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Kansas Journal of Law & Public Policy  
Spring 2011**\*199 COOPERATION, COMMANDEERING, OR CROWDING OUT?: FEDERAL INTERVENTION AND STATE CHOICES IN HEALTH CARE POLICY**

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## I. Introduction

The Patient Protection and Affordable Care Act (“ACA”) [FN1] will dramatically reshape federal-state relations in health care policy. [FN2] Both state and federal governments play a role in the regulation of health insurance and the provision of health care programs. The ACA substantially alters these roles, extending and deepening federal regulation of health insurance, creating new health care “exchanges,” expanding federally subsidized medical care programs (such as Medicaid), and increasing pressure on state governments to follow the federal government's lead. As two commentators noted, this law “marks the beginning of a new chapter in the centuries-long debate about the appropriate balance between the states and the federal government in the development, administration, and enforcement of domestic policy in the United \*200 States.” [FN3] Others go even further, suggesting the ACA “radically alter[s] the relationships between individuals and the government as well as the national government and the states,” [FN4] or it constitutes a “health care revolution” more dramatic than the adoption of Medicare in 1965. [FN5]

Most legal discussion and litigation over the ACA to date has focused on the “individual mandate,” a requirement that all Americans obtain and maintain health insurance that meets federally prescribed minimum standards. [FN6] Twenty-eight states and numerous private organizations have filed suit alleging that the individual mandate exceeds the federal government's limited and enumerated powers. [FN7] Among other things, those challenging the mandate argue that requiring all Americans to purchase a privately-offered good or service is unprecedented and improper. [FN8] Unless the mandate is repealed, most observers expect the question to reach, and ultimately be resolved by, the U.S. Supreme Court. [FN9]

Whether the individual mandate is consistent with the text and structure of the Constitution is only one of the federalism-related questions raised by the ACA. Other provisions of the law could test other constitutional limits on federal power, particularly if the law is implemented without due regard for state interests and relevant constitutional constraints. Insofar as the law \*201 restructures federal and state roles and responsibilities in health care policy, the ACA should prompt reconsideration of how the respective levels of government act and interact within this policy area. Many details respecting implementation of the ACA have yet to be determined. Decisions made by the Department of Health and Human Services (“HHS”), as well as other federal agencies, [FN10] will define the contours of the new federal and state relationship in health care policy for years, if not decades, to come. Due consideration of how different implementation choices affect federal-state interactions can ensure that the law is implemented in an effective and desirable way. Failure to consider such factors could precipitate further litigation and frustrate the ACA's objectives.

This Article's analysis proceeds in three parts. Part II of this article outlines the policy considerations in determining

the proper federal and state balance in health care policy. There are strong arguments for state primacy in health care policy, but also substantial justifications for federal intervention. Part III discusses the concept of “cooperative federalism,” under which the federal government encourages state governments to implement policies in accord with federal priorities, and identifies constitutional limitations on the federal government's ability to direct or even influence state policy choices. Even if the constitutional challenges to the individual mandate fails, federalism-based challenges to implementation of the ACA could succeed.

Additionally, there are practical limitations on the federal government's ability to influence state policy choices. Part IV discusses how federal policy decisions can influence state policy choices, and not always in the way federal policy-makers intend. Federal actions can have both direct and indirect effects on state regulatory choices. These effects may be either positive or negative, in both quantitative and qualitative terms. The potential of both positive and negative effects weakens the common presumption that adopting a federal “floor”—a minimum federal standard below which no state may operate—will increase social welfare. The adoption of policies designed to raise the “floor” across states may also discourage state-level innovation and create the practical effect of lowering the “ceiling” as well. Considering these potential effects can reduce the unintended consequences of federal action and intervention in health care policy.

## II. Jurisdictional Choice in Health Care

The U.S. Constitution establishes a system of “dual sovereignty,” under which both the federal and state governments are “sovereign.” [FN11] The Constitution delegates to the federal government a set of limited and \*202 enumerated powers, while state governments retain a plenary police power that empowers them to protect public health, safety, welfare, and morals. [FN12] This federalist structure supports a general, albeit rebuttable, presumption that any given policy question should be addressed by state governments. [FN13] Before the federal government can act, it must demonstrate that a given policy is within the scope of its enumerated powers. [FN14] With few exceptions, where the federal government does not act, things will remain in state hands. [FN15]

The presumption for decentralization can be overcome, but should not be cast aside lightly, as there are several potential benefits to decentralized policy-making. Among other things, decentralization of policy decisions will increase preference satisfaction, help overcome the “knowledge problem” that vexes centralized-decision-making, enhance political accountability, and could foster innovation.

In a decentralized system, there is likely to be a greater “fit” between a given jurisdiction's policies and the preferences of local residents. [FN16] Health policy often implicates subjective value preferences that may vary across the nation, including preferences for greater or lesser degrees of economic redistribution or risk avoidance. Some jurisdictions may be more comfortable than others with policy measures that restrict consumer choice, restrain industry competition, or allow individuals to take certain types of economic or health-related risks. As a result, there is not always a single “right” answer to a given health policy question, such as the minimum amount of coverage an insurer should be allowed to provide or the degree to which insurance companies should be allowed to account for various risk factors in the pricing of insurance products. Different rules impose different trade-offs among competing values and interests for which there is no single “right” answer.

Given varied preferences, a decentralized system will result in greater net satisfaction of individual policy preferences than will a uniform federal \*203 system. [FN17] To illustrate, consider a hypothetical nation consisting of two states, K and M, each of which has 100 residents. [FN18] Assume that seventy percent of the people in State K support a mandate that health care insurance cover mental health services equally with traditional health care services, while only forty percent of people in State M share this preference for mental health parity. The remaining people in each state op-

pose the proposed mandate. If a decision on mental health parity is made at the national level, based upon popular preferences, it will pass, and 110 people will live in a jurisdiction in which the policy matches their preferences. If, however, each state is free to adopt its preferred policy, mental health parity will be adopted in State K, but not in State M. The result now is that 130 people will live in a jurisdiction in which the relevant policy matches their preferences. If citizens of each state are mobile, and exit remains an option, the percentage of people who live in a jurisdiction with policies that match their preferences could be higher still. This is obviously a stylized example, but it illustrates the point that a decentralized system will result in greater preference satisfaction than the centralized, uniform alternative.

The failure to take into account local conditions, tastes, preferences, and economic conditions, can lead to “one size fits all” policies that fit few areas well. [FN19] There are tremendous socio-economic, demographic, and other differences across states that can influence what mix of policies are optimal for a given jurisdiction. The ideal policy for a jurisdiction with an older average population may not be the same as for an area with a younger population or in which there are more children. Factors ranging from population density and climate to socio-economic differences and cultural norms can influence what set of policies or institutions will maximize welfare. Matching policies with local preferences and conditions often requires local knowledge and expertise that is unavailable at the federal level. A more decentralized system is better able to overcome this “knowledge problem,” [FN20] and ensure that regulatory \*204 measures take account of local conditions and preferences. [FN21]

Decentralization can also enhance accountability. Local officials may be more in touch with and responsive to the concerns of their constituents. If nothing else, a lower ratio between policymakers and those subject to policy decisions may reduce agency costs, facilitate monitoring, and strengthen communication between policymakers and the public at large. As Marci Hamilton observes, “[t]he smaller the polity in geography and in population, the easier it is for the people (1) to monitor what their government is doing, (2) to criticize or praise, and therefore (3) to affect public policy.” [FN22] Decentralized systems are also less prone to rent-seeking. [FN23]

