoting THE FEDERALIST NO. 39, at 245 (James Madison) (Clinton Rossiter ed., 1961))); *New York v. United States*, 505 U.S. 144, 156 (1992) (noting that the Constitution, "[b]eing an instrument of limited and enumerated powers, it follows irresistibly, that what is not conferred, is withheld, and belongs to the state authorities") (citing JOSEPH STORY, COMMENTARIES ON THE CONSTITUTION OF THE UNITED STATES 3, at 752 (1833)); *Collector v. Day*, 78 U.S. 113, 124 (1870) (overruled on other grounds) (quoting Tenth Amendment on reserved powers and noting that "[t]he government of the United States, therefore, can claim no powers which are not granted to it by the Constitution, and the powers actually granted must be such as are expressly given, or given by necessary implication"); Thomas R. McCoy & Barry Friedman, *Conditional Spending: Federalism's Trojan Horse*, 1988 SUP. CT. REV. 85, 85 ("It is basic civics that the national government is one of delegated powers. All powers not delegated are retained by the state governments.").

Some of the most important powers reserved to the states are the “police powers” to protect the health, safety, and welfare of citizens.¹⁹⁷ Most state healthcare programs, including Medicaid, fall clearly within states’ broad police powers. Federal authority limits state police powers only if the state action or law violates the U.S. Constitution or is preempted by federal enumerated powers.¹⁹⁸ In addition, the federal government cannot require states to legislate according to Congress’s instructions.¹⁹⁹ “[A]n essential attribute of the States’ retained sovereignty [is] that they remain independent and autonomous within their proper sphere of authority.”²⁰⁰ The Framers’ express assignment of power to the federal government and reservation of all other powers to the states preserved broad state sovereignty.²⁰¹ The challenge is defining the scope of the limited enumerated federal powers and broad reserved powers, especially when the two governments are attempting to regulate in the same area or coordinate regulatory responses.²⁰²

A. *Two Theoretical Views*

In this discussion, I suggest two theoretical approaches to the federalism turf war. First, federalism may be viewed as a structural limit on respective federal and state powers that is hard-wired into the Constitution. Alternatively, federalism may be viewed as a contractual limit on the respective powers, allowing either side to freely agree to assign duties to or assume additional duties from the other.

1. Structural Limit

If federalism operates as a structural limit on respective federal and state powers, it would be impermissible for Congress to impose certain regulatory burdens on states, even if states agreed to them.²⁰³ The Framers are

197. See Levy, *supra* note 193, at 1633 (noting that the “Tenth Amendment was interpreted as reserving the ‘police power’ to the states and federal legislation that usurped that power was invalid”).

198. U.S. CONST. art I, § 8; U.S. CONST. amend. X.

199. *New York*, 505 U.S. at 162.

200. *Printz*, 521 U.S. at 928.

201. See THE FEDERALIST NO. 45, at 288, 292-93 (James Madison) (Clinton Rossiter ed., 1961).

202. *New York*, 505 U.S. at 155 (“[T]he task of ascertaining the constitutional line between federal and state power has given rise to many of the Court’s most difficult and celebrated cases.”).

203. See, e.g., *New York v. United States*, 505 U.S. at 182 (“Where Congress exceeds its authority relative to the States, therefore, the departure from the constitutional plan cannot be ratified by the ‘consent’ of state officials.”); *Wilkerson v. Rahrer*, 140 U.S. 545, 560 (1891) (“It does not admit of argument that congress can neither delegate its own powers, nor

assumed to have included structural limits in Constitution itself to avoid concentration of power in the federal government or dilution of coordinated, centralized power to the separate states.²⁰⁴ The structural view also may reflect the notion that states lack institutional competence in certain areas and, therefore, may not voluntarily assume those duties expressly enumerated as federal powers.²⁰⁵ As the Supreme Court noted, “Where Congress exceeds its authority relative to the States, . . . the departure from the constitutional plan cannot be ratified by the ‘consent’ of state officials.”²⁰⁶

An analogy in administrative law is the non-delegation doctrine which prohibits Congress from delegating certain functions and administrative agencies from making independent choices about what powers to assume.²⁰⁷ From a states’ rights perspective, the structural view undermines state autonomy. States cannot agree to assume duties that are identified as

enlarge those of a state.”); *United States v. Jones*, 109 U.S. 513, 518-19 (1883) (federal government’s “sovereign attributes” cannot “be transferred to a state”).

204. See *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 550-52 (1985) (noting that the “composition of the Federal Government was designed in large part to protect the States from overreaching by Congress” and that “[s]tate sovereign interests, then, are more properly protected by procedural safeguards inherent in the structure of the federal system than by judicially created limitations on federal power”); see also *McAllister*, *supra* note 193, at 240-41 (describing values of federalism); *McCoy & Friedman*, *supra* note 196, at 89 (“Federalism has allowed for national control over problems truly national in scope, while preserving participatory democracy at the local level of governance.”). See generally Malcolm Wallop, *The Centralization of Power and Governmental Unaccountability*, 4 CORNELL J.L. & PUB. POL’Y 487 (1995) (bemoaning recent shift of power away from self-government toward central government).

205. See *Hills*, *supra* note 5, at 832-35 (providing support for view that Framers harbored “a deep distrust and disapproval of state officials”); H. Geoffrey Moulton, Jr., *The Quixotic Search for a Judicially Enforceable Federalism*, 83 MINN. L. REV. 849, 900 (1999) (suggesting that “American federalism was a pragmatic invention, a compromise designed to leave the states with primary responsibility for governing while granting the national government sufficient power to handle those aspects of government beyond the states’ institutional competence”).

206. *New York*, 505 U.S. at 182.

207. See *Immigration & Naturalization Serv. v. Chadha*, 462 U.S. 919 (1983); *Buckley v. Valeo*, 424 U.S. 1, 120-24 (1976); see also *New York*, 505 U.S. at 182 (citing *Chadha* and *Buckley* in discussion regarding structural limits on separation of powers into three branches of government); *Hills*, *supra* note 5, at 831-32 (suggesting non-delegation doctrine as analogy to nationalistic theory of state sovereignty); *id.* at 840-43 (describing Justice Story’s dissent in *Houston v. Moore*, 18 U.S. (5 Wheat.) 1 (1820), and opinion in *Martin v. Hunter’s Lessee*, 14 U.S. (1 Wheat.) 304 (1816), as suggesting a “nationalistic nondelegation theory” of state autonomy).

federal powers because it would exceed their competence and violate the Constitution.²⁰⁸

2. Contractual Limit

Under the alternative view of federalism as a contractual limit on power, the federal government can delegate even enumerated powers to states, and states can freely agree to a federal regulatory scheme or assume a burden.²⁰⁹ The delegation is limited only to the extent that states must be given clear notice of the terms and conditions so they can knowingly and voluntarily agree.²¹⁰ Accordingly, the federal government will have to offer adequate incentives, typically money, to elicit the states' agreement.²¹¹

Consistent with the structural view, simple commandeering is still impermissible under the contractual view because it denies states the ability to opt in or out of assuming federal powers.²¹² One commentator described this view of federalism as assigning a "New York entitlement" to states, meaning that states hold the right to refuse participation in the federal program but can freely bargain away that entitlement if, given the terms and conditions of the offer, doing so is in their or their constituents' interests.²¹³ This view is similar to Coasian land use rules: no matter which

208. See *Prigg v. Pennsylvania*, 41 U.S. 539, 615-16 (1842) (concluding that federal government could not force state to enforce Fugitive Slave Clause, even if it wanted to do so because clause was found in federal Constitution); see also *Printz v. United States*, 521 U.S. 898, 935 (1997) (holding that federal government cannot unconditionally force states to implement federal regulatory program).

