A PERMANENT INCREASE IN THE FEDERAL MEDICAID ASSISTANCE PERCENTAGE: AN IDEA WHOSE TIME IS NOW

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ABSTRACT

Medicaid is a crucial component of the healthcare system's response to Covid-19 and will also be important in how we respond to future pandemics. The current pandemic has not only strained the healthcare system but has left millions of individuals relying on Medicaid at a time in which the reassurance of coverage is more important than ever. It has also had a devastating impact on state budgets.

This Article explores the role of Medicaid and proposes a solution to mitigate the repercussions Covid-19 has had on state budgets while ensuring the security of the country's principal health insurance safety net at a time in which such security has never been more critical. The solution that is proposed and supported by this Article is action by Congress to pass legislation that will permanently increase the Federal Medicaid Assistance Percentage to provide states with desperately needed fiscal relief.

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INTRODUCTION

Medicaid is a crucial component of the healthcare system's response to Covid-19. The pandemic has not only strained the healthcare system but has left millions of individuals relying on Medicaid at a time in which the reassurance of coverage is more important than ever.[1] Never before have the tenets of Medicaid been tested in such a way. Still, Covid-19 elicits the importance of a program that subsidizes healthcare for those individuals whose sole insurance option is Medicaid, and, in time, enrollment is likely to increase further as Covid-19 continues to adversely affect the economy.[2] Moreover, the public health crisis is compounded by a state budget crisis that has left states reeling.[3] The depth of these two issues poses both an opportunity and threat to Medicaid's solvency. Lawmakers must ensure that Medicaid is able to meet the needs of those whom the program is designed to insure; they must also ensure that states have the means to provide for these needs. Therefore, a response must be expedient.

A solution to ensure Medicaid's security and ease the state budget crisis is permanently increasing the Federal Medicaid Assistance Percentage (FMAP).[4] In the past, the FMAP has been used as a tool of economic recovery and healthcare security. Despite the most recent temporary increase in the FMAP via the Families First Coronavirus Response Act (FFCRA),[5] states are still facing revenue shortages that leave Medicaid, and the program's enrollees, vulnerable. Permanently increasing the FMAP would alleviate the current budget crisis by offsetting the costs incurred by states to

1. There has been an increase of 18.7 million Medicaid enrollees since February 2020. *See* Bradley Corallo & Sophia Moreno, *Analysis of Recent National Trends in Medicaid and CHIP Enrollment*, KAISER FAM. FOUND. (Nov. 2, 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/.

2. *Id.*

3. *See States Grappling with Hit to Tax Collections*, CTR. ON BUDGET & POL'Y PRIORITIES (Nov. 6, 2020) https://www.cbpp.org/research/state-budget-and-tax/states-grappling-with-hit-to-tax-collections.

4. The FMAP is the federal share of Medicaid expenditures.

5. Families First Coronavirus Response Act, Pub. L. No. 116–27, § 6008, 134 Stat. 178, 208 (2020) (codified as amended at 42 U.S.C § 1396).

administer Medicaid programs and would do so irrespective of an arbitrary timeline.[6]

This Comment proposes a draft statute that will permanently increase the FMAP following the end of the public health emergency, as designated in the FFCRA.[7] This draft statute is modeled after previous temporary increases in the FMAP.[8] The sole difference in this instance is the timeline concerning the increase. Previous increases in the FMAP have not faced substantial legal challenges albeit the Patient Protection and Affordable Care Act's challenge in *NFIB v. Sebelius*,[9] which only tangentially concerned the FMAP.[10]

Nevertheless, a permanent increase in the FMAP would have standing under the spending power as explained under the framework presented in *South Dakota v. Dole*.[11] Particularly in view of Covid-19, permanently increasing the FMAP would provide for the general welfare of the United States, would be drafted under unambiguous conditions, would be directly related to the federal interest, and would inhibit no independent constitutional bar.[12]

Part I of this Comment explains Medicaid and the FMAP in historic and legislative context. Part II describes a permanent increase in the FMAP by exploring the legislative history of previous increases in the FMAP and an explanation of a draft statute that would serve this end. Part III evaluates the constitutionality of a permanent increase in the FMAP as designated under the *Dole* framework.

I. BACKGROUND

A. Medicaid in Historical Context

Medicaid is a means-tested health insurance program for low-income individuals in the United States, and it is funded jointly by the state and the federal government.[13] Medicaid is an extensive program that provides health

6. Corallo & Moreno, *supra* note 1.

7. *Id.*

8. Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108–27, § 401, 117 Stat. 752, 764; American Recovery and Reinvestment Act of 2009, Pub. L. No. 111–5, § 5001, 123 Stat. 115, 496 (codified as amended at 42 U.S.C. § 1396); Families First Coronavirus Response Act § 6008.

9. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 530 (2012).

10. *Id.* at 531.

11. South Dakota v. Dole, 483 U.S. 203, 207–08 (1987).

12. *See id.* (listing the necessary criteria of a constitutional use of the spending power).