Decentralization, and the resulting policy experimentation and inter-jurisdictional competition, can encourage policy innovation as policymakers seek to meet the economic and other demands of their constituents. [FN24] As a result of such competition, states are able to learn from each other's successes and failures. [FN25] In this way, states are able to act as “laboratories” [FN26] developing new and improved ways of addressing health policy concerns. [FN27] The federal government also benefits from state-level experimentation and innovation because local initiatives can provide federal policymakers with evidence of how certain types of policies will affect health outcomes. Most observers credit state-level experimentation in the provision of federally funded welfare \*205 programs with providing the basis for federal welfare reforms enacted in the 1990s. [FN28] Such experimentation has also been important in environmental policy. [FN29] Prior to the enactment of the ACA, state-level experimentation was alive and well in health care policy, as illustrated by recent health care reforms adopted in states like Massachusetts and Indiana. [FN30]

While there may be a strong case for decentralization--perhaps even justifying a general presumption in favor of decentralization--that presumption can be overcome in any specific context by demonstrating the potential benefits of federal intervention in a specific instance. In some cases, there may be economies of scale that favor federal intervention. The federal government may enjoy a comparative advantage in certain matters that rely upon technical expertise. It may also be more efficient to maintain national markets with national regulatory standards than to risk the balkanization of such markets through the adoption of variable state standards. Federal intervention may also be justified insofar as there is a preference for using health policy to redistribute wealth or to ensure a national “floor” that no jurisdiction may drop below.

There are definite economies of scale in some types of economic and medical research that can inform the develop-

ment of health care policy and insurance regulation at all levels of government. While much of the information required for the development of efficient health care policies may be local in nature, information about the cost-effectiveness of given types of health interventions or the likely market effects of certain types of policies are likely to apply across jurisdictions. Cancer cells do not care whether they are in Russell, Kansas or La Russell, Missouri. Scientific or technical expertise will have public good characteristics, and it would be inefficient to force each jurisdiction to engage in duplicative research. [FN31] In addition, there are likely to be scale economies in the resources and technical expertise required for some forms of health-related research. Centralized data collection and analysis may be more efficient if done at the federal level. It may also make sense for the federal government to provide “expertise” on the technical aspects of \*206 regulation, [FN32] investigating such matters as regulatory design and implementation. [FN33] Duplicating this sort of research at the state level would serve little purpose and divert resources from other policy priorities.

While it would not make sense to force each jurisdiction to develop technical expertise that could be provided at the federal level, it is important not to conflate the argument for federally supported and conducted research and analysis, on the one hand, and federal policy making, on the other. Unless one assumes that all states and localities should adopt the same health policy measures irrespective of their local preferences and conditions, the case for federal expertise does not, by itself, establish the case for federal policy-making. The cancer cell may not care, but cancer rates could well vary across jurisdictions for a variety of reasons, as could voter preferences for how certain types of cancer risks should be addressed or how cancer treatment should be conducted or funded.

There may also be economies of scale in making some regulatory decisions at a national level insofar as a single national standard is more efficient than a multiplicity of state standards. Specifically, a single set of regulations may make more sense for a single, integrated national economy. [FN34] In the case of health insurance, for example, a single, integrated national market may be more efficient, and more competitive, than individual state markets, particularly when compared to smaller states. A single, uniform set of regulatory requirements could enable firms to offer standardized products throughout the nation. It may be more efficient for a drug or medical device maker to manufacture uniform products for a single national market than to adopt and implement different product or package designs for different states. Consumers may also benefit from national standards because lower compliance costs result in lower consumer prices. In contrast, allowing states to adopt more stringent standards for insurance products poses the risk of balkanizing the national market and cost externalization. These costs must be balanced against the benefits of allowing local regulators to adopt policies that reflect local preferences and conditions.

Not all favor the variability and competitive pressures generated by a decentralized system. The flexibility of states to implement programs in line with local preferences can allow for innovation, but it can also permit states to \*207 deviate from desired outcomes and drop below a minimum level. [FN35] If a given policy “floor” is considered necessary for normative or other reasons, this provides a reason for more centralized policy control. Similarly, competitive decentralized systems can make economic redistribution more costly, this could be a reason to favor greater policymaking centralization. Some jurisdictions are inevitably poorer than others, and centralized control can provide a means of redistributing wealth and associated capabilities from jurisdictions that “have” to jurisdictions that “have not.” [FN36] Ensuring minimum funding levels for health care services across the nation may well require federal intervention.

A rebuttable presumption in favor of leaving health care policy choices in state hands does not ensure the adoption of optimal health care policies. It does, however, lessen the likelihood of federal overreach and preserves a greater realm for state-level experimentation and innovation. While some states will inevitably make mistakes, so will the federal government. This does not mean the federal government should never intervene--quite to the contrary. It does, however, suggest the virtues of a system in which federal intervention is reserved for those instances when it is most likely to improve the situation.

### III. Cooperative Federalism and Constitutional Constraints

The federal government has ample power to regulate health care and health insurance markets, as well as provide health care services directly. Under existing doctrine, the federal power to “regulate commerce . . . among the several states” [FN37] can be used to regulate health insurers, medical service providers, drug manufacturers, and other companies involved in health care related services. The federal spending power can be used to fund social welfare programs, such as Medicare and Medicaid, which provide health care benefits to populations in need of care. [FN38]

The choice between federal and state action is not simply binary, and the respective powers of the federal and state governments are not entirely exclusive. There is a great degree of overlap, particularly in the economic \*208 sphere. Through its commerce power, the federal government may reach much economic activity, even if it is also subject to regulation by state governments. In these areas, the federal and state governments may act separately or together.

Health care is among those areas of state and federal overlap. While states remain the primary regulators of medical practice and have, for some time, had primary authority over the regulation of insurance, the federal government may regulate insurance under the Commerce Clause. As Justice Black explained in 1944, “No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.” [FN39] The Supreme Court further explained in *Gonzales v. Oregon*, “Even though regulation of health and safety is ‘primarily, and historically, a matter of local concern,’ . . . there is no question that the Federal Government can set uniform national standards in these areas.” [FN40]

Although the federal government has the power to intervene directly in health care markets, as either a regulator, funder, or direct provider, the federal government may also use its powers to encourage or discourage state efforts in this field. The most direct way for the federal government to influence state-level policy decisions is to dictate state policies from Washington, D.C. Yet, such “commandeering” is off the table. Rather, the federal government must use other means to encourage state action. The federal government may regulate insurance companies directly, it may preempt states from regulating, and it may even authorize state regulations that, in the absence of federal legislation, might run afoul of the Dormant Commerce Clause. The federal government may not, however, require states to regulate on its behalf. [FN41] As the Supreme Court explained in *New York v. United States*:

The Constitution enables the Federal Government to pre-empt state regulation contrary to federal interests, and it permits the Federal Government to hold out incentives to the States as a means of encouraging them to adopt suggested regulatory schemes. It does not, however, authorize Congress simply to direct the States . . . . [FN42] \*209 State governments remain “sovereign” under the doctrine of “dual sovereignty,” [FN43] and therefore cannot be commandeered by the federal government. Whether to ensure sufficient disposal capacity for low-level radioactive waste [FN44] or remedy lead contamination in drinking water, [FN45] the federal government cannot require state governments to adopt desired policy measures. Articulated by the Supreme Court in clear and unequivocal terms, this anti-commandeering principle admits no exceptions. [FN46]

