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As Supreme Court Justice Powell once observed, the Medicaid Act's "Byzantine construction" makes the Act "almost unintelligible to the uninitiated." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (citing Second Circuit Judge Friendly). Justice Powell's words came to mind as the Supreme Court heard oral argument on the claims of 26 state officials that the Affordable Care Act's (ACA) Medicaid expansion is unconstitutionally coercive. Five misstatements made during the oral argument are addressed below.

#1: Paul Clement, arguing on behalf of the 26 state officials, said the ACA expansion stood in stark contrast to Congress's previous Medicaid expansions that were "totally voluntary" for the states, and he cited the 1972 Medicaid expansion as an example. Tr. 9:25-10:17; Tr. 20:21-25.

The Facts: Medicaid has *always* set minimum eligibility requirements and given participating states options to do more. Medicaid began by confining its minimum eligibility requirements to standards set by state cash welfare programs, which have always varied dramatically from state to state. The Social Security Act Amendments of 1972 established Supplemental Security Income (SSI), a single federal cash assistance program for low-income elderly people and people with disabilities. SSI replaced previously state-administered cooperative-federalism

programs that used different financial eligibility rules and different definitions of disability and blindness. *See* Social Security Act Amendments of 1972, Pub. L. No. 92-603, § 209(b), 86 Stat. 1329, 1381-82 and § 301, 86 Stat. 1329, 1465-78 (replacing Title XVI of the Social Security Act); *see also* Pub. L. No. 93-233, § 13(A)(3), 87 Stat. 947 (amending 42 U.S.C. § 1396a(a)(10)(A)). As part of the new law, Congress encouraged states to extend Medicaid to everyone who was eligible for the newly enacted SSI program. Congress made expanded Medicaid coverage of the aged, blind and disabled mandatory; it did not give States a voluntary, "take-it-or-leave it" proposal. Instead, states were given a choice: they could extend Medicaid to recipients of federal SSI, or they could extend Medicaid to those who met the state's 1972 definitions of aged, blind or disabled--and the latter only
if
they created programs that allowed these aged, blind and disabled individuals to obtain Medicaid eligibility by "spending down" their incomes on medical care to reach the state-set "medically needy" income level.
See
42 U.S.C. § 1396a(f) (also called § 209(b)).
See
S. Rep. No. 93-553 at 55-57 (1973).

#2: Mr. Clement argued that if a state does not want to cover the newly eligible individuals, "you don't just not get the new money; you don't get any of the money." Tr. 10:25-11:2. Mr. Clement based the argument on the Medicaid compliance provision, 42 U.S.C. § 1396c, and an April 1, 2010 CMS letter to the Arizona Medicaid agency.

The Facts: The compliance provision, section 1396c, has been part of the Medicaid Act since 1965. It does not require the Secretary to terminate funding to a non-compliant state, but rather gives the Secretary broad discretion to withhold full or partial payments. The language giving the Secretary discretion is no accident. As originally enacted in 1935, the Social Security Act (of which Medicaid is a part) contained "all-or-nothing" language that prohibited any payments to a noncompliant program. *See* Social Security Act of 1935, Pub. L. No. 74-271, §§ 4, 404, 1004, 49 Stat. 620, 622, 628-29, 646-47. In 1962, however, Congress specifically provided

the Secretary with discretion to withhold *partial* funding when it established a program for State aid to the aged, blind, or disabled. Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 141(a), 76 Stat. 172, 204. That language was subsequently included in the Medicaid Act. See Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 351. In 1968, Congress went back to the other then-existing grant-in-aid programs and amended them to allow partial payments to noncompliant states, noting that suspension of federal funds for the entire program "is such a severe penalty that is it virtually impossible to invoke." S. Rep. No. 744, 90th Cong., 1st Sess. 169, reprinted in 1967 U.S.C.C.A.N. 3006.

The letter from CMS to Arizona came in response to a March 2010 letter from Arizona describing numerous cutbacks the State was planning to make, including terminating its Children's Health Insurance Program (CHIP). Contrary to Mr. Clement's argument, however, CMS did not send the letter pursuant to its authority under section 1396c. Rather, the letter was based on language in the ACA itself that creates a temporary CHIP maintenance of effort requirement. See ACA §§ 2101 and 10203. Moreover, the letter was written by the Acting Director of the CMS Division of State Children's Health Insurance, an individual who does not have--and that a Medicaid participating state would know does *not* have--authority to terminate all Medicaid funding. Finally, the letter represented the Acting Director's initial reactions to the Arizona proposals. Precisely because of the cooperative federal-state nature of the program, where both governments *want* Medicaid to ensure benefits for needy residents, the governments engaged in negotiations over Arizona's request and ultimately came to a mutually agreeable resolution, one that allowed Arizona to freeze any additional enrollment in its CHIP.

#3: Mr. Clement argued that "Congress has created a separate part of the program for the newly eligible mandatory individuals ... and those individuals are treated separately from the rest of the program going forward forever." Tr. 10:13-19.

The Facts: The ACA does not create a separate program for the newly eligible. The new eligibility requirements were placed in the state plan requirements section of the Medicaid Act, section 1396a(a)(10); the new enhanced funding provisions were placed in the funding section of the Act, section 1396b. Repercussions from a state's failure to implement the expansion are subjected to the compliance section of the Medicaid, section § 1396c. This is exactly how Congress has implemented numerous other Medicaid expansions over the history of the program.

#4: Mr. Clement argued that the "sheer size" of the Medicaid program makes the ACA coercive.

The Facts: The Medicaid program is a large federal program. The program size is, for the most part, attributable to the actions of the states themselves. The states have made exceptional use of Medicaid options-choosing to expand their programs beyond the minimum coverage floors established in the Medicaid Act to include groups and services that Congress does not require them to cover. In fiscal year 2007, 60.4% of all Medicaid spending was attributable to states' *optional* expenditures on mandatory populations and expenditures on *optional* populations. As is typical for Medicaid, there is variation among the states. For example, 76.5% of expenditures in Petitioner North Dakota are attributable to this optional spending; 74.7% in Ohio; 74% in Wisconsin; 69.4% in Iowa; 69.2% in Maine; 67.4% in Nebraska; 61.5% in Indiana; and 53% in Florida (source: Kaiser Fam. Found).

#5: Mr. Clement stated, "We all know that in the real world, that to the extent the Federal Government continues to increase taxes, that decreases the ability of the State to tax their own citizenry, and it's a real tradeoff." Tr. 6:17-20.

The Facts: Even when states and the federal government tax the same persons, they are not typically competing for the same finite body of revenue. For the past several decades, state and federal taxes have tended not to substitute for each other but instead to rise and fall at the same time. Amici Br. of David Satcher et al. at 21-22 (citing C. Eugene Steuerle, Contemporary U.S. Tax Policy 34-36 (2d ed. 2008)). A recent empirical study found that increased federal taxes may shift which taxes the states assess, but that "[t]he overall burden of state taxation tends to be largely independent of federal tax burdens." *Id.* (quoting Howard Chernick & Jennifer Tennant, *Federal-State Tax Interactions in the United States and Canada*, 40 Publius: The Journal of Federalism 508, 526 (2010)).