209. See *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).

210. See, e.g., *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 247 (1985) (superseded by statute) (statute must provide a clear expression of Congress's "intent to condition participation in the program[] . . . on a State's consent to waive its constitutional immunity"); *Pennhurst*, 451 U.S. at 17 ("The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract'"); David E. Engdahl, *The Spending Power*, 44 DUKE L.J. 1, 71-72 (1994) (noting that "*Pennhurst's* contractual characterization of spending conditions has been repeatedly reaffirmed" and citing cases); Levy, *supra* note 193, at 1654-55 (describing Court's "clear statement" limit on spending power, "requiring conditions on federal monies to be explicitly stated in the pertinent statutes").

211. See *Hills*, *supra* note 5, at 860-61 (describing system of conditional grants and one-on-one bargaining between state and federal government over whether to accept conditions and apply for funds).

212. See *Pennhurst*, 451 U.S. at 17 ("[L]egislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions.").

213. See *Hills*, *supra* note 5, at 822-23 (describing rule); see also Edward A. Zelinsky, *Accountability and Mandates: Redefining the Problem of Federal Spending Conditions*, 4 CORNELL J.L. & PUB. POL'Y 482 (1995) ("Is it meaningful to conceive of the states as

party holds the initial property right, parties will, in the absence of transaction costs, negotiate for the most efficient allocation of resources.²¹⁴ The contractual view of federalism enhances state autonomy by allowing states to accept responsibilities, and the attached funds, even if structural limits would seem to prevent such delegation of power.

B. Conditional Spending Power

The federal government may constitutionally legislate for the general welfare under its spending power, as long as the legislation addresses a matter of public concern.²¹⁵ Public benefits programs, such as Social Security, Medicare, Medicaid, and the Children's Health Insurance Program, are spending power enactments that have withstood constitutional challenges.²¹⁶ The federal government may also exercise its spending power to encourage states to adopt various laws and programs by offering financial inducements.²¹⁷ The federal government can offer funds with strings attached, thereby effecting state-level legislation, even though Congress could not mandate that states enact those laws without violating federalism principles.²¹⁸

bargaining with the federal government? Can the states protect themselves politically in Congress?"

214. R.H. Coase, *The Problem of Social Cost* (1960), reprinted in *THE FIRM, THE MARKET, AND THE LAW* 95, 102-04 (Univ. of Chicago Press 1988); see also RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 8, 55-58 (5th ed. 1998) (applying the Coase theorem, defined simply as the notion that "if transactions are costless, the initial assignment of a property right will not affect the ultimate use of the property," to address the problem of incompatible land uses); Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 *HARV. L. REV.* 1089, 1106 (1972) ("Why cannot a society simply decide on the basis of the already mentioned criteria who should receive any given entitlement, and then let its transfer occur only through a voluntary negotiation?"); RICHARD A. EPSTEIN, *BARGAINING WITH THE STATE* 32-38 (1993) (describing the effect of the initial position, or baseline, of rights and bargaining difficulties to discuss the problem of "unconstitutional conditions" and the power of the state over individuals).

215. *South Dakota v. Dole*, 483 U.S. 203, 207 (1987); *Comm'r v. Davis*, 301 U.S. 619, 640 (1937); *United States v. Butler*, 297 U.S. 1, 65 (1936).

216. See Robert L. Glicksman, *From Cooperative to Inoperative Federalism: The Perverse Mutation of Environmental Law and Policy*, 41 *WAKE FOREST L. REV.* 719, 725-26 (2006) (cataloging federal programs and citing cases involving spending power legislation); A. Raymond Randolph, *Panel Two: Limits on National Power and Unconstitutional Conditions*, 4 *CORNELL J.L. & PUB. POL'Y* 457, 458 (1995) (examining limits of the federal conditional spending power).

217. See *Dole*, 483 U.S. at 206-07 (citing cases that exemplify use of the conditional spending power); *New York v. United States*, 505 U.S. 144, 167 (1992) (same).

218. See *Dole*, 483 U.S. at 206 (noting that "objectives not thought to be within Article I's 'enumerated legislative fields' . . . may nevertheless be attained through the use of the spending power and the conditional grant of federal funds") (citing *United States v. Butler*,

The leading case upholding the federal government's conditional spending power is *South Dakota v. Dole*.²¹⁹ The challenged federal law conditioned states' receipt of federal highway funds on states establishing a minimum drinking age of twenty-one years.²²⁰ Because states could freely opt out and maintain laws allowing alcohol sales to younger people, thus retaining their state sovereignty, the Court upheld the federal law.²²¹ A pair of earlier cases, *Commissioner v. Davis*²²² and *Steward Machine Co. v. Davis*,²²³ authorized use of the federal spending power to achieve regulatory ends and held that applying a federal tax on employers to support the federal Social Security Act and unemployment compensation funds did not violate the Tenth Amendment or impinge unjustifiably on state sovereignty.²²⁴

Those and subsequent cases outline the limits of the conditional spending power. First, the exercise of spending power must be in the pursuit of "the general welfare."²²⁵ Second, the conditions must be stated unambiguously, allowing states to exercise their choice "knowingly, cognizant of the consequences of their participation."²²⁶ Third, conditional spending power projects must be related "to the federal interest in particular national projects or programs."²²⁷ Finally, the conditional grant of funds must not violate other constitutional provisions—the so-called independent constitutional bar.²²⁸ There may also be a germaneness limit that requires

297 U.S. 1, 65 (1936)); see also *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) ("[O]ur cases have long recognized that Congress may fix the terms on which it shall disburse federal money to the States.").

219. 483 U.S. 203 (1987).

220. *Id.* at 205.

221. *Id.* at 211-12 (characterizing condition on funds as "mild encouragement" and suggesting that "enactment of [minimum drinking age] remains the prerogative of the States not merely in theory but in fact").

222. 301 U.S. 619 (1937).

223. 301 U.S. 548 (1937).

224. *Davis*, 301 U.S. at 645-46 (regarding Social Security Act); *Steward Mach. Co.*, 301 U.S. at 592-93 (regarding unemployment compensation law). The cases, decided on the same day, overruled *United States v. Butler*, 297 U.S. 1 (1936), where the Court struck down provisions of Agricultural Adjustment Act as invading states' reserved rights. See generally Robert M. Cover, *Federalism and Administrative Structure*, 92 YALE L.J. 1342, 1342-43 (1983) (describing cases); Lynn A. Baker & Mitchell N. Berman, *Getting off the Dole: Why the Court Should Abandon Its Spending Doctrine, and How a Too-Clever Congress Could Provoke It to Do So*, 78 IND. L.J. 459, 461-69 (2003) (describing *Dole* and cases in its aftermath).