The inability to commandeer state governments to enact a federally desired program or regulatory scheme does not leave the federal government powerless to induce state action or cooperation. To the contrary, the federal government retains ample authority to encourage state action through the provision of positive and negative incentives for state action. Both carrots and sticks are permissible. As the Court further explained in *New York*:

[W]here Congress has the authority to regulate private activity under the Commerce Clause, we have recognized Congress' power to offer States the choice of regulating that activity according to federal standards or having

state law pre-empted by federal regulation . . . This arrangement . . . has been termed “a program of cooperative federalism.” [FN47]

The most straightforward way to encourage state activity is to offer financial support for state programs that meet federal requirements or to otherwise confer benefits on compliant state governments. [FN48] Such funding can be a powerful inducement to state cooperation, as it can serve to multiply state investments in a given field. The federal government can also induce states to regulate in a desired field by threatening to preempt state policymaking in a given area. In effect, the federal government can say to the states “Regulate X, or we'll do it for you.” Insofar as state policymakers wish to retain control \*210 over a given field, this may be sufficient incentive to act. The federal government may also combine these incentives, simultaneously offering to fund compliant state programs and threatening to preempt noncompliant programs.

The federal government has broad authority to incentivize state behavior, but such power is not unlimited. Where the federal government seeks to encourage state action by offering financial support subject to certain conditions, there are constitutional constraints on what strings the federal government may attach. In *South Dakota v. Dole*, the Supreme Court identified five potential restraints upon Congress's use of conditional federal spending. First, the appropriation of funds must be for the “general welfare” and not for a narrow special interest. [FN49] This is not much of a practical constraint, however, as the Court explained that federal courts should “defer substantially to the judgment of Congress” in making this determination. [FN50] Under this deferential standard, programs such as Medicare and Medicaid are clearly constitutional.

Second, “the condition imposed by Congress is directly related to one of the main purposes for which . . . funds are expended.” [FN51] As reaffirmed in *New York v. United States*, the “conditions must . . . bear some relationship to the purpose of the federal spending; otherwise, of course, the spending power could render academic the Constitution's other grants and limits of federal authority.” [FN52] Thus, the federal government can require health care providers to observe certain practices if they receive Medicare reimbursements or funding for medical research. More questionable, however, would be the imposition of such requirements as a condition of receiving funding for highway construction or community policing.

Third, there can be no independent constitutional bar to the condition imposed upon the federal spending. [FN53] In other words, Congress may not place conditions on the receipt of federal funds that would require states to engage in conduct that would otherwise be unconstitutional.

A fourth requirement is that any conditions imposed upon the receipt of federal funds must be clear and unambiguous. [FN54] Specifically, recipients of federal funds must have notice of any conditions with which they must comply, and the scope of their obligation. [FN55] As the Court noted in *Pennhurst State School & Hospital v. Halderman*, “the legitimacy of Congress's power to legislate under the spending power . . . rests on whether the State voluntarily \*211 and knowingly accepts the terms of the ‘contract.’” [FN56] As the Court recently explained,

Congress has broad power to set the terms on which it disburses federal money to the States, but when Congress attaches conditions to a State's acceptance of federal funds, the conditions must be set out “unambiguously” . . . “[L]egislation enacted pursuant to the spending power is much in the nature of a contract,” and therefore, to be bound by “federally imposed conditions,” recipients of federal funds must accept them “voluntarily and knowingly.” [FN57]

States cannot knowingly accept conditions of which they are “unaware” or which they are “unable to ascertain.” [FN58] *Dole* also suggested a possible fifth limitation on the use of conditional spending: “coercion.” After identifying the four requirements just outlined, the Court noted that “in some circumstances the financial inducement offered by

Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’” [FN59] This point has been reiterated in subsequent cases, albeit without much elaboration. [FN60] While not explaining what would be necessary to turn “pressure” into “compulsion,” the Dole majority made clear that conditioning a relatively small amount of money on compliance with modest regulatory requirements would not satisfy this test. [FN61]

Federal appellate courts have not been particularly demanding of conditional federal spending. Following the Dole majority, courts have not second-guessed legislative judgments that a given spending program advances the “general welfare” or that conditions are sufficiently connected to the purposes of the spending at issue. [FN62] The requirement that Congress make any conditions imposed upon the receipt of federal spending explicit and unambiguous provides a more readily justifiable limitation on conditional \*212 spending.

In *Virginia Department of Education v. Riley*, an en banc panel of the U.S. Court of Appeals for the Fourth Circuit invalidated limitations the Department of Education imposed on the receipt of federal funds under the Individuals with Disabilities Education Act (“IDEA”). [FN63] The Fourth Circuit held that the Department of Education could not impose conditions on state receipt of IDEA funds that were not explicit in the statute itself, such as a requirement that state provide educational services to students expelled for misconduct unrelated to their disabilities. [FN64] According to the court, “Language which, at best, only implicitly conditions the receipt of federal funding on the fulfillment of certain conditions is insufficient to impose on the state the condition sought.” [FN65] Since, “at most [the IDEA] only implicitly conditions the States’ receipt of funds” upon the requirement enforced by the Department of Education, the condition could not be imposed on a non-consenting state. [FN66] The court explained further:

Insistence upon a clear, unambiguous statutory expression of congressional intent to condition the States’ receipt of federal funds in a particular manner is especially important where, as here, the claimed condition requires the surrender of one of, if not the most significant of, the powers or functions reserved to the States by the Tenth Amendment. [FN67]

Federal appellate courts have not found conditions placed upon the receipt of federal Medicaid funding to be coercive or otherwise problematic under *South Dakota v. Dole*. [FN68] Nonetheless, the constitutional limitations on commandeering and coercive use of conditional federal spending could constrain certain aspects of the ACA, particularly if sufficient attention is not paid to sovereign state interests as the law is implemented. [FN69] Some provisions of the ACA, at least when viewed in isolation, could present significant constitutional concerns. The imposition of additional requirements on states by HHS or other federal agencies could create additional problems.

\*213 Consider the ACA’s provisions concerning health benefit exchanges and the expansion of Medicaid. Section 1311(b) provides that every state “shall . . . establish an American Health Benefit Exchange” by 2014. [FN70] The ACA further requires that each state exchange must provide a marketplace for the purchase of health insurance plans, [FN71] determine participant eligibility for federal subsidies and Medicaid, [FN72] and administer the statutory exemptions to the individual mandate. [FN73] In the future, HHS will detail additional requirements for state health benefit exchanges and the conditions states must meet to obtain waivers from the Act’s requirements. [FN74]

Section 1311 in isolation would unquestionably violate the constitutional prohibition on commandeering. Congress may not simply dictate to states or mandate that state governments implement a federal law or administrative scheme. Section 1311 is not the only relevant provision, however. Perhaps recognizing the potential commandeering problem, the ACA’s authors added Section 1321, which provides that a state must “elect” to establish an exchange in accordance with the Act or the federal government “shall . . . establish and operate” an exchange within that state. [FN75] This provision seems to turn the exchange requirement from a simple (unconstitutional) mandate to a constitutional inducement. States have the option of implementing an exchange or accepting an exchange created by the federal government. [FN76]