13. *See Medicaid*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/index.html (reporting the current Medicaid enrollment as the official website for Medicaid) (last visited Dec. 2, 2022).

insurance for nearly 83.5 million Americans and is widely considered the primary healthcare safety net in the United States.[14] As a federal-state partnership, Medicaid does not exist as a cohesive program among states as each state has the autonomy to make decisions regarding the extent and scope of coverage.[15] Examples of variant scopes of coverage include eligibility criteria, levels of federal funding,[16] and whether a state expanded coverage following the Patient Protection and Affordable Care Act (PPACA).[17]

Medicaid's convoluted history stems from its amalgamation of existing social insurance programs and its status as a relative afterthought to its favored counterpart, Medicare.[18] Medicaid emerged from the Social Security Amendments of 1965 and was primarily a program for the indigent and disabled.[19] Though Medicaid and Medicare were implemented via the same legislation, Medicaid and Medicare originated from very distinct ideological arguments.[20] During this time, society was wrestling with its ambivalence regarding healthcare for the poor and elderly.[21] Several presidential administrations had tried to pass some form of national healthcare plan, but

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14. As of June 2020, roughly 82 million Americans were enrolled in Medicaid, and roughly 7 million Americans were enrolled in the Children's Health Insurance Program (CHIP). Medicaid and CHIP are distinct in that CHIP is a health insurance program for children of families who earn too much to qualify for Medicaid yet too little to purchase healthcare in the private market. CHIP is a block grant program that provides states with the funds to expand Medicaid for children beyond current eligibility levels, insure children via a separate CHIP program, or combine the two approaches. *See The Children's Health Insurance Program*, GEO. UNIV. HEALTH & POL'Y INST., (Feb. 6, 2017), https://ccf.georgetown.edu/2017/02/06/about-chip/; *June 2022 Medicaid & CHIP Enrollment Data Highlights,* MEDICAID.GOV (June 2022), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

15. States have the discretion to extend eligibility past federally mandated levels, so some states have more generous eligibility standards than others. Examples of states that have expanded eligibility past 133% of the federal poverty line include Massachusetts, New York, and Vermont. *See Medicaid and CHIP in Massachusetts*, MEDICAID.GOV, https://www.medicaid.gov/state-overviews/stateprofile.html?state=massachusetts (last visited Dec. 2, 2022) (detailing a comprehensive account of Massachusetts's expansion status).

16. The amount of funding states receive from the federal government is unique to each state. The federal match is calculated by considering the per capita income of each state in relation to the aggregate per capita income of the United States. Since each state likely has a different per capita income, each state receives different levels of federal funding. *See* CONG. RSCH. SERV., R43847, CRS REPORT: MEDICAID'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAPS) 2 (2020) [hereinafter CRS REPORT].

17. *See generally Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (July 21, 2022) https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ (noting that, states that have not yet expanded coverage include Wyoming, South Dakota, Wisconsin, Kansas, Texas, Tennessee, Mississippi, Alabama, Georgia, South Carolina, North Carolina, and Florida).

18. LAURA KATZ OLSON, THE POLITICS OF MEDICAID 1 (2010).

19. *See id.* at 23.

20. *Id.*

21. *Id.*

none were successful in implementing a cohesive federal plan.[22] Though public and political sentiment began to shift in the 1960s with legislation such as the Kerr-Mills Program of 1960 and the King-Anderson Bill of 1962,[23] substantial reform remained elusive.

Thus, the Johnson administration faced a myriad of policy issues related to healthcare.[24] Though President Johnson prepared to make healthcare a cornerstone of his domestic policy agenda, those whom he appointed to research the country's healthcare infrastructure, and members of Congress, continued to disagree on a plan to achieve healthcare reform.[25] One group that appealed to a wide array of policymakers and researchers alike was the elderly population.[26] The elderly were an appealing population because they were a growing political constituency and were endearing to the public.[27] Many believed that there should be some form of health insurance to protect people from the high costs that are often associated with aging irrespective of the socioeconomic status one occupied in their life.[28]

Lawmakers did not share a similar sentiment when discussions shifted to providing healthcare to low-income people.[29] Although there was already a patchwork system of health services that provided healthcare for the poor, pregnant women with dependent children, and the blind and disabled, lawmakers still viewed the lack of a federal healthcare system as a reinforcement of normative societal values.[30] A prevalent theme that arose during discussions of healthcare reform was the need for individualism over collectivism. That is, the United States often viewed itself as a country that prized values such as hard work, autonomy, and responsibility for oneself and one's family.[31] Conversely, and as a result of a conflict among the value

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22. *Healthcare Crisis Timeline*, PBS, https://www.pbs.org/healthcarecrisis/history.htm (last visited Dec. 2, 2022) (providing an overview of healthcare reform history).

23. Both the Kerr-Mills Program and the King-Anderson Bills are often cited as the political and legislative origins for Medicaid. Though Kerr-Mills was deemed unsuccessful, and the King-Anderson Bills were subsequently defeated in committee, both pieces of legislation signaled a shift in attitudes surrounding national healthcare. *See* SHANNA ROSE, FINANCING MEDICAID 36–38 (2016).