225. *Dole*, 483 U.S. at 207 (citing *Davis*, 301 U.S. at 640-41).

226. *Id.* (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)).

227. *Id.* (citing *Massachusetts v. United States*, 435 U.S. 444, 461 (1978) (plurality opinion)).

228. *Id.* at 208, 210 (discussing limitation); *Lawrence County v. Lead-Deadwood Sch. Dist.*, 469 U.S. 256, 269-70 (1985); *Buckley v. Valeo*, 424 U.S. 1, 91 (1976).

the conditions to bear some relationship to the overall purpose of the legislation.²²⁹

Dole makes clear a limit on the conditional spending power that is particularly relevant to analyzing the constitutionality of the clawback: conditions or inducements may be offered to states, but compulsion or coercion is unlawful.²³⁰ The financial inducement offered by Congress might be “so coercive as to pass the point at which ‘pressure turns into compulsion.’”²³¹ The *Dole* Court rejected South Dakota’s inference of coercion from the fact that the program was very successful, i.e., most states agreed to the condition on receipt of highway funds.²³² The fact that most states go along with an offer does not prove that it is coercive; it may be simply that the federal government’s offer is sufficiently attractive to most states.²³³ In addition, requiring states to give up a small percentage of federal highway funds if they refuse to abide the minimum drinking age does not prove coercion.²³⁴ Likewise, it could be argued that the potential loss of a small percentage of Medicaid funds if states refuse to pay the clawback might not cross the line from pressure into compulsion.

C. *The Clawback and Conditional Spending Power*

As pointed out in the previous Section, the argument can be made that the clawback’s effect of withholding a small percentage of federal funds from a state that refuses to comply with its mandate is not compulsion. But there are also potential arguments against the constitutionality of the clawback under *Dole* and the conditional spending cases. In early drafts of the Professors’ Brief, I argued that the clawback failed the *Dole* limits by operating as an ambiguous condition on states’ receipt of federal Medicaid funds because the states were not notified of its consequences. The

229. See *Dole*, 483 U.S. at 208-09, 208 n.3 (finding limit met on the facts of the case, although not holding it is required in all cases); *New York v. United States*, 505 U.S. 144, 167 (1992) (noting that conditions must “bear some relationship to the purpose of the federal spending”). See generally Huberfeld, *supra* note 45, at 489 n.255 (observing that the “germaneness limit” was “key to Justice O’Connor’s dissent” in *Dole*, 483 U.S. at 212-14); McCoy & Friedman, *supra* note 196, at 120-21 (noting that Justice Rehnquist’s footnote suggests that congressional spending power may be limited by “a requirement that any condition attached to a federal grant bear some relationship to that grant” and that Justice O’Connor appeared to rely on that limit in her dissent (citations omitted)).

230. *But see* Baker & Berman, *supra* note 224, at 467-68 (suggesting that *Dole*’s “coercion” test has failed to operate as a meaningful limit on federal spending power and that “lower courts have consistently failed to find impermissible coercion”).

231. *Dole*, 483 U.S. at 211 (quoting *Steward Mach. Co.*, 301 U.S. 548, 590 (1937)).

232. *Id.*

233. *Id.* (“We cannot conclude . . . that a conditional grant of federal money of this sort is unconstitutional simply by reason of its success in achieving the congressional objective.”).

234. *Id.*

Medicare Part D clawback, and the statutory authority to offset unpaid clawback amounts against states' FMAP, disrupts the fundamental "cooperative federalism" Medicaid funding arrangement.²³⁵ The clawback penalty offset exposes states to the costs of unilaterally funding their Medicaid programs without federal contribution for the first time since Medicaid's enactment. Thus the clawback violates the "contract" that states accepted when they first established their state Medicaid programs and were promised federal matching grants. As the Court has clearly stated, Congress "did not intend a participating State to assume a *unilateral funding obligation* for any health service in an approved Medicaid plan."²³⁶ Up to the amount of the penalty, states' Medicaid spending will be unmatched by federal dollars, contrary to the statutory requirements, congressional intent, and recognized judicial limits.

My argument, however, was incompatible with the States' intergovernmental tax immunity argument that the clawback operated as a mandatory tax on states qua states. It would be inconsistent to suggest, on the one hand, that the clawback was an unconstitutional condition on grant of federal funds, and, on the other hand, that it was an unconditional federal tax on state governments.²³⁷ For reasons discussed in more detail below, I continue to find merit in the *Dole* arguments against the clawback and encourage future litigants to consider them as a potentially fruitful line of objection to the funding mechanism's continued operation.

1. The clawback exceeds congressional spending power.

The Medicaid program is a federal spending power program that extends federal dollars to states on the condition that they establish state Medicaid plans in compliance with certain federal requirements and mandates.²³⁸ Conditions on Medicaid funding include providing certain mandatory services to certain categories of beneficiaries.²³⁹ The Medicaid program has never required states to fund most of the costs of a separate federal program as a condition of federal matching dollars. To the contrary, the Medicaid statute promises open-ended federal funding to match states' spending on a dollar-for-dollar percentage basis, without

235. See Weissert & Miller, *supra* note 7, at 138 (noting that "[s]ince the founding of the Republic, the federal and state governments have worked interactively to expand health care coverage to increasingly larger swaths of the poor and near-poor population" and that "MMA represents a major change in federal-state relations").

236. *Harris v. McRae*, 448 U.S. 297, 309 (1980) (emphasis added).

237. See States' Brief, *supra* note 1, at 15 n.10.

238. See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (recognizing Medicaid as spending power legislation); see also *Atkins v. Rivera*, 477 U.S. 154, 156-57 (1986).

239. 42 U.S.C. § 1396a(a)(10)(A) (2000).

caps, as long as the state spending is for an approved Medicaid program that complies with federal requirements.²⁴⁰

The Part D clawback and corresponding automatic penalty for nonpayment, an offset against otherwise due federal Medicaid matching dollars, operate together as a new, unconstitutional condition on states' Medicaid participation. The Part D statute expressly provides: "As a condition of its State plan under [Medicaid] and receipt of any Federal financial assistance under [Medicaid]," states must comply with certain requirements, including the clawback and offset provisions.²⁴¹ The clawback is unconstitutional because it does not provide adequate, unambiguous notice of the condition, allowing states freely to exercise the choice to decline federal funding.