Such conditional preemption schemes are presumptively constitutional. Yet much may depend on how the exchange provisions are implemented. HHS is still in the process of issuing regulations clarifying the precise requirements that health exchanges and participating insurers must meet. Until these rules are finalized, it will be difficult for the federal government to argue that states voluntarily accepted any and all requirements that are subsequently imposed. At present, it is uncertain whether states will agree to implement exchanges in accord with federal requirements. Much may depend on the rate at which the federal government can clarify the requirements and provide greater certainty about the extent to which financial assistance will (or will not) be available. More than twenty states declined to accept federal funds to create temporary state-based high-risk insurance pools. [FN77]

**\*214** The ACA contains another provision that may complicate any coercion analysis under the Dole test. The ACA provides tax credits for the purchase of health insurance plans through state-based exchanges. [FN78] The purpose of this provision is to subsidize the purchase of health insurance and help expand coverage. Yet under Section 1401, these tax credits are only for insurance purchased “through an Exchange established by the State under Section 1311,” not for exchanges created under Section 1321. [FN79] In other words, the tax credits for state citizens are only available if the state itself creates the exchange. If the federal government creates the exchange, the state's citizens lose their tax benefits. Under most conditional spending statutes, states may risk losing direct financial support if they fail to follow federal dictates. Here, however, it is state citizens who lose a financial benefit if their state does not act. This structure could create potential coercion concerns insofar as the Dole test focuses on whether the relevant conditions “interfere[] with the state's sovereign accountability.” [FN80]

The ACA's revisions to the federal Medicaid program may also press up against the constitutional limits on conditional spending as they are implemented in the years ahead. The ACA dramatically changed the federal Medicaid program. According to the Supreme Court, “Medicaid is a cooperative federal-state program . . . [and] participation in the program is voluntary.” [FN81] As the Court explained in another case, “participation in the Medicaid program is entirely optional, [but] once a State elects to participate, it must comply with the requirements . . . .” [FN82] Further, Congress expressly reserved the rights to “alter, amend, or repeal” Medicaid in its authorizing legislation. [FN83] Yet these declarations do not necessarily establish that newly adopted Medicaid requirements (and those yet to be adopted by HHS) pass constitutional muster.

Medicaid is an increasingly important share of state budgets and accounts for approximately twenty one percent of state spending. [FN84] It has been called “the Pac-Man of state budgets.” [FN85] The expanded coverage requirements imposed by the ACA, specifically the requirement that states cover those **\*215** below 133% of the poverty line, [FN86] will increase these costs and long-term federal financial support is not guaranteed. The expanded eligibility requirements are expected to result in an additional sixteen to twenty two million Medicaid enrollees. [FN87] Much of these costs will be covered by the federal government, but even a small increase in states' financial obligations under Medicaid could be quite significant. [FN88] Few states voluntarily opted to extend Medicaid coverage this far prior to enactment of the ACA. [FN89]

Although legally voluntary, most analysts believe Medicaid is, for all practical purposes, “obligatory.” [FN90] Legal scholars have begun to question whether Medicaid can still be considered a fully voluntary program, and whether Congress retains the ability to redefine state obligations without, in effect, offering a new set of contractual terms. [FN91] According to John Holahan of the Urban Institute's Health Policy Research Center, “No state has ever seriously considered walking away” from Medicaid. [FN92] One wonders if a state actually could. Under the ACA, states that participate in Medicaid are subject to new requirements, including a “maintenance of effort” mandate that prevents states from restricting state program eligibility. [FN93] If, as some suggest, Medicaid has a political “lock-in effect” that limits the ability of states to opt out of the program, then it may not make sense to continue to characterize state participation as

“voluntary.” [FN94]

As with the exchanges, some new Medicaid requirements will be fleshed out through administrative proceedings and rulemakings. Other decisions, such as whether the federal government will continue to support higher doctor reimbursement rates after 2014, will have to be resolved by Congress. The success or failure of health benefit exchanges could affect whether eligible individuals and families rely upon Medicaid or obtain private coverage through \*216 the exchanges. There is a limit to how much exchanges can be expected to assume responsibility for those on Medicaid, however, because the tax credits for the purchase of health insurance plans in exchanges only apply to those in between 100 and 400 % of the federal poverty level. [FN95] Those at or below the poverty line will receive no such tax credits, and are thus more likely to stay on Medicaid.

It is too soon to know whether the ACA's exchange or Medicaid provisions run into constitutional problems, and much will depend upon how these, and other, provisions are implemented. It is far more difficult for states to mount facial challenges to requirements imposed on the receipt of federal funding than to challenge specific impositions and administrative enforcement decisions. [FN96] Insofar as Dole limits administrative interpretations and implementation, more than the statute itself, it is too soon to challenge the ACA on such grounds. Rather, it will be necessary to see how the law works in practice.

#### IV. Federal Influences on State Policy Choices

It is evident that the federal government may directly influence actions taken by state governments, such as by preempting state action or providing financial inducements for states to act. Such direct interventions are only half of the picture, however. Just as federal action may encourage or discourage state regulatory action directly, federal action may indirectly, or even incidentally, encourage or discourage state regulatory action.

Federal policies can facilitate greater state regulation where such actions reduce the costs of state implementation, such as by subsidizing necessary research or reducing infrastructure costs. Similarly, where federal policies increase the demand for given regulatory policies at the state level, the federal policies have the practical effect of altering or setting state policy agendas. The positive effects of federal action on state policy initiatives are less significant, and perhaps more obvious, than the potential negative effects.

Federal policies will discourage state regulatory action where they “signal” that state regulatory action is excessive or unnecessary, or where they reduce the marginal benefits of adopting state regulatory programs--benefits either to the general welfare, those interest groups demanding state regulatory activity, or to the policymakers responsible for adopting the relevant policies. [FN97] \*217 Such “crowding out” is most likely to occur where federal regulations serve as a substitute for state regulations, though there may be other factors that have a similar effect. Adding in these indirect influences-- facilitation, agenda setting, signaling, and crowding out--produces a more complete matrix of ways that federal policies influence state regulatory choices, which is illustrated in Figure 1. [FN98]

Figure 1

#### Federal Influence on State Regulatory Activity

Direct

Indirect

More State Regulation	Commandeering	Agenda Setting
(“positive”)	Inducement	Facilitation
Less State Regulation		Signaling
	Preemption	
(“negative”)		Crowding Out

Without offering any direct inducements, the federal government may encourage state policymakers to adopt regulations that they would not otherwise enact by affecting the costs and benefits of state regulatory measures, or by increasing the demand for given policies at the state level. By taking high-profile actions, the federal government may elevate the salience of particular issues to state policymakers, thereby increasing the demand for regulation or other policy action in a given state. [FN99] In this fashion, federal policymakers may engage in “agenda setting” that influences state regulatory policy choices.

Actions by all three branches can have an agenda setting effect. For example, a study by an executive agency or congressional committee may identify a particular health concern and could prompt local action to reduce the threat. A presidential address or legislative hearing may drive media coverage \*218 of a particular policy concern and increase calls for a particular solution. National debate over a given issue, such as whether to create or reform a new entitlement or whether to mandate certain types of insurance coverage, may prompt states to act where the federal government does not. Similarly, a judicial decision either requiring the federal government to act, or perhaps finding that the federal government lacks the power to address a given concern, may raise the profile of a given issue and increase the demand for action at the state level.

A second way that federal action may indirectly encourage greater state action is by reducing the costs of developing or implementing policy measures at the state level. Federally funded scientific research, data collection, and information disclosure requirements may reduce the fixed costs of developing, implementing, and enforcing state-level programs. Federal tax credits for the purchase of health insurance through state-run exchanges could increase participation rates and help hold down average costs.