24. JONATHAN ENGEL, POOR PEOPLE'S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965, at 45 (2006).

25. *Id.*

26. *Id.* at 46.

27. *Id.*

28. *Id.*

29. *Id.* at 51.

30. OLSON, *supra* note 18, at 26–29 (describing the politicization of welfare medicine).

31. Value conflicts of individualism over collectivism pose implications in current policy debates as well. Many controversial policy issues stem from the stark contrast of individualism versus collectivism, and legislators' fierce disagreement regarding policy that doesn't align with their respective preference choice often results in policy stalemates. *See* Lawrence Bobo, *Social Responsibility, Individualism, and Redistributive Policies*, 6 SOCIO. F. 71, 73 (1991).

preferences that are endemic to the cultural makeup of the United States, society often viewed the poor as being responsible for their poverty because they seemingly did not possess the values of hard work and autonomy.[32]

These value conflicts plagued the debate over the efficacy of Medicaid and the deservedness of the poor. Though Medicaid eventually passed, a herculean effort nonetheless, the program differed considerably when compared to its favored counterpart, Medicare. The extolled virtues associated with Medicare resulted in a funding structure that provided for equitable access and delivery of care, streamlined eligibility processes, and a comprehensive set of benefits.[33] In other words, there was no variation in coverage that often time results from dissimilar funding. Thus, while Medicare was enacted as, and continues to be, a federally funded health insurance program, Medicaid has differed in its funding structure from the beginning due to its nature as a joint-partnership program between the states and federal government.

The FMAP varies in amount from state to state based on the per capita income in each state.[34] Funding that is not provided by the federal government is provided by the states.[35] Given that states are fronting some of the costs associated with administering state Medicaid programs, states also have the discretion to decide on matters regarding the scope and depth of services provided.[36] Therefore, while Medicaid's federal-state partnership provides states with the flexibility they value, the joint partnership also often results in inequitable care and guidelines from state to state.

The juxtaposition of states' joint partnerships with the federal government and state discretion regarding Medicaid services is evidenced by the fallout that resulted from the PPACA. Initially, the PPACA mandated that all states expand Medicaid eligibility to 133% above the federal poverty line.[37] Those states that refused to expand eligibility risked losing federal funding used to offset costs incurred to administer state Medicaid programs.[38] Nevertheless, state governors and other interested parties demurred and were successful in evading the eligibility expansion requirement as a consequence of *NFIB v. Sebelius*, which resulted in some states expanding Medicaid eligibility while other states refrained.[39]

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32. *Id.*

33. ENGEL, *supra* note 24, at 46.

34. *See* CRS REPORT, *supra* note 16, at 2.

35. *See id.* at Summary.

36. *Id.* at 2.

37. 42 U.S.C § 1936(l)(2)(A)(ii)(II) (expanding Medicaid coverage to more than "the deserving poor" at higher levels of income).

38. *Id.* § 1936(l)(2)(A)(iii).

39. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 540 (2012).

The ensuing implications are best explained by comparing the health outcomes in states that expanded coverage and states that did not. For instance, states that did expand coverage witnessed a comparatively diminished decrease in the number of uninsured,[40] in addition to a myriad of other health benefits.[41] Conversely, the number of uninsured individuals is higher among those states that did not expand coverage.[42] What follows is a stark contrast in the eligibility criteria among states by which one may be eligible for Medicaid in a neighboring state yet not eligible for coverage in the state in which they reside.

While *NFIB v. Sebelius*, and the fallout from the PPACA more generally, exacerbated the disparate variation in Medicaid eligibility and coverage, states have always varied in the ways in which they administered state Medicaid programs.[43] Inherent in Medicaid's federal-state partnership is the ability for states to "experiment" with how they administer Medicaid to perhaps identify more efficient means to administer care.[44] Such experimentation was often extolled by Justice O'Connor as being endemic to the ideals of federalism.[45]Often, states used waivers to alter Medicaid's delivery, and such waivers for research and demonstration[46] have been used

40. Among states that expanded coverage below 138% of the Federal Poverty Line, states witnessed a 13.7 percentage point decline in the number of uninsured. States that did not expand coverage did not witness a decline in the number of uninsured. Sharon K. Long et al., *Taking Stock at Mid-Year: Health Insurance Coverage under the ACA as of June 2014*, URB. INST. (July 29, 2014), https://www.urban.org/sites/default/files/publication/41476/taking-stock-at-mid-year.pdf.

41. States that expanded coverage witnessed an uptake in the use of primary care, greater access to prescription medication, and decreased use of emergency room visits for non-emergency reasons. *See* Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA INTERNAL MED. 1501, 1501–03 (2016).

42. Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAM. FOUND. (Mar. 17, 2020), https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report.

43. *See* OLSON, *supra* note 18, at 27.

44. *See* Gregory v. Ashcroft, 501 U.S. 452, 458 (1991) (regarding Gregory, Justice O'Connor extolled the idea of "laboratories of the states" in discussing the virtues and importance of federalism where federalism assures a decentralized government which will better serve a heterogenous society; increasing political engagement among the citizenry; providing states with the opportunity to experiment with policy initiatives; and providing states with a competitive advantage whereby the federal government may be more responsive).