2. The clawback fails to provide clear notice of the consequences of Medicaid participation.

The clawback fails the second *Dole* limit, which requires the conditions on federal grants to be unambiguous, allowing states to exercise their choices knowingly, aware of the consequences of participation.²⁴² States were entirely blindsided by the new condition on Medicaid participation. The Part D statutory provision that allows federal authorities to collect the unpaid clawback amount, plus interest, through an automatic and immediate offset of Medicaid funding otherwise due, deprives states of the opportunity to opt into Medicaid, fully aware of the consequences of participation.²⁴³

The clawback is a new condition on federal dollars, enacted long after all states already had agreed to participate in the Medicaid program and comply with the broad federal requirements. The federal government cannot constitutionally impose a substantial, *ex post facto* condition on Medicaid funding.²⁴⁴ The only way for states to exercise their sovereign discretion, from now on, is to opt out of the Medicaid program entirely.²⁴⁵

240. See NAT'L HEALTH POLICY FORUM, THE BASICS: MEDICAID FINANCING 1 (Sept. 13, 2006), available at www.nhpf.org/pdfs_basics/Basics_MedicaidFinancing_09-13-06.pdf (last visited Nov. 11, 2007).

241. See 42 U.S.C. § 1396u-5(a), (c)(1)(A), (c)(1)(C) (2000) (emphasis added). Likewise, the legislative history of the clawback expressly provides: "The provision establishes certain requirements, as a condition of receiving federal Medicaid assistance," to share certain costs of the new Part D benefit. H.R. REP. NO. 108-391, at 509 (2003) (Conf. Rep.).

242. *South Dakota v. Dole*, 483 U.S. 203, 207 (1987); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). See generally *Huberfeld*, *supra* note 45.

243. See 42 U.S.C. § 1396u-5(c)(1)(C).

244. See *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213-14 (1988).

245. See *Huberfeld*, *supra* note 45, at 482 (noting that "[i]f states do not pay the federal government the 'clawback' amount, they stand to lose all of their federal Medicaid funding").

States could not possibly have been cognizant that Medicaid participation required them to fund a separate, expanded federal Medicare benefit. Therefore, the condition fails the *Dole* test.

3. The clawback passes the point at which pressure turns into compulsion.

Dole also provides that federal spending power is exceeded if the financial inducement that Congress offers leaves states effectively no choice but to participate. Conditions on federal grants may be unconstitutional if they are so “coercive as to pass the point at which ‘pressure turns into compulsion.’”²⁴⁶ Nevertheless, Congress may “encourage” activity through the spending power that it could not compel pursuant to other powers. In *Dole*, the court held that conditioning federal highway funds on states enacting a minimum drinking age operated as “relatively mild encouragement to the States.”²⁴⁷

A condition becomes unduly coercive if it leaves states with no option to avoid the federal demand. Moreover, a choice between two unconstitutional conditions is no choice at all. In *New York v. United States*, the State of New York challenged certain federal environmental laws involving radioactive waste disposal. The federal law required states to take responsibility for low-level radioactive waste generated within their borders.²⁴⁸ The law offered various incentives to encourage states to comply with their statutory obligation. Together, the incentives effectively left states with the choice to either implement the federal regulatory scheme or take title to radioactive waste and pay all fines and damages as if the state itself generated or owned the waste.²⁴⁹ Likewise, here, states face two options that effectively leave them no choice. On the one hand, states can pay the demanded clawback, or, on the other hand, they can assume full financial responsibility for their Medicaid programs. The first option is not a choice but merely a mandate. The second option directly contradicts the Court’s clear recognition that Congress did not intend for states to bear the burden of unilaterally funding Medicaid services:

The Medicaid program is one of federal and state cooperation in funding medical assistance; a complete withdrawal of the federal prop in the system with the intent to drop the total cost of providing the service upon the states, runs directly counter to the basic structure of the program and could

246. *Dole*, 483 U.S. at 211 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

247. *Id.*

248. 505 U.S. 144, 150-51 (1992).

249. *Id.* at 175-76. (“A choice between two unconstitutionally coercive regulatory techniques is no choice at all.”)

seriously cripple a state's attempts to provide other necessary medical services embraced by its plan.²⁵⁰

In sum, the Part D clawback and automatic offset penalty operate as a condition on Medicaid matching dollars that states have no choice but to accept. Accordingly, the clawback turns strong pressure into compulsion by leaving states no choice but to pay the demanded amount to support the federal prescription drug benefit. The only way to avoid the clawback is to opt out of the federal program. States choosing not to pay the clawback could continue to provide healthcare benefits to their residents, free of any requirements under the federal Medicaid statute, but with no federal financial support.

All states have established and administered state Medicaid programs over many years. Those choosing not to accept the clawback condition would be forced to dismantle a broad, essential medical insurance program for the states' poorest residents and expose themselves to statutory entitlement, constitutional due process, and other legal challenges from patients and providers suddenly left out in the cold.²⁵¹ Alternatively, states could assume the entire cost of maintaining their existing Medicaid programs. But continuing to fund a fully state program that previously received substantial federal financial assistance is a solution that hamstringing state budgetary and administrative discretion.

4. The clawback is an unconstitutional, retroactive condition.

Even when viewed as a condition on Medicaid participation, the clawback is a new, potentially onerous condition about which states had no notice at the time they agreed to accept federal Medicaid grants.²⁵² Accordingly, states could not have possibly knowingly and voluntarily agreed to this condition, fully cognizant of its consequences. State Medicaid funding can be pulled for noncompliance through the automatic offset of amounts otherwise due.²⁵³ Thus, the clawback also effectively denies States a promised portion of FMAP.

The clawback effectively imposed a new, retroactive condition on Medicaid participation that is contrary to the *Dole* "unambiguous condition"

250. *Harris v. McRae*, 448 U.S. 297, 309 n.12 (1980) (citing *Preterm, Inc. v. Dukakis*, 591 F.2d 121 (1st Cir. 1979)).

251. See, e.g., Barbara R. Grumet, *Who is "Due" Process?*, 42 PUB. ADM. REV. 321, 323 (1982) (describing the property interest created by Medicare's and Medicaid's entitlement nature).

252. See *supra* Part III.B.

253. See 42 U.S.C. § 1396u-5(c)(1)(A), (C).

or “clear statement” limit.²⁵⁴ In *Pennhurst State School & Hospital v. Halderman*,²⁵⁵ the State of Pennsylvania faced a challenge from a state resident and recipient of residential services for the mentally retarded who claimed that the state failed to provide “appropriate treatment” in the “least restrictive” environment, as required by the federal Developmentally Disabled Assistance and Bill of Rights Act.²⁵⁶ Under this congressional spending power Act, states could receive federal financial assistance for creating programs to care for and treat persons with developmental disabilities.²⁵⁷

The Court rejected the resident’s claim, however, on the grounds that “findings” in the Act did not operate as conditions on federal funding but, rather, as general statements of federal policy.²⁵⁸ A federal statute can impose conditions on granting funds to states only if Congress unambiguously expressed intent to do so,²⁵⁹ which it did not do here. This rule operates on the premise that Congress knows how to explicitly state conditions on funding, so statements may be deemed merely precatory if they do not make conditions explicit.²⁶⁰ The Court concluded that the Act’s

254. *South Dakota v. Dole*, 483 U.S. 203, 207 (1987); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); Peter J. Smith, *Pennhurst, Chevron, and the Spending Power*, 110 YALE L.J. 1187, 1188-89, 1198-201 (2001) (describing *Pennhurst* doctrine and requirement that conditions be “unambiguously expressed”). Constitutional principles of fairness and due process generally oppose retroactive laws. See *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208-10, 213-15 (1988) (disallowing HCFA’s retroactive promulgation of wage index rules to adjust hospital reimbursement); see also *Landgraf v. USI Film Prods.*, 511 U.S. 244, 263-64 (1994) (recognizing a presumption against retroactivity; firmly rooted in jurisprudence; fairness).