Federal programs could also have both sorts of positive effects simultaneously. A federal program that requires the production and disclosure of certain information may have an agenda-setting effect by illustrating and exposing a problem to local officials. At the same time, the production and disclosure of relevant information may facilitate state agencies to implement their own policies to address the problem.

The positive effects of federal action on state policy initiatives are less significant, and perhaps more obvious, than the potential negative effects. As a consequence, the potential negative effects deserve greater consideration. This is particularly so because it is generally presumed that federal intervention to establish a national “floor” has the primary effect of increasing the aggregate level of protection or government action in a given area. [FN100] Yet if federal action can discourage state action in a given area, the net effect of such federal action is not necessarily positive.

Federal action may discourage state regulatory action in at least two ways. First, the adoption of a federal regulatory

standard may “signal” that more stringent state regulations are unnecessary. In effect, the federal action may be seen as evidence that a given level of government intervention is sufficient to safeguard relevant public interests, and more stringent measures are unnecessary. As a result, the adoption of a federal “floor” may induce state policymakers to lower comparable state protections. In addition, the adoption of a federal regulation may “crowd out” state regulatory measures by reducing the net benefits provided by additional state measures. As a result, the existence of federal regulation may discourage the adoption of additional state-**\*219** level regulatory protections in the future.

Signaling occurs when federal intervention provides a “signal” that a given level of government action is the appropriate level, thereby discouraging states from adopting more stringent or protective policies. [FN101] Specifically, the adoption of a given regulatory standard by a federal agency sends a “signal” that the relevant standard is worthwhile and that additional requirements may be unnecessary. One reason for this effect is that federal policymakers, and expert federal agencies in particular, are presumed to have substantial technical expertise. Prominent federal action may convince state policymakers, or their constituents, that additional safeguards are “unnecessary” or that the benefits of more stringent regulatory protections are not worth their costs. The magnitude of this effect is likely to correspond with the magnitude of the difference between the relevant federal and state standards. In this way, federal standards can discourage state policymakers from adopting and maintaining more stringent measures of their own, even where such measures could be justified. As a practical matter, the federal “floor” may become a “ceiling” as well.

There are several reasons why this “signaling” effect may be of concern. First, and perhaps most important, the existence of a signaling effect that reduces the level of state regulations below what they would otherwise be, could reduce the net benefits provided by federal regulations. When the federal government adopts a federal standard, this will increase the level of protection in those states with standards that are below the federal “floor.” At the same time, it risks lowering the level of protection in any state that responds to the federal signal.

This effect is not merely hypothetical. In the environmental context, state legislatures sometimes adopt measures to prevent state regulatory agencies from adopting regulatory standards that are more stringent than federal rules. [FN102] Between 1987-1995, nearly twenty states adopted at least one statute limiting the ability of state agencies to adopt regulatory controls more stringent than relevant federal standards. [FN103]

A similar effect is possible in the health care context. If the federal government adopts a particular minimum package of health care benefits for **\*220** poorer Americans, this may send a signal to state policymakers that providing benefits beyond the federal level is unnecessary or imprudent. Similarly, if the federal government imposes a set of minimum coverage that health insurers must offer, in the context of an exchange or otherwise, this may signal to state policymakers that there is no real need to mandate a different degree or mix of coverage. Such responses by state policymakers could be entirely rational insofar as they may presume that federal policymakers have greater expertise in the given policy area. Moreover, state policymakers could rationally conclude that deferring to federal policy judgments is a way to economize on information and policy development costs.

The potential for federal intervention to “crowd out” preferable state policy initiatives in a given area is of at least equal concern. [FN104] Crowding out may occur when federal action serves as a substitute for state-level action. Where this occurs, federal intervention can reduce the marginal benefits of adopting or maintaining similar policies at the state level. Over time, this can discourage the adoption of optimal state-level policy responses. If the federal government dominates health policy, entrepreneurial state policymakers may opt to focus their efforts where the playing field is clear.

The effect of crowding out is not simply that states will intervene less if the federal government is involved. The more troubling possibility is that federal intervention will discourage states from adopting better or more protective

policies than that established by the federal “floor.” Further, insofar as federal intervention may have this effect, it can discourage state-level policy innovation, as there will be less incentive for state policymakers to devote their efforts to developing new policy initiatives in areas dominated by the federal presence. This is particularly true if a set of policy interventions is subject to diminishing marginal returns. In such a case, the federal government is likely to displace the most cost-beneficial state efforts. For instance, the creation of health insurance exchanges may discourage states from experimenting with alternative ways of meeting the same underlying policy goals. Because of crowding out, there may be less government intervention and policy innovation than had the federal government not intervened at all. The adoption of a federal “floor” may actually prevent further and future upward progress.

Crowding out occurs, in part, because there are significant fixed costs to policy change. Therefore, federal interventions that reduce the net positive benefits of state action on the margin may reduce the likelihood of state action at all because state policymakers are only likely to act where the benefits of policy change are greater than the total costs of such change. The inevitable inertia that affects all policymaking processes combines with the federal involvement to discourage net beneficial state-level policy changes that would have otherwise been enacted. An implication of crowding out is that federal intervention does not necessarily increase the net amount of government <sup>221</sup> involvement in a given policy space over time. Further, when the crowding out effect is combined with the signaling effect discussed above, the likelihood that federal intervention could cause a net decline in the aggregate level of regulatory protection increases. At the very least, the possibility of signaling and crowding out threaten to reduce the net benefits of federal intervention in a given policy sphere.

## V. Conclusion

The ACA is not the last word on health care reform. It is but the latest chapter in a decades-long debate over the proper federal role in the provision and regulation of health care services. Substantial federal intervention in health care markets may be justified, but such intervention is never without its costs. Among other things, federal action can discourage complementary state efforts or incite federal-state conflict. Failure to consider the practical and constitutional limitations on federal power to intervene in health care can result in counterproductive policies and make it more difficult to achieve national health care goals. The federal and state governments are capable of working together, but they can also work apart.

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[FN1]. Patient Protection and Affordable Care Act, [Pub. L. No. 111-148](#), 124 *Stat.* 119 (2010) (to be codified in scattered sections of 42 U.S.C. & 26 U.S.C.).

[FN2]. At the time of this writing there is substantial uncertainty as to how and even whether all of the Patient Protection and Affordable Care Act (“ACA”) will be implemented. Several court challenges are pending and the Republican major-

ity in the House of Representatives has pledged to block funding necessary to implement aspects of the law. See Edward Eynon & Leslie Levinson, Healthcare News from Capitol Hill and the Department of Health and Human Services, *InsureReinsure.com* (Feb. 22, 2011, 9:10 AM), [http:// www.insurereinsure.com/?entry=3215](http://www.insurereinsure.com/?entry=3215).

[FN3]. Christopher C. Jennings & Katherine J. Hayes, Health Insurance Reform and the Tensions of Federalism, 362 *New Eng. J. Med.* 2244, 2244 (2010).

[FN4]. Robert E. Moffit, Revitalizing Federalism: The High Road Back to Health Care Independence, Heritage Found., Backgrounder No. 2432, (June 30, 2010), <http://www.heritage.org/research/reports/2010/06/revitalizing-federalism-the-high-road-back-to-health-care-independence>.