45. The Rehnquist Court is often cited as reviving the ideal of federalism through a number of important cases such as *Gregory v. Ashcroft* and *New York v. United States*. *Id.* ; New York v. United States, 505 U.S. 1408, 1424 (1992).

46. ROSE, *supra* note 23, at 169 (discussing the history of waivers for the purpose of providing states with flexibility to manage state Medicaid programs).

to provide states with the flexibility to administer Medicaid as they deemed necessary.[47]

Thus, while states have maintained discretion to administer Medicaid as they deem appropriate, such autonomy has often led to inequity in eligibility and care. Moreover, the scope of states' respective Medicaid eligibility rules also poses funding implications as it relates to state budgets due to the federal matching mechanism inherent to Medicaid's funding structure. Since states receive a minimum of a 50% federal match in state spending, states receive one dollar from the federal government for every state dollar expended.[48] Therefore, states that spend more on Medicaid-related services receive more funding from the federal government, which provides for the necessary funding to stabilize state budgets during a time of duress.[49]

Despite the generous funding states may receive from the federal government, 12 states have yet to expand Medicaid coverage up to 138% of the federal poverty line.[50] What follows are the implications that have been previously discussed including disparate funding levels that impact state budgets, inequitable care and guidelines among states, and a general trend towards path dependence.[51] However, to best understand the financial

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47. There are three types of waivers that are most commonly used by states, and they are as follows: Sections 1115 for demonstration and research projects, whereas demonstration projects refer to projects that aim to find better and more efficient policy approaches to serve Medicaid populations. *See About Section 1115 Demonstrations*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html (last visited Dec. 2, 2022); Section 1915(b) for managed care/freedom of choice. This section is essentially a group of services arranged through contracted arrangements between state and Medicaid agencies and managed care organizations. *See* Jessica Van Parys, *How Do Managed Care Plans Reduce Healthcare Costs?*, (Oct. 29, 2014), http://www.columbia.edu/~jnv2106/jvanparys.jmp.pdf (providing an analysis of the outcomes associated with managed care plans); Section 1915(c) for home and community-based service allowing long-term care services to be delivered in community settings as an alternative to institutionalized settings. *See Home & Community-Based Services 1915(c)*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html (last visited Oct. 25, 2022).

48. The maximum federal match a state may receive is 83%; a state which receives a higher federal match receives a maximum of three federal dollars for every dollar spent administering state Medicaid programs. *See* CRS REPORT, *supra* note 16, at 2.

49. *See* Gabriel Chodorow-Reich et al., *Does State Fiscal Relief During Recessions Increase Employment? Evidence from the American Recovery and Reinvestment Act*, 4 AM. ECON. J. 118, 119–37 (2012) (explaining the benefits associated with increased federal funding for state Medicaid programs).

50. *Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 17.

51. Path dependence is a way to describe the importance of history as it relates to why an issue is debated, considered, or evaluated against a set of antiquated ideals or facts despite social and political change. The result of path dependence is a less deliberate set of priorities, which leads to policy incoherence. With respect to Medicaid, path dependence has resulted in a complex, inefficient approach to healthcare delivery under the current policy framework. *See* JAMES MAHONEY, *Analyzing Path Dependence: Lessons from the Social Sciences*, *in* UNDERSTANDING CHANGE 129, 129–30 (Andreas Wimmer & Reinhart Kössler eds., 2006) (providing a comprehensive explanation of path dependence).

implications that result from Medicaid's path-dependent nature, it is necessary to evaluate how the PPACA tried to reform Medicaid from a majoritarian joint-partnership to a health insurance program with a greater federal scope.

B. Medicaid Expansion and the FMAP

As mentioned above, several previous presidential campaigns and administrations focused on healthcare reform, from Roosevelt to Clinton.[52] Although the Johnson administration was the first administration that was able to legislate gradual healthcare reform through the passage of Medicare and Medicaid, no legislation had holistically reformed the American healthcare system until the passage of the PPACA on March 23, 2010.[53] While passing the PPACA was indeed significant for numerous reasons, it was exceptionally groundbreaking because it was the first multifaceted regulatory overhaul of the American healthcare system.[54]

The PPACA reformed the healthcare system by reducing costs and reducing the number of the uninsured.[55] To achieve these concurrent objectives, the PPACA enacted a number of provisions including the individual mandate, subsidies to contain costs, and reforms to streamline

52. Teddy Roosevelt believed paying for health on a fee-for-service basis was inefficient, and he therefore energetically lobbied to pass a comprehensive social insurance program as a cornerstone of his 1912 campaign for the presidency. NOAM SCHIMMEL, PRESIDENTIAL HEALTHCARE REFORM RHETORIC 4 (Alan Finlayson et al. eds., 2016). Although Roosevelt was unsuccessful in his bid for re-election in 1912, and thus unsuccessful in his efforts at healthcare reform, his fierce defense of healthcare reform provided precedence upon which future healthcare reform efforts were based. *See id*. While Roosevelt's efforts at healthcare reform fell upon deaf ears due in part to a lack of precedence for healthcare reform, and social insurance more broadly, the Clinton healthcare initiative failed for different reasons altogether in 1993. At this point, healthcare reform had been discussed on the national stage for decades, and the defeat of reform was mainly due to conflicting ideological arguments and Congress's ambivalence regarding the federal government's role in implementing a single-payer system. Furthermore, Congress felt rebuffed that it did not have strong representation in discussions surrounding reform as the task-force responsible for implementing reform was headed by then-First Lady Hillary Clinton. *See* W. John Thomas, *The Clinton Health Care Reform Plan: A Failed Dramatic Presentation*, 7 STAN. L. & POL'Y REV. 83, 83–92 (1996) (providing a comprehensive account of the Clinton healthcare initiative).