255. 451 U.S. at 1.

256. Pub. L. No. 94-103, 89 Stat. 486, 502 (1975) (formerly codified at 42 U.S.C. § 6010 but omitted by amendment in 1984). This provision contained congressional findings respecting rights of the developmentally disabled similar to those found in 42 U.S.C. § 6009 (2000).

257. *Pennhurst*, 451 U.S. at 11.

258. *Id.* at 19 (reading section 6010 in the context of “other, more specific provisions of the Act, does no more than express a congressional preference for certain kinds of treatment. It is simply a general statement of ‘findings’ and, as such, is too thin a reed to support the rights and obligations read into it by the court below”); see also Note, *Making the Old Federalism Work: Section 1983 and the Rights of Grant-in-Aid Beneficiaries*, 92 YALE L.J. 1001, 1006-07 (1983) (describing Court’s holding that Act was “a ‘mere federal-state funding statute,’ intended to encourage but not to coerce, the states to develop certain programs” (citations omitted)).

259. See *Dole*, 483 U.S. at 207. See generally 42 U.S.C. 1396u-5 (2000).

260. *Pennhurst*, 451 U.S. at 18; see Smith, *supra* note 254, at 1199 (noting Court’s conclusion that “findings” in section 6010 did not create rights but “were mere precatory statements by Congress”).

provisions did not create enforceable rights.²⁶¹ The language fell well short of providing clear notice to states that they would have to comply with them to receive federal funds.²⁶² *Pennhurst* also recognized that Congress cannot require states to comply with new, retroactive conditions, after they have already accepted federal funds.²⁶³

The unambiguous condition or clear statement rule comports with the contract view of federalism. The legitimacy of an offer turns on whether a state “voluntarily and knowingly accepts the terms of the ‘contract.’”²⁶⁴ There can be no knowing acceptance if states are unaware or unable to ascertain what is expected of them.²⁶⁵ But if states do receive clear, unambiguous notice of the terms of the contract, this view seems to say they could freely acquiesce to even onerous conditions.²⁶⁶ To deny states the possibility of that choice, on structural federalism grounds, would violate state autonomy. If the conditions are clear and sufficiently attractive to states, they should have the option to accept them.²⁶⁷

The clawback violates both the clear statement rule and the retroactivity principle. States cannot knowingly and voluntarily agree to a condition of which they were unaware at the time they accepted federal Medicaid funds. There was no clear—nor, indeed, any—notice of the clawback condition at the time that the states accepted federal funds. Therefore, states could not choose to opt out of Medicaid to avoid the consequences of the condition. Furthermore, the clawback operates retroactively because it was imposed after states agreed to accept Medicaid funds. Even if states could be deemed aware in year 2007 and forward, the condition would be coercive at that point because states would have no choice but to comply or restructure and fully fund state welfare programs.²⁶⁸

261. *Pennhurst*, 451 U.S. at 18.

262. *Id.*

263. *Id.* at 25 (“Though Congress’ power to legislate under the spending power is broad, it does not include surprising participating States with post acceptance or ‘retroactive’ conditions.”).

264. *Id.* at 17; see also Huberfeld, *supra* note 45, at 448 (describing *Pennhurst* and noting that “[i]n analyzing the ability of Congress to place conditions on the use of federal funds, the Court emphasized a now-familiar analogy that Spending Clause legislation is ‘in the nature of a contract.’”); Engdahl, *supra* note 210, at 70-72 (discussing *Pennhurst* as contractual limit on federal spending power).

265. *Pennhurst*, 451 U.S. at 17.

266. See *id.*

267. See Hills, *supra* note 5, at 822-23; Engdahl, *supra* note 210, at 71 (“What makes such conditions obligatory is that essence as contract, wholly apart from the circumstance that they happen to be spelled out as a statute or an agency rule. Although articulated in a statute or rule, they have no force as ‘law’; their only force is contractual.”)

268. See *supra* notes 246-251 and accompanying text (describing “pressure turns to compulsion” arguments).

Conditions on federal grants that operate retroactively or fail to give states clear notice of the consequences of participation violate the contract view of federalism.²⁶⁹ States cannot freely and voluntarily agree to enter a contract with the federal government to assume federal regulatory functions if they do not know the contractual terms.²⁷⁰ In traditional contract law, courts may declare a contract void if the terms are hidden or ambiguous.²⁷¹ In addition, one party would not be permitted to enforce a new, substantive provision of the contract against the other party without that party's agreement to be bound by the new term.²⁷² States did not receive clear notice of the clawback as a condition of FMAP and were not given an opportunity to decide whether to accept the new condition before the federal government demanded payment.²⁷³ Thus, the clawback is an unconstitutional exercise of federal spending power.

D. *Commandeering*

The States raised a different federalism argument than the argument that I advanced above that the clawback exceeds the *Dole* limits on conditional spending power. In their intergovernmental tax immunity argument, the States urged that the clawback was not a condition on federal Medicaid money but a mandatory tax.²⁷⁴ Accordingly, they could not then argue that the clawback was an ambiguous or otherwise unconstitutional condition. Instead, the States argued that the clawback "commandeered" state legislative and budgetary processes, requiring them to allocate an undeterminable portion of state budgets to fund the federal prescription drug benefit.²⁷⁵ The Court had previously recognized that Congress could not commandeer state legislatures to implement a federal regulatory scheme for low-level radioactive waste²⁷⁶ or enlist state law enforcement

269. See *Pennhurst*, 451 U.S. at 25.

270. See *id.* at 17.

271. See, e.g., *Local Motion, Inc. v. Niescher*, 105 F.3d 1278, 1280 (9th Cir. 1997) ("The presence of an ambiguous material term may indicate that no meeting of the minds occurred when the document was signed."); 1 ARTHUR L. CORBIN, CORBIN ON CONTRACTS § 4.10 (rev. ed. 1993); RESTATEMENT (SECOND) OF CONTRACTS § 20 (1981) (regarding effect of misunderstanding).

272. RESTATEMENT (SECOND) OF CONTRACTS § 50 (1981) (regarding acceptance of offer).

273. See *Weissert & Miller*, *supra* note 7, at 137 (discussing states' loss of Medicaid federal matching funds as result of MMA).

274. See *supra* Part II.B.1.

275. See *supra* Part II.B.2 (describing States' argument). For similar successful arguments, see *Printz v. United States*, 521 U.S. 898 (1997) (regarding unconstitutional obligations placed on local officers under the Brady Handgun Violence Prevention Act); *New York v. United States*, 505 U.S. 144 (1992) (regarding unconstitutionality of toxic waste take-title).