[FN5]. Richard A. Epstein, [Bleak Prospects: How Health Care Reform Has Failed in the United States](#), 15 *Tex. Rev. L. & Pol.* 1, 2-3 (2010).

[FN6]. § 1501(a), 124 Stat. at 242-44; I.R.C. § 5000A (2006). The law contains a few minor exemptions for, among other things, religious reasons. See § 5000A(d)(2)(A), (B), 124 Stat. at 246 (creating a religious exemption).

[FN7]. See *Mead v. Holder*, No. 10-950, 2011 WL 611139 (D.D.C. Feb. 22, 2011); *Florida ex rel. Bondi v. U.S. Dept. Of Health And Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011); *Goudy-Bachman v. U.S. Dept. of Heath and Human Servs.*, No. 1:10-CV-762, 2011 WL 223010 (M.D. Pa. Jan. 24, 2011); *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F.Supp.2d 768 (E.D. Va. 2010); *U.S. Citizens Ass'n v. Sebelius*, No. 5:10 CV 1065, 2010 WL 4947043 (N.D. Ohio Nov. 22, 2010); *Florida ex rel. McCollum v. U.S. Dept. of Health and Human Servs.*, 716 F.Supp.2d 1120 (N.D. Fla. 2010); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010); *Baldwin v. Sebelius*, No. 10CV1033 DMS, 2010 WL 3418436 (S.D. Cal. Aug. 27, 2010).

[FN8]. See Randy Barnett, [Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional](#), 5 *N.Y.U. J. L. & Liberty* 581, 587 (2011) (concluding the individual mandate is unconstitutional and unprecedented). Contra Mark Hall, *Commerce Clause Challenges to Health Care Reform*, 159 *U. Penn. L. Rev.* (forthcoming June 2011) (concluding the individual mandate is constitutional and supported by precedent).

[FN9]. See, e.g., Michael Kirkland, *U.S. Supreme Court: Challenges Could Burst Healthcare Triumph*, *UPI.com* (March 22, 2010, 2:51 PM), [http://www.upi.com/Top\\_News/US/2010/03/22/US-Supreme-Court-Challenges-could-burst-healthcare-triumph/UPI-53811269283884](http://www.upi.com/Top_News/US/2010/03/22/US-Supreme-Court-Challenges-could-burst-healthcare-triumph/UPI-53811269283884) (discussing looming legal challenges expected to make their way to the Supreme Court).

[FN10]. See generally Curtis W. Copeland, *Cong. Research Serv.*, R41180, *Regulations Pursuant to the Patient Protection and Affordable Care Act (PPACA) (2010)* (detailing rulemakings required by the ACA).

[FN11]. *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991).

[FN12]. See, e.g., *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006) (“[T]he structure and limitations of federalism ... allow the States ‘great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.’” (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996))).

[FN13]. Portions of this discussion are adapted from Jonathan H. Adler, [Jurisdictional Mismatch in Environmental Federalism](#), 14 *N.Y.U. Envtl. L.J.* 130, 133-57 (2005).

[FN14]. See, e.g., *Marbury v. Madison*, 5 U.S. 137, 176 (1803) (“The powers of the legislature are defined, and limited;

and that those limits may not be mistaken, for forgotten, the constitution is written.”).

[FN15]. For further discussion of the application of constitutional federalism principles to environmental policy, see Jonathan H. Adler, [Judicial Federalism and the Future of Federal Environmental Regulation](#), 90 *Iowa L. Rev.* 377 (2005). For a somewhat different perspective on this question, see Robert V. Percival, “[Greening the Constitution - Harmonizing Environmental and Constitutional Values](#), 32 *Envtl. L.* 809 (2002).

[FN16]. See, e.g., Michael W. McConnell, [Federalism: Evaluating the Founders' Design](#), 54 *U. Chi. L. Rev.* 1484, 1493-94 (1987) (discussing how a decentralized government can be more responsive to diverse local interests and preferences).

[FN17]. See [id.](#) at 1494.

[FN18]. This illustration is adapted from a hypothetical that discusses satisfaction with legislation outlawing smoking in public buildings. See [id.](#)

[FN19]. See Karol Ceplo & Bruce Yandle, [Western States and Environmental Federalism: An Examination of Institutional Viability](#), in *Environmental Federalism* 225, 225-26 (Terry L. Anderson & Peter J. Hill eds., 1997) (“There is recognition that homogenous solutions applied to heterogeneous problems often yield high costs and weak results.”). While, as a theoretical matter, federal regulation could take into account regional variation, “federal regulation generally imposes uniform requirements throughout the country” and, where variable standards exist, it is not due to regional environmental differences. Richard L. Revesz, [The Race to the Bottom and Federal Environmental Regulation: A Response to Critics](#), 82 *Minn. L. Rev.* 535, 537 (1997).

[FN20]. See generally Friedrich. A. Hayek, [The Use of Knowledge in Society](#), 35 *Am. Econ. Rev.* 519, 519-20 (1945) (detailing the economic problem resulting from the fact that “the knowledge of the circumstances of which we must make use never exists in concentrated or integrated form but solely as the dispersed bits of incomplete and frequently contradictory knowledge which all the separate individuals possess.”).

[FN21]. See Daniel A. Farber, [Eco-Pragmatism: Making Sensible Environmental Decisions in an Uncertain World](#) 180 (1999) (“By decentralizing environmental decision-making, we may be able to obtain improved responsiveness to changing circumstances and new information.”).

[FN22]. Marci A. Hamilton, [Federalism and the Public Good: The True Story Behind the Religious Land Use and Institutionalized Persons Act](#), 78 *Ind. L.J.* 311, 321 (2003); see also Henry N. Butler & Jonathan R. Macey, [Using Federalism to Improve Environmental Policy](#) 7 (1996) (“[A]llocation to local governments of regulatory authority over local externalities allows decisions to be made by the representatives of the citizens who benefit the most and pay the most for higher environmental quality.”).

[FN23]. Rent seeking is “the attempt to obtain economic rents ... through government intervention in the market.” Jonathan R. Macey, [Promoting Public-Regarding Legislation Through Statutory Interpretation: An Interest Group Model](#), 86 *Colum. L. Rev.* 223, 224 n.6 (1986). In the regulatory context, rent-seeking typically consists of pursuing those government interventions that will provide comparative advantage to a particular industry or subsector. See Barry R. Weingast, [The Economic Role of Political Institutions: Market-Preserving Federalism and Economic Development](#), 11 *J.L. Econ. & Org.* 1, 6 (1995) (discussing federalism as a constraint on rent-seeking).

[FN24]. See Charles M. Tiebout, [A Pure Theory of Local Expenditures](#), 64 *J. Pol. Econ.* 416, 418 (1956) (discussing the

impact of constituents on the policymaking process).

[FN25]. Paul Teske, Regulation in the States 240 (2004) (“[Even when state experiments fail] they provide important information for other states and for national policy.”).

[FN26]. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

[FN27]. See *id.*; David A. Dana, *State Brownfields Programs as Laboratories of Democracy?*, 14 N.Y.U. Envtl. L.J. 86, 97-104 (2005).

[FN28]. See Jonathan H. Adler, Letting Fifty Flowers Bloom: Using Federalism to Spur Environmental Innovation, in *The Jurisdynamics of Environmental Protection: Change and the Pragmatic Voice in Environmental Law* 272 (Jim Chen ed., 2003).

[FN29]. See *id.* at 266-67.