53. Patient Protection and Affordable Care Act, Pub. Law. No. 118–48, § 2001, 124 Stat. 119 (2010).

54. The Social Security Amendments of 1965 did not address the inherent inefficiencies endemic to the insurance industry and people's access to employer-sponsored health insurance. Thus, while the PPACA indeed expanded Medicaid, the PPACA was also significant because of its systematic reform of the American healthcare system as it related to employer-sponsored health insurance and the health insurance exchanges. *See* EZEKIEL J. EMANUEL, REINVENTING AMERICAN HEALTHCARE 204, 209, 218 (Marrathon Prod. Servs. ed., 2014) (detailing how the PPACA reformed the healthcare system).

55. *Id.* at 204.

delivery of care.[56] Efforts to streamline delivery of care included requirements that insurers cover all applicants and offer the same rates irrespective of gender or pre-existing conditions.[57] Many of these regulatory amendments affected the vast majority of Americans who were insured under an employer-sponsored health insurance plan.[58]

Nevertheless, the PPACA also abridged the coverage gap[59] by expanding Medicaid eligibility to 138% below the federal poverty line.[60] Therefore, many consider the PPACA's Medicaid expansion as among the first steps toward a single-payer system in the United States given that the program legislated access to healthcare beyond those classified as the deserving poor.

Medicaid was amended in two ways to expand coverage. First, as once mentioned, Medicaid eligibility was extended to those earning below 138% of the federal poverty line;[61] second, the PPACA expanded the scope of Medicaid coverage to include childless adults.[62] Still, the federal government's efforts to provide healthcare for the working poor had been contentious for decades,[63] so the PPACA needed to include provisions that would persuade states to expand coverage to those with higher incomes. In other words, the federal government needed to identify why states were reluctant to expand coverage and address those issues directly. Seeing that states were reluctant to expand coverage due to financial reasons, the federal government sought to persuade states to expand Medicaid with a financing package that would be difficult to refuse.

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56. *Id.* at 206 (explaining in detail the individual mandate, subsidies to contain costs, and reforms to the delivery of care).

57. The expansion population received a benefits package that fulfilled the designated requirements of "essential benefits," which are in keeping with those benefits provided via health insurance plan in the exchanges. *Id.* at 207. While this benefits package is less comprehensive than previous Medicaid benefits packages, the new benefits offerings were meant to streamline access to care among those in the expansion population and those purchasing healthcare in the exchange. *Id.*

58. *See* Fredric Blavin et al., *An Early Look at Changes in Employer-Sponsored Insurance under the Affordable Care Act*, HEALTH AFFS. 170, 171–75 (2015).

59. *See* Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid–An Update*, KAISER COMM'N ON MEDICAID & UNINSURED (Oct. 2015), https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/KFF_coverage-gap-uninsured-in-states-not-expanding-medicaid.pdf (noting that the coverage gap consists of those who do not qualify for Medicaid under its previous eligibility rules yet are too poor to purchase health insurance on the market exchange).

60. *Id.*

61. EMANUEL, *supra* note 54, at 207.

62. In keeping with Medicaid's affinity for path dependence, those who were historically eligible for coverage were the indigent, pregnant women with dependent children, or the blind and disabled. Thus, expanding Medicaid coverage outside of this group was historic because it was a significant diversion from Medicaid's path dependent history. *Id.*

63. ENGEL, *supra* note 24, at 48.

The federal government's financing approach was two-fold, with the first approach being more direct in its delivery. The objective was to take advantage of the FMAP to subsidize the expansion.[64] The federal government would provide states with a 90% federal match[65] to sustain the healthcare costs of the expanded population.[66] Given that states receive an average federal match of 57%,[67] many states viewed the enhanced federal match rate favorably. Yet, several states demurred and refused to expand coverage under the guise of Medicaid's inherent cost containment inefficiencies.[68]

States that did not expand coverage did not receive an enhanced federal match, and the distinction between non-expansion states and expansion states is stark. States that did not expand Medicaid experienced higher rates of uninsurance and received an aggregate 8.4 billion less in federal payments than states that did expand coverage.[69] Furthermore, non-expansion states faced indirect opportunity costs by spending more on uncompensated care.[70] Less federal funding often results in states needing to navigate difficult financial obstacles, and many states rejecting Medicaid expansion were left worse off and with less federal funding.