276. *New York*, 505 U.S. at 188.

officers to execute federal handgun control law by performing background checks on prospective handgun purchasers.²⁷⁷ In both cases, the Court recognized that Congress cannot “conscript” state governments or officers to carry out federal legislation.²⁷⁸

In a sense, *New York*, *Printz*, and the commandeering line of cases, represent not so much a new limit on federal spending power, but another way to think about the ultimate limit in *Dole*. That is, when does pressure turn to compulsion and thus commandeering? In some cases, Congress may attempt to directly conscript state legislative or executive functions to carry out a federal regulatory scheme. In other cases, Congress may ostensibly hold out a federal funding “carrot” to encourage state participation in a federal program. But when the carrot is one that states simply cannot afford to refuse, the offer turns from a conditional grant into commandeering. As one commentary summarized, “The basis of the Court’s holding [in *Dole*] is that there is a difference between coercing compliance (an exercise of regulatory power) and buying compliance (an exercise of the spending power).”²⁷⁹ When a condition leaves states not merely with a hard choice, but with no choice at all about whether to accept federal funds, the program becomes commandeering.²⁸⁰

The commandeering cases involve congressional attempts to enlarge federal power and encroach on the states’ reserved powers. Under this structural view of federal-state relations, commandeering is unconstitutional because Congress cannot interfere with states’ autonomy, and states “cannot consent to the enlargement of the powers of Congress beyond those enumerated in the Constitution,”²⁸¹ even if attractive incentives for doing so exist. Structural limits prohibit states from assuming certain federal powers, even voluntarily.²⁸² The rationale for enforcing structural limits on states assuming federal powers is grounded in political accountability, a sort

277. *Printz*, 521 U.S. at 935.

278. *New York*, 505 U.S. at 178 (“Where a federal interest is sufficiently strong to cause Congress to legislate, it must do so directly; it may not conscript state governments as its agents.”); *Printz*, 521 U.S. at 935 (“We held in *New York* that Congress cannot compel the States to enact or enforce a federal regulatory program. Today we hold that Congress cannot circumvent that prohibition by conscripting the State’s officers directly.”); see Evan Caminker, *The Unitary Executive and State Administration of Federal Law*, 45 U. KAN. L. REV. 1075, 1075 (1997) (suggesting that the “Supreme Court has held that principles of state sovereignty preclude Congress from ‘commandee[ring] the legislative processes of the States by directly compelling them to enact and enforce a regulatory program’”) (quoting *New York*, 505 U.S. at 161); Sarnoff, *supra* note 5, at 207 (noting that *New York* clarified that Congress may not direct state legislatures to implement federal programs).

279. See McCoy & Friedman, *supra* note 196, at 101.

280. See *South Dakota v. Dole*, 483 U.S. 203, 211 (1987).

281. *New York*, 505 U.S. at 182.

282. *Id.* at 181-82.

of federalism “hot potato” for controversial reforms.²⁸³ Without structural limits, the federal government could enact sweeping reforms and require states to implement them, thereby avoiding accountability for implementation decisions, such as where to locate a radioactive waste disposal site or restricting handgun availability. States, on the other hand, might disavow responsibility for the disposal site’s location or the difficulty of obtaining firearms by claiming to act under congressional directive.²⁸⁴ Citizens, accordingly, are left with no one willing to accept responsibility for the unpopular or controversial decision.

The structural view purports to protect states’ “retained sovereignty” by allowing them to “remain independent and autonomous within their proper sphere of authority.”²⁸⁵ Compelling, commandeering, or leaving states with no real choice but to participate in a federal regulatory program “reduce[s] the states to puppets of a ventriloquist Congress.”²⁸⁶ But, I suggest that denying states the option to implement a federal program, especially when attractive, yet onerous, incentives are offered, undermines states’ autonomy by disallowing them to freely and voluntarily enter certain “contracts” with the federal government.

If federalism is viewed as a contract, then states are entitled to assume responsibility for administering, funding, or implementing federal regulatory programs if doing so is in their interest. The baseline is that states, not the federal government, hold the entitlement to deny federal government use of a state regulatory apparatus.²⁸⁷ Under this view, state autonomy and reserved powers are preserved because states make the choice. They can freely refuse to participate but can also freely agree to assume federal powers. The structural view, by contrast, denies states the entitlement to assume powers considered in the exclusive province of the federal government, based on formal constitutional grounds, and removes from

283. See Zelinsky, *supra* note 213, at 482 (“Federal spending conditions frequently blur lines of accountability, making it difficult for citizens to discern who is making the policy impacting upon them.”), 485 (“*New York v. United States* reflects an understanding that federally-imposed mandates improperly reduce the accountability of officeholders, forcing state and local officials to bear the political costs of decisions made in Washington.”); Rose-Ackerman, *supra* note 182, at 1347 (suggesting that conditional spending legislation “is relatively easy for Congress [sic] to pass because legislators can take credit for bold, new initiatives without having to face up to the problem of finding tax money to cover the costs of those programs”); Cover, *supra* note 224, at 1343 (“By debilitating, if not disarming, the alternative sources of political power in our federal structure, ‘cooperative federalism’ undermines the only viable restraint on the congressional exercise of enumerated powers: the political process.”).

284. See *New York*, 505 U.S. at 182-83.

285. *Printz v. United States*, 521 U.S. 898, 928 (1997).

286. *Brown v. Envtl. Prot. Agency*, 521 F.2d 827, 839 (9th Cir. 1975).

287. See *Hills*, *supra* note 5, at 822-23.

states' consideration a whole range of potentially attractive programs and incentives.

Applied to the clawback, however, the States made a valid argument under the commandeering line of cases. As discussed above under the *Dole* limits,²⁸⁸ the clawback passed the line between pressure and coercion because states received no notice of the new condition on Medicaid participation. States have to pay the demanded clawback amount, with no opportunity to review, object to, or appeal the demand to perpetually support an expansive and expensive new federal benefit. The only choice remaining to states that do not wish to pay is to cease participation in the Medicaid program and decline all federal monies. That option is practically impossible for most states from humanitarian, budgetary, and liability perspectives. Accordingly, the clawback is an unconstitutional exercise of federal spending power.

E. Commerce Power

Although not directly on point but still useful to the analysis, Supreme Court cases on the limits of the commerce power delineate federal and state governments' respective powers. *United States v. Lopez* brought a sea change in Commerce Clause jurisprudence by invalidating a congressional enactment under the commerce power, for the first time in nearly sixty years.²⁸⁹ *Lopez* involved a challenge to the Gun-Free School Zones Act of 1990,²⁹⁰ a federal statute enacted under the Commerce Clause that made possessing a firearm in a school zone a federal crime. The Court struck down the law on the ground that possession of firearms within a school zone did not have a "substantial effect" on interstate commerce.²⁹¹ Thus, the law exceeded Congress's enumerated powers and unconstitutionally

288. See *supra* Part IV.A (describing alternative argument that States could not proffer, without contradicting intergovernmental tax immunity argument).