[FN30]. See, e.g., The Kaiser Commission on Medicaid and the Uninsured, *States Moving Toward Comprehensive Health Care Reform*, <http://www.kff.org/uninsured/upload/State-Health-Reform1.pdf> (last updated July 10, 2009); Sam Wainwright, *In the States: Indiana's Health Care Equation*, *The New Health Dialogue*, (Jun. 18, 2010), [http://health.newamerica.net/blogposts/2010/in\\_the\\_states\\_governor\\_daniels\\_health\\_care\\_equation-33224](http://health.newamerica.net/blogposts/2010/in_the_states_governor_daniels_health_care_equation-33224).

[FN31]. See Daniel C. Esty, *Revitalizing Environmental Federalism*, 95 Mich. L. Rev. 570, 614-15 (1996) (“Absent centralized functions, independent state regulators will either duplicate each other's analytic work or engage in time-consuming and complex negotiations to establish an efficient division of technical labor.”).

[FN32]. Wallace E. Oates, *Resources for the Future, A Reconsideration of Environmental Federalism* 1, 22 (November 2001), <http://ageconsearch.umn.edu/bitstream/10460/1/dp010054.pdf>.

[FN33]. See Esty, *supra* note 31, at 615-16 (“[T]he smaller the regulating entity, the more likely it is to suffer from the absence of scientific scale economies.”).

[FN34]. See, e.g., Pietro S. Nivola & Jon A. Shields, AEI-Brookings Joint Ctr. for Regulatory Studies, *Managing Green Mandates: Local Rigors of U.S. Environmental Regulation* 17 (2001) (“Business interests, not without justification, often prefer nationwide regulatory standards to a hodgepodge of local rules: broad scope and standardization may lower uncertainty and increase efficiency.”).

[FN35]. See Jennings & Hayes, *supra* note 3, at 2244 (“The flexibility that allows states and local governments to move quickly to address varying needs, to innovate, and to set geographically sensitive priorities locally also permits the creation of tremendous disparities in the availability of high-quality, affordable health care.”).

[FN36]. Senator Max Baucus, for instance, justified enactment of the ACA because, among other things, it would address the “maldistribution of income in America.” See Byron York, *ObamaCare Was Mainly Aimed at Redistributing Wealth*, *Wash. Examiner*, (Apr. 2, 2010, 3:00 AM), <http://washingtonexaminer.com/politics/obamacare-was-mainly-aimed-redistributing-wealth>.

[FN37]. U.S. Const. art. 1, § 8, cl. 3.



[FN38]. The permissibility of using the spending power in this fashion was established in [Steward Machine Co. v. Davis](#), 301 U.S. 548 (1937), in which the Supreme Court upheld unemployment compensation provisions of the Social Security Act of 1935.

[FN39]. [United States v. Se. Underwriters Ass'n](#), 322 U.S. 533, 553 (1944), superseded by statute, McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified at 15 U.S.C. §§ 1011-1015 (2006)).

[FN40]. [Gonzales v. Oregon](#), 546 U.S. 243, 271 (2006) (citation omitted).

[FN41]. See generally [Printz v. United States](#), 521 U.S. 898 (1997) (holding unconstitutional a federal law requiring state officers to perform background checks on handgun purchasers); [New York v. United States](#), 505 U.S. 144 (1992) (holding unconstitutional a federal law requiring states to accept ownership of waste or regulate according to instructions of Congress).

[FN42]. [New York](#), 505 U.S. at 188.

[FN43]. See *infra* notes 11-12 and accompanying text.

[FN44]. See [New York](#), 505 U.S. at 188 (holding that portions of the Low-Level Radioactive Waste Policy Act Amendments unconstitutionally commandeered state governments).

[FN45]. [ACORN v. Edwards](#), 81 F.3d 1387 (5th Cir. 1996) (invalidating portions of the Lead Contamination Control Act).

[FN46]. See [Printz](#), 521 U.S. at 935 (“[N]o case-by-case weighing of the burdens or benefits is necessary; such commands are fundamentally incompatible with our constitutional system of dual sovereignty.”). There is language in [Printz](#) that suggests purely ministerial requirements might be exempt from the anti-commandeering rule, but the federal courts have not, as yet, found an attempted commandeering that was sufficiently immaterial to warrant an exception. See [Printz](#), 521 U.S. at 936 (O'Connor, J., concurring) (noting the Court “appropriately refrains from deciding whether other purely ministerial reporting requirements” represent unconstitutional commandeering of state governments). This may be due, in part, to the fact that relatively few statutes commandeer state governments.

[FN47]. [New York](#), 505 U.S. at 167 (citations omitted).

[FN48]. See [South Dakota v. Dole](#), 483 U.S. 203, 206 (1987) (noting permissibility of imposing conditions on the receipt of federal funds to achieve “broad policy objectives”).

[FN49]. *Id.* at 207.

[FN50]. *Id.*

[FN51]. *Id.* at 208.

[FN52]. [New York](#), 505 U.S. at 167 (citations omitted).

[FN53]. [Dole](#), 483 U.S. at 208.

[FN54]. *Id.* at 207.

[FN55]. *Id.* at 207.

[FN56]. 451 U.S. 1, 17 (1981). The interpretive rule urged in *Pennhurst* is arguably in tension with Chevron deference for agency interpretations of ambiguous statutory language. See David E. Engdahl, *The Spending Power*, 44 *Duke L.J.* 1, 70-71 (1994) (discussing the *Pennhurst* decision).

[FN57]. *Arlington Cent. Sch. Dist. v. Murphy*, 548 U.S. 291, 296 (2006) (citations omitted) (quoting *Pennhurst*, 451 U.S. at 17).

[FN58]. *Pennhurst*, 451 U.S. at 17.

[FN59]. *Dole*, 483 U.S. at 211.

[FN60]. See, e.g., *Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999) (noting that, in some instances, “the financial inducement offered by Congress might be so coercive as to pass the point at which pressure turns into compulsion” (quoting *Dole*, 483 U.S. at 211)); see also *New York v. United States*, 505 U.S. 144, 167 (noting limits of federal spending power).

[FN61]. *Dole*, 483 U.S. at 211.

[FN62]. See, e.g., *Nevada v. Skinner*, 884 F.2d 445 (9th Cir. 1989) (holding the conditioning the receipt of federal funds for highway maintenance on the establishment of a national speed limit was not coercive).

[FN63]. 106 F.3d 559 (4th Cir. 1997) (en banc).

[FN64]. *Id.* at 560.

[FN65]. *Id.* at 561.

[FN66]. *Id.* at 563 (Luttig, J., dissenting).

[FN67]. *Id.* at 566.

[FN68]. See, e.g., *California v. United States*, 104 F.3d 1086 (9th Cir. 1997) (upholding requirement that states provide emergency medical services to illegal aliens as condition on receipt of Medicaid funding); *Padavan v. United States*, 82 F.3d 23 (2d Cir. 1996); *Oklahoma v. Schweiker*, 655 F.2d 401 (D.C. Cir. 1981). But see *W. Va. v. U.S. Dept. of Health & Human Svcs.*, 289 F.3d 281, 291 (4th Cir. 2002) (“[F]ederal statutes that threaten the loss of an entire block of federal funds upon a relatively minor failing by a state are constitutionally suspect.”).

[FN69]. James F. Blumstein, *Vanderbilt Health Pol'y Ctr.*, *Who's in Charge? More Legal Challenges to the Patient Protection and Affordable Care Act*, Dec. 6, 2010, <http://www.aei.org/docLib/Blumstein20101206.pdf>.