It is during times of economic duress when states often face budget deficits that require states to cut spending. Medicaid's nature as a counter-cyclical program lends it to be a difficult program to fund during times of economic uncertainty when enrollment and spending increase at a time in which states' economic activity declines.[71] Otherwise stated, recessions place acute fiscal pressures on states that occasionally lead to limited benefits and restricted eligibility at the exact time when people need access to healthcare the most.[72]

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64. EMANUEL, *supra* note 54, at 206.

65. 29 U.S.C. §§ 49(d)–49(f) (phasing down the federal match incrementally between 2014–20 to a final 90% federal match by January 1, 2020).

66. *Id.*

67. *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)*, KAISER FAM. FOUND. (Sept. 2012), https://www.kff.org/wp-content/uploads/2013/01/8352.pdf.

68. CRS REPORT, *supra* note 16, at 15; Nicole Huberfeld, *Federalizing Medicaid*, 14 U. Pa. J. Const. L. 431, 464, 472 (2011) (explaining that states challenged Medicaid expansions for economic reasons).

69. Carter C. Price & Christine Eibner, *For States That Opt Out of Medicaid Expansion: 3.6 Million Fewer Insured and $8.4 Billion Less in Federal Payments*, 32 HEALTH AFFS. 1030, 1035 (2013).

70. *Id.*

71. OLSON, *supra* note 18, at 81.

72. *See generally* Allan Baumgarten & Katherine Hempstead, *Recession and Medicaid Budgets: What Are the Options?*, HEALTH AFFS. BLOG (Sept. 10, 2012), https://www.healthaffairs.org/do/10.1377/hblog20200908.169117/full/ (noting how additional healthcare funding is critical during a recession).

This counter-cyclical pattern is expressly prevalent now given the unemployment and health insurance related concerns surrounding Covid-19. The sharp reduction in economic activity resulting from the pandemic has resulted in millions of Americans losing their jobs and employer-sponsored health insurance.[73] A subset of those who find themselves uninsured as a result of losing their employer-sponsored health insurance plans may qualify for Medicaid if they reside in a state that expanded coverage.[74] However, given the precarious financial position in which many states find themselves, some may have difficulty enrolling in Medicaid even if they are eligible,[75] or they may even be ineligible if they reside in a state that did not expand coverage in the first place.

Over time, to address the funding issues endemic to Medicaid's counter-cyclical nature, Congress has passed legislation that has provisionally increased the FMAP. The purpose was to provide states with discretionary funding to prevent states from reducing access to Medicaid during times of economic duress.[76] It is also why policymakers used the FMAP to entice states to further expand Medicaid coverage under the PPACA. For these reasons, the FMAP is essential to Medicaid's funding structure and is a critical metric by which to safeguard Medicaid as a lifeline for the poor.

C. Medicaid's Funding Framework

The FMAP is calculated vis-a-vis the per capita income of states and the United States.[77] The FMAP is inversely related to state per capita income, meaning that states with a lower per capita income receive a higher federal match whereas states with a higher per capita income receive a lower federal match.[78] The minimum federal match a state may receive is 50%, and the

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73. M. Kate Bundorf et al., *Trends in US Health Insurance Coverage During the COVID-19 Pandemic*, JAMA HEALTH FORUM. (Sept. 3, 2021), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2783874?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=090321.

74. *Id.*

75. Samantha Artiga & Olivia Pham, *Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage*, KAISER FAM. FOUND. (Sept. 24, 2019), https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/.

76. Families First Coronavirus Response Act, Pub. L. No. 116–27, § 6008(a), 134 Stat. 178, 208 (2020) (codified as amended at 42 U.S.C § 1396) (Examples of such legislation include the Jobs and Growth Tax Relief Reconciliation Act of 2003, and most recently, the Families First Coronavirus Response Act (FFCRA). The FFCRA Act specifically increased the FMAP by 6.2 percentage points effective until the public health emergency ends.).

77. *See* CHRIS L. PETERSON, CONG. RSCH. SERV., RL43847, MEDICAID: THE FEDERAL MEDICAID ASSISTANCE PERCENTAGE (FMAP) 1 (2020).

78. *Id.*

maximum federal match is 83%.[79] Overall, the federal government pays a larger percentage of total state Medicaid expenditures than do states.[80]

Enrollment and total expenditure have a positive relationship because the costs to insure increase as more become eligible for Medicaid. Before the pandemic, states expected a comparatively stable enrollment growth rate of 6.3% for fiscal year (FY) 2020.[81] However, the fallout from Covid-19 has exacerbated economic conditions and left many vulnerable and without insurance.[82] Thus, many states predicted that enrollment would jump to a growth rate of 8.2% for FY2021 and beyond.[83]

States also projected significant budgetary shortfalls until 2022.[84] Given states must meet balanced budget requirements, states often resort to spending cuts to contain costs and reduce budget deficits. Considering the nature of the ongoing public health emergency facing the country, cutting Medicaid expenditures as a cost-containment measure is no longer viable as people need reliable healthcare now more than ever. Reducing a healthcare program during a pandemic not only fails the standard of care that Medicaid is to provide but also makes little economic sense in the long-term.