289. See generally *United States v. Lopez*, 514 U.S. 549 (1995). The Court's decision in *NRLB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937), is generally regarded as the case in which the Court began to move away from a restrictive definition of interstate commerce and towards the "zenith" of the commerce power under *Wickard v. Filburn*, 317 U.S. 111 (1942). See McAllister, *supra* note 193, at 217 ("In *United States v. Lopez*, the Supreme Court of the United States, for the first time in a long time, held that Congress had exceeded its constitutional authority under the Commerce Clause"), 223-24 (discussing the Commerce Clause "Modern Era," beginning with *Jones & Laughlin* and culminating in *Wickard v. Filburn*); see also KATHLEEN M. SULLIVAN & GERALD GUNTHER, *CONSTITUTIONAL LAW* 106-07 (Foundation Press 16th ed.).

290. 18 U.S.C. §922(q) (1994), *invalidated by United States v. Lopez*, 514 U.S. 549 (1995).

291. *Lopez*, 514 U.S. at 559-61. *But see Filburn*, 317 U.S. at 128 (holding that home-grown wheat could be regulated under commerce power "substantial effects" test).

encroached on states' police powers.²⁹² Subsequent congressional attempts to regulate social problems have met a similar fate.²⁹³

Like the spending power cases, the commerce power cases struggle to define the line between federal enumerated and state reserved powers. For many years, the test was whether the area of regulation fell within "traditional state powers."²⁹⁴ Activities typical of state and local governments include fire prevention, police protection, sanitation, public health, and parks. Accordingly, in *National League of Cities v. Usery*, the Court held that federal laws mandating employment terms could not apply to state and local employees because employer-employee relationships were within states' traditional powers.²⁹⁵

Several years later in *Garcia v. San Antonio Metropolitan Transit Authority*,²⁹⁶ the Court overruled *Usery* and rejected the traditional state powers distinction as unworkable.²⁹⁷ The Court "reject[ed], as unsound in principle and unworkable in practice, a rule of state immunity from federal regulation that turns on a judicial appraisal of whether a particular governmental function is 'integral' or 'traditional.'"²⁹⁸ The *Usery* test left too many gray areas and failed to allow for state powers to evolve over time. After rejecting that approach, the Court held that federal fair labor standards did not violate the federal commerce power, even as applied to states.²⁹⁹

Garcia offered a different approach to determining limits on federal power to regulate states, suggesting that the limits inhere in the federal government's structure, particularly the representative Congress and political process. Rather than defining the scope of federal power through judicially created limitations, the Court suggested that "[s]tate sovereign interests . . .

292. See *Lopez*, 514 U.S. at 568, 576-77 (Kennedy, J., concurring) (discussing structural limits of federal power and states' reserved powers).

293. See, e.g., *United States v. Morrison*, 529 U.S. 598 (2000) (striking down federal Violence Against Women Act); see also *Printz v. United States*, 521 U.S. 898, 921-22 (discussing constitutional system of dual sovereignty). But see *Gonzales v. Raich*, 545 U.S. 1 (2005) (holding that Congress may ban use of marijuana even where states have deemed it legal for medicinal uses).

294. See *Nat'l League of Cities v. Usery*, 426 U.S. 833, 852 (1976) (striking down federal minimum wage and maximum hour standards as applied to states and their subdivisions).

295. *Id.* at 851-52; McCoy & Friedman, *supra* note 196, at 93-94 (discussing "traditional governmental functions" test and suggesting that *Usery* was the only case in which the Court used it to invalidate national legislation).

296. 469 U.S. 528 (1985) (upholding application of federal minimum wage and overtime pay laws to metropolitan transit authority); McCoy & Friedman, *supra* note 196, at 94-96 (suggesting that *Usery* "was destined for failure from the start").

297. *Garcia*, 469 U.S. at 545-47.

298. *Id.* at 546-47.

299. *Id.* at 548, 554.

are more properly protected by procedural safeguards inherent in the structure of the federal system.”³⁰⁰ The Court asserted that states are adequately protected at the federal level through elected representatives who participate in one branch of the federal government.³⁰¹ The Court demonstrated this approach’s effectiveness in preserving state sovereignty by noting that states have obtained substantial federal funding for a range of “traditional” state services, including “police and fire protection, education, public health and hospitals, parks and recreation, and sanitation.”³⁰² In other words, state representatives were politically effective in securing advantages for their citizens. If the political system functions as intended, there should be no need to carve out a rigid zone of protection for traditional state functions.³⁰³ States, through their elected congressional representatives, should be able to freely lobby and vote for laws that would best serve them and their constituents.³⁰⁴

The more flexible *Garcia* test for the scope of state and federal powers is consistent with the contractual view of federalism, which supports states’ autonomy to accept or decline federal incentives to enact certain regulations or acquiesce to federal powers to enforce a federal law.³⁰⁵ But it does not relegate states’ powers to only the “traditional” state functions identified by the Court in prior cases.³⁰⁶ Although *Garcia* suggests that the structure of government is the source of the protection for state sovereignty, it is not an inflexible rule.³⁰⁷ Separation of powers and representative democracy are the structural basis, instead of an arbitrary definition of what states traditionally do.³⁰⁸

If protection of state sovereignty rides on the federal system’s structure, then it is even more important that states’ elected representatives receive clear, unambiguous notice of the terms of the “contract” offered so they can make an informed decision to accept or decline it. Accordingly, the *Pennhurst* “clear statement” limit on cooperative federal-state legislation is

300. *Id.* at 552.

301. *Id.*; see also McCoy & Friedman, *supra* note 196, at 123 (“*Dole* in effect relegates disputes over relative spheres of authority to the political process.”).

302. *Garcia*, 469 U.S. at 552-53.

303. See McCoy & Friedman, *supra* note 196, at 94.

304. *Id.* at 96-97 (characterizing *Garcia* “as a return to the delegation construct” and shifting “focus not upon whether the enactment infringed some core state power, but upon whether the enactment was a proper subject of federal regulation.”).

305. See *supra* Part IV.A.2. (discussing contractual view of federalism).

306. See, e.g., *Nat’l League of Cities v. Usery*, 426 U.S. 833 (1976); *United Transp. Union v. Long Island R.R.* 455 U.S. 678 (1982) (operation of railroads not traditional state function).

307. See *Garcia*, 469 U.S. at 554; Smith, *supra* note 254, at 1202, 1213.

308. Smith, *supra* note 254, at 1213.

essential to the *Garcia* approach.³⁰⁹ A state representative cannot adequately protect state sovereignty if he or she is unaware of the terms of a proposal that requires states to enforce or enact federal laws.

The clawback seems to violate both the old *Usery* traditional state functions test and *Garcia*'s structural approach to federalism. As the States' Petition argued, managing budgets and appropriations for state programs are core state functions.³¹⁰ Those processes may be even more traditional state powers than managing public-employee working conditions and terms, which was the power at issue in *Usery*. Accordingly, the clawback would readily fail the *Usery* limit on federal power.