[FN70]. Patient Protection and Affordable Care Act, *Pub. L. No. 111-148*, § 1311(b), 124 *Stat.* 119, 173-182 (2010) (to be codified at 42 U.S.C. § 18024) (emphasis added).

[FN71]. § 1321, 123 *Stat.* at 186-87.

[FN72]. § 1413, 124 *Stat.* at 233-35.

[FN73]. [Sec. 5000a, § 1501, 124 Stat.](#) at 244-49.

[FN74]. See Moffit, *supra* note 4, at 4.

[FN75]. [§ 1321\(b\), \(c\), 124 Stat.](#) at 186; see also Peter Suderman, *Rogue States: The Revolt Against ObamaCare*, Reason, (Oct. 2010), <http://reason.com/archives/2010/09/14/rogue-states> (noting much of the language in the ACA “was never intended to be final” and reads like “beta software” that was “still crawling with bugs” when enacted).

[FN76]. [§ 1321\(b\), \(c\), 124 Stat.](#) at 186.

[FN77]. Kevin Sack, *High-Risk Insurance Pools Are Attracting Few*, N.Y. Times, Nov. 5, 2010, at A19 (noting twenty-seven states opted to run high-risk pools, leaving the federal government to operate the pools in the remaining states directly).

[FN78]. [§ 1401, 124 Stat.](#) at 213-19.

[FN79]. [Sec. 36B\(b\)\(2\)\(A\), § 1401, 124 Stat.](#) at 213.

[FN80]. Celestine Richards McConville, [Federal Funding Conditions: Bursting Through the Dole Loopholes](#), 4 *Chap. L Rev.* 163, 173 (2001) (“Coercion implicates a state's ability to act as a representative of its people, not the state's level of temptation in choosing among alternatives.”).

[FN81]. [Wilder v. Va. Hosp. Ass'n](#), 496 U.S. 498, 502 (1990).

[FN82]. [Harris v. McRae](#), 448 U.S. 297, 301 (1980).

[FN83]. See [42 U.S.C. § 1304 \(2006\)](#) (“The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress.”).

[FN84]. See Peter Suderman, *ObamaCare and the Medicaid Mess*, Wall St. J., (Feb. 15, 2011), <http://online.wsj.com/article/SB10001424052748703843004576138682854557>.

[FN85]. Leighton Ku, *Ready, Set, Plan, Implement: Executing the Expansion of Medicaid*, 29 *Health Aff.* 1173, 1175 (2010).

[FN86]. Patient Protection and Affordable Care Act, [Pub. L. No. 111-148, § 2001\(a\), 124 Stat. 119](#), 271 (2010) (to be codified at [42 U.S.C. § 1396\(a\)](#)).

[FN87]. Kenneth Jost, *States and Federalism: The Issues*, 20 *CQ Researcher* 847, 852 (2010).

[FN88]. Some analysts suggest that additional state financial obligations under the ACA will be offset by cost-savings generated by other portions of the law. See Jost, *supra* note 87, at 852 (arguing savings in other areas, including unreimbursed medical care for uninsured individuals, could “be more than enough to offset” new spending required by the law). Estimates of the likely fiscal impact of the ACA on states vary dramatically. See Congressional Research Service, *RL 7-5700, Variation in Analyses of PPACA's Fiscal Impact on States* (2010) (discussing the impact of ACA on Medicaid).

[FN89]. Edmund F. Haislmaier & Brian C. Blase, *Obamacare: Impact on States*, Heritage Found., Background No. 2433 (July 1, 2010), <http://www.heritage.org/research/reports/2010/07/obamacare-impact-on-states>.

[FN90]. Jost, *supra* note 87, at 853.

[FN91]. See James F. Blumstein & Frank A. Sloan, [Health Care Reform Through Medicaid Managed Care: Tennessee \(TennCare\) as a Case Study and Paradigm](#), 53 *Vand. L. Rev.* 125, 141-42 (2000) (discussing states' ability to “departicipate” from Medicaid).

[FN92]. Jost, *supra* note 87, at 852-53.

[FN93]. Patient Protection and Affordable Care Act, [Pub. L. No. 111-148, § 2001](#), 124 *Stat.* 119, 275 (2010) (to be codified at 42 U.S.C. § 1396(a)).

[FN94]. Blumstein & Sloan, *supra* note 91, at 133, 141-42.

[FN95]. [Sec. 38B\(c\)\(1\)\(B\), § 1401](#), 124 *Stat.* at 215.

[FN96]. See *W. Va. v. U.S. Dept. of Health & Human Serv.*, 289 F.3d 281, 291 (4th Cir. 2002) (noting the state has a “very heavy burden to carry” in facial challenge, particularly if federal officials have enforcement discretion).

[FN97]. It should be noted that the hypotheses presented in this section are not dependent upon any particular theory about what sorts of interests ultimately drive the policymaking process. The hypotheses are equally compatible with public interest and public choice theories of policy formation. See Andrew P. Morriss et al., [Choosing How to Regulate](#), 29 *Harv. Envtl. L. Rev.* 179, 214-23 (2005) (summarizing various theories of regulation); Daniel A. Farber, *Politics and Procedure in Environmental Law*, 8 *J.L. Econ. & Org.* 59, 62-70 (1992).

[FN98]. This table is reproduced from Jonathan H. Adler, [When Is Two a Crowd? The Impact of Federal Action on State Environmental Regulation](#), 31 *Harv. Envtl. L. Rev.* 67, 89 (2007).

[FN99]. William W. Buzbee, [Recognizing the Regulatory Commons: A Theory of Regulatory Gaps](#), 89 *Iowa L. Rev.* 1, 55 (2003) (“[I]ncreased activity and publicity about an issue can over time change stakeholder perceptions and possibly preferences.”).

[FN100]. See, e.g., Rena I. Steinzor, [Devolution and the Public Health](#), 24 *Harv. Envtl. L. Rev.* 351, 375 (2000) (noting need for “strong federal regulatory floor”); Barry G. Rabe et al., [State Competition as a Source Driving Climate Change Mitigation](#), 14 *N.Y.U. Envtl. L.J.* 1, 6-7 (2005) (noting “the notion of federal policy as a ‘floor’ protecting certain ‘fundamental rights’ still has vitality” in environmental policy debates).

[FN101]. See [McNollgast, Legislative Intent: The Use of Positive Political Theory in Statutory Interpretation](#), 57 *Law & Contemp. Probs.* 3, 25 (1994) (noting “an action is informative if it is taken by an informed person who pays a fee, expends effort, or foregoes some valuable alternative activity in order to take the action.”). On signaling generally, see Jeffrey S. Banks, *Signaling Games in Political Science* (1991).

[FN102]. See Jerome M. Organ, [Limitations on State Agency Authority to Adopt Environmental Standards More Stringent than Federal Standards: Policy Considerations and Interpretive Problems](#), 54 *Md. L. Rev.* 1373, 1376-86 (1995); see also Arnold W. Reitze, Jr., [Federalism and the Inspection and Maintenance Program Under the Clean Air Act](#), 27 *Pac. L.J.* 1461, 1465 (1996) (stating there is a “movement among state legislatures to prohibit more stringent state standards.”).

[FN103]. See Organ, *supra* note 102, at 1376 n.13.

[FN104]. The “crowding out” theory is fleshed out in Adler, *supra* note 98, at 98-106.

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