The FFCRA addressed rising costs by temporarily increasing the FMAP to 6.2%.[85] Yet this aid is estimated to offset only a fraction of projected budgetary shortfalls.[86] Thus, while a temporary increase in the FMAP was a useful step in the right direction, this temporary increase is not enough to address the budget and health crisis many states are currently experiencing.[87] Furthermore, a temporary increase in the FMAP is not sustaining as many

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79. *Id.*

80. *Id.* at Summary.

81. *See* Robin Rudowitz et al., *Medicaid Enrollment & Spending Growth: FY 2020 & 2021*, KAISER FAM. FOUND. (Oct. 14, 2020), https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2020-2021/.

82. *See* Bundorf et al., *supra* note 73.

83. Robin Rudowitz et al., *supra* note 81.

84. *See generally* Elizabeth McNichol & Michael Leachman, *States Continue to Face Large Shortfalls Due to Covid-19 Effects*, CTR. ON BUDGET & POL'Y PRIORITIES (July 7, 2020) https://www.cbpp.org/research/state-budget-and-tax/states-continue-to-face-large-shortfalls-due-to-covid-19-effects (noting that, states are expecting a cumulative shortfall of $555 billion between 2020–2022).

85. Families First Coronavirus Response Act, Pub. L. No. 116–27, § 6008, 134 Stat. 178, 208 (2020) (codified as amended at 42 U.S.C § 1396).

86. PETERSON, *supra* note 77, at 7.

87. *See generally* Aviva Aron-Dine et al., *Larger, Longer-Lasting Increases in Federal Medicaid Funding Needed to Protect Coverage*, CTR. ON BUDGET & POL'Y PRIORITIES (May 5, 2020), https://www.cbpp.org/research/health/larger-longer-lasting-increases-in-federal-medicaid-funding-needed-to-protect (explaining the need for an increase in FMAP to protect coverage).

states are consistently forecasting high unemployment rates throughout 2021.[88]

A long-term solution is necessary to address the worsening state deficits and healthcare needs that have resulted from the fallout of this pandemic. Medicaid covers millions of Americans who would otherwise be uninsured.[89] The vitality and efficacy of the program must be maintained. A permanent increase in the FMAP would ensure that states need not cut Medicaid spending amid the pandemic. Several states have already signaled the need for budget cuts to mitigate worsening economic conditions,[90] but a permanent increase in the FMAP would preclude states from cutting Medicaid spending that would be disastrous for those whom Medicaid insures.

State policymakers have urged Congress on a bipartisan basis to adopt and enact legislative efforts to increase the FMAP.[91] Increasing the FMAP serves a dual purpose that secures Medicaid funding while alleviating other budgetary pressures at the state level. Since an increase in the FMAP would reduce state Medicaid spending by the same amount provided by the federal government, states would be able to employ the elective funds for other purposes. Thus, increasing the FMAP not only poses positive implications for the salvation of state Medicaid programs, but an increase in the FMAP also relieves state budgets and provides for the protection of other state programs.

Indeed, there is substantive legislative history related to the FMAP for these reasons. However, a critical distinction between previous increases in the FMAP and the present need for an increase relates to context. Former increases in the FMAP ameliorated economic conditions that resulted from

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88. *See* CONG. BUDGET OFF., INTERIM ECONOMIC PROJECTIONS FOR 2020 AND 2021, at 14–15 (2020) (noting that unemployment is expected to average 16% in the third quarter).

89. *See* Huberfeld, *supra* note 68, at 432.

90. *See* Wesley Tharpe, *States*, *Localities Need More Federal Aid to Avert Deepening Budget Crisis*, CTR. ON BUDGET & POL'Y PRIORITIES (July 21, 2020), https://www.cbpp.org/blog/states-localities-need-more-federal-aid-to-avert-deepening-budget-crisis.

91. *See* Larry Hogan & Andrew Cuomo, *Governors' Letter Regarding Covid-19 Aid Request*, NAT'L GOVERNOR'S ASS'N (Apr. 21, 2020) https://www.nga.org/advocacy-communications/letters-nga/governors-letter-regarding-covid-19-aid-request/ (requesting a temporary increase in FMAP funding); *See* Beth Kidder & Jami Snyder, *NAMD Requests Congress Provide Additional COVID-19 Resources to States and Providers*, NAT'L ASS'N MEDICAID DIRS. (Apr. 13, 2020) https://medicaiddirectors.org/wp-content/uploads/2022/02/NAMD-Requests-Congress-Provide-Additional-COVID-19-Resources-to-States-and-Providers-updated_pdf.pdf; *See* Tracy Wareing Evans & Duke Storen, *Letter to Congress*, AM. PUB. HUM. SERV. ASS'N (Apr. 10, 2020) https://files.constantcontact.com/391325ca001/7e59b34b-1e83-433e-82bd-4522dff54285.pdf (requesting expanded aid for infrastructure and health services).

national crises and inherent issues to the economy.[92] Now, deteriorating national and state economic conditions stem from a public health crisis that has not only halted economic activity in a previously unseen way but has produced a crisis in which guaranteeing the security of Medicaid is more important than ever.[93] As such, a previous increase in the FMAP is no longer enough, and Congress should act to legislate a permanent increase in the FMAP.