The clawback also runs afoul of federalism under *Garcia*'s structural-political approach. Members of Congress could not effectively serve their constituents' interests without clear, prior notice of the clawback condition on Medicaid participation when the Social Security Act was passed and states agreed to accept federal dollars based on the conditions therein. Regarding the enactment of the clawback itself, states were represented in Congress when the MMA was debated and finalized.³¹¹ But the clawback was an eleventh-hour amendment that ran awry of both the Senate and House versions of the bill.³¹² Although the MMA calls it the "phased down state percentage," the clawback was, perhaps, more accurately characterized in the legislative history as the "phased-in" assumption of federal administrative costs of the new drug benefit.³¹³ Despite the statutory language, the MMA's proponents never intended to phase out states' substantial funding requirement or shift the cost of the federal benefit to the federal budget.³¹⁴ If a federal program's conditions are not made clear to states, the political process "check" on federal power, endorsed by *Garcia*, fails to protect state sovereignty. Just as *Dole* and *Pennhurst* require clear notice of conditions on federal grants, *Garcia* requires clear notice of the terms of legislation for the constitutional limits on federal power to operate effectively. The clawback, thus, violates state sovereignty under both analyses.

309. *Id.* at 1202-03 (suggesting that "*Pennhurst*'s clear statement rule . . . ensures that the structural protections on which the Court relied in *Garcia* operate properly"); see also *supra* notes 221-236 and accompanying text (describing *Pennhurst* and *Dole* limits on conditional spending power).

310. See *supra* Part III.B. (describing the States' substantive arguments).

311. See generally Louise M. Slaughter, *supra* note 26 (describing the political process that passed Part D).

312. See *supra* Part II (describing legislative history of clawback).

313. See Weissert & Miller, *supra* note 7, at 136-37.

314. *Id.*

V. CLAWBACK FEDERALISM

In sum, the MMA clawback is a departure from traditional “cooperative federalism” legislation in several respects. First, it inverts the usual funding relationship. In conditional spending legislation, the federal government offers money to states as incentive to implement federal regulatory priorities and encourage “enlarged activity” in state programs consistent with the federal agenda. These federal grants allow states to pursue policies that they otherwise might not have been able to achieve at the state level.³¹⁵ While under the original Medicaid Act, states may receive federal funds to match state money spent on Medicaid programs, under the clawback, states give money to the federal government to support an enlarged and over-budget federal program. In addition, the clawback may compromise state programs because state funds have to be re-allocated to satisfy the federal payment demand.

The clawback also undermines accountability at both the federal and state levels.³¹⁶ The federal government insulated itself from backlash about Part D’s price tag by shifting a substantial portion of the cost to the states. States face potential objections from state residents about the program’s cost but have no way of responding to constituents’ objections or effectively managing their state budgets under the clawback. Thus, the clawback exceeds structural and political checks on federal power and leaves states powerless to meet their residents’ interests.³¹⁷

Furthermore, the clawback denies states autonomy. The formula and factors for calculating the clawback are wholly within federal authorities’ control. The statute does not provide a means to challenge or appeal the demand and denies states any administrative or budgetary discretion with respect to the payment. If states do not pay, the amount due is automatically extracted from their federal Medicaid matching dollars.

States have no real choice but to pay the clawback. The only way to avoid paying it is to opt out of Medicaid altogether. Choosing this option, however, would force states to fully fund their existing Medicaid programs without federal financial support or drastically reduce or eliminate benefits, on pain of possible liability to program beneficiaries and providers. Thus, the clawback seems to exceed Congress’s spending power because it gives states no choice but to comply with a condition on federal grants.³¹⁸

Because states have no real choice, the clawback violates the contract view of federalism. Whether construed as a mandatory tax, commandeering

315. Strong, *supra* note 132, at 501-02.

316. See *supra* note 283 and accompanying text (describing accountability objections to conditional spending programs and citing sources).

317. See *supra* notes 298-316 and accompanying text.

318. See *supra* Parts III.B.2. & IV.D. (describing Dole and commandeering arguments).

of state budgetary processes, or a condition that lacks a clear statement or operates retroactively, the clawback is not a valid exercise of the federal power to tax and spend for the general welfare. The contract notion of federalism presumes that states hold the entitlement to accept or refuse to take on federal regulatory responsibilities.³¹⁹ Although not structurally barred from doing so, states can validly agree to enter such a contract only if clearly informed of the terms, in advance. The clawback violates the basic contract by leaving states without notice of the contract terms and no real choice about whether to accept them.

The structural view of federalism is also violated. Just as the structural separation of powers under the Constitution prohibits Congress from delegating federal legislative power to executive branch authorities, structural federalism limits in the Constitution prohibit the federal government from delegating federal powers and obligations to states, even if states chose to accept them.³²⁰ With the clawback, Congress delegated to the states the responsibility for appropriations to expand federal health and welfare programs. Providing the funds for a federal program seems to fall clearly within the federal powers and, thus, cannot constitutionally be assigned to the states.

VI. CONCLUSION

Medicaid is a traditional conditional funding program and represents an established, relatively uncontroversial example of cooperative federalism. States agree to implement state healthcare programs consistent with broad federal guidelines in exchange for federal funding. The conditional funding approach respects state sovereignty by allowing states to refuse to participate as long as they are willing to turn down the federal dollars. The clawback, however, differs significantly from traditional conditional funding structures and disrupts the accepted cooperative federalism structures of the Medicaid program. States agreed to establish their state programs under the assumption that they would receive federal matching dollars, on a percentage basis, for every state dollar spent on Medicaid, including medical care and prescription drugs for dually eligible beneficiaries. The clawback alters the federal end of the bargain because states no longer receive a portion of promised federal funding, namely the federal dollars based on dually eligible beneficiaries' prescription drug costs. Moreover, states now must pay the federal government for the entire cost of dual

319. See *supra* Part IV.A.2. (describing Hills' "functional" theory of federalism).

320. See *supra* notes 209-210 and accompanying text (describing non-delegation doctrine analogy).

eligibles' drugs. Adding insult to injury, states that refuse or are unable to pay the clawback lose all federal Medicaid funding.

Recent state healthcare reform efforts to achieve universal coverage and federal proposals to expand government programs and coordinate tax and other market incentives with state plans will likely raise additional, unique cooperative federalism questions.³²¹ With the Part D clawback, the federal government sought to claim credit for implementing broad national healthcare reforms while leaving the financial burden of the sweeping new benefit on states. Similar legislation seems likely, given the continuing healthcare funding challenges and demand for reform. Therefore, the clawback provision merits closer analysis than the Supreme Court's cursory denial or review, even if states do not pursue the litigation in lower courts, before Congress implements similar mechanisms in the current wave of reform efforts.

321. For a discussion of similar federalism implications for watershed healthcare reform efforts under the Clinton Administration, see Rich & White, *supra* note 115, at 861-62 ("As a society, we have witnessed several negotiations and renegotiations over what the appropriate or proper mix should be between federal, state, and local government 'interventions,' on the one hand, and the role of the private sector and the free market, on the other.").