II. A PERMANENT INCREASE IN THE FMAP

A. Previous Legislation that Increased the FMAP

Using the FMAP as a tool of healthcare security and economic recovery has been a key aspect of several pieces of previous legislation that provided state relief. The first instance in which the FMAP was increased as a tool of economic recovery was in the Jobs and Growth Tax Relief and Reconciliation Act of 2003 (JGTRRA).[94] Between 2001–2004, most state governments experienced severe fiscal crises that left states needing to abridge large budget deficits.[95] Since state budgets must balance, the precipitous decline in state revenues during this time led many states to cut spending to close large deficits.

While the JGTRRA was in large part focused on tax reform,[96] the legislation addressed the extraordinary state budget crises by providing states with $10 billion that increased the FMAP to prevent states from implementing aggressive cost-containment strategies that would have likely resulted in harsh reductions in Medicaid spending.[97] Though the passage of JGTRRA was at best contentious,[98] disagreements regarding the efficacy and intent of the legislation were not fixed with respect to the legislation's increase of the FMAP.[99] Interestingly, there were concerns regarding

92. Paul N. Van de Water, *Increasing Federal Medicaid Assistance Provides Effective Economic Stimulus*, CTR. ON BUDGET & POL'Y PRIORITIES (July 17, 2020), https://www.cbpp.org/blog/increasing-federal-medicaid-assistance-provides-effective-economic-stimulus.

93. *See* Bundorf et al., *supra* note 73.

94. Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108–27, § 401, 117 Stat. 752, 764 (codified as amended at 42 U.S.C. § 1396).

95. Laura Kalambokidis & Andrew Reschovsky, *States' Responses to the Budget Shortfalls of 2001–2004*, 48 CHALLENGE 76, 77 (2005).

96. *See* Susan Kalinka, *Highlights of the 2003 Jobs and Growth Tax Relief Reconciliation Act: Economic Stimulus or Long-Term Disaster?*, 64 LA. L. REV. 219, 219 (2004).

97. $10 billion was in general assistance. *Id.* at 264.

98. *Id.* at 219.

99. Jobs and Growth Tax Relief Reconciliation Act of 2003 § 401 (noting that there was no significant mention of the statute's temporary increase in the FMAP from the Committee on Ways and Means. Indeed, the few instances that the FMAP was specifically mentioned was in the original statute).

Medicaid's solidity due to the derivative implications the statute's tax reform would have on state budgets. In other words, tax increases and spending cuts at the state level posed serious deleterious effects for state fiscal stability and programs funded by states.[100]

In similar fashion, albeit the highly contentious tax reform, the American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased the FMAP by 6.2 percentage points from FY2009 to the first quarter of FY2011.[101] Furthermore, there was a provision that mandated that an additional percentage point increase be applied based upon the unemployment rate in the state.[102] The House Bill originally proposed a 4.9 percentage point increase in the FMAP,[103] plus additional aid provided for states with high unemployment rates.[104] Conversely, the Senate Bill proposed a 7.6 percentage point increase in the FMAP,[105] in addition to unemployment contingent increases.[106]

Both the House and Senate versions of the Bill also included certain maintenance of effort provisions such as ensuring that eligibility requirements were no more restrictive after the fact of receiving aid[107] and that local non-state governments did not pay a larger portion of state's nonfederal Medicaid expenditures after receiving federal aid.[108] In committee, it was decided that the FMAP would be increased by 6.2 percentage points, which is in keeping to the FMAP increase in the JGTRRA.[109]

Most recently, the FFCRA temporarily increased the FMAP by 6.2 percentage points as well.[110] Similar to the Bill variations of the ARRA, the House and Senate proposed different percentage point increases in the FMAP. The House initially proposed an 8.0 percentage point increase in the FMAP,[111] and the Senate version proposed a 6.2 percentage point increase in the FMAP.[112] Subsequently, the final statute increased the FMAP by

100. H.R. REP. NO. 108–94, at 88 (2003).

101. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111–5, § 5001(b), 123 Stat. 115, 497 (2009) (codified as amended at 42 U.S.C. § 1396).

102. *Id.* at § 5001(c)(1)(A)(i).

103. H.R. REP. NO. 111–16, at 757 (2009) (Conf. Rep.).

104. *Id.*

105. *Id.* at 758.

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.* at 759.

110. Families First Coronavirus Response Act, Pub. L. No. 116–127, § 6008, 134 Stat. 178, 208 (2020) (codified as amended at 42 U.S.C § 1396); *see also infra* note 112 (citing the Senate version of the bill).

111. H.R. 6201, 116th Cong. § 109 (2020).

112. H.R. 6201, 116th Cong. § 6008 (2020).

6.2 percentage points pursuant to the Senate version of the bill.[113] The final version of the Bill passed on a bipartisan basis to provide states with needed fiscal relief.[114] Thus, it may be gleaned that previous increases in the FMAP follow a similar pattern: across the board increases of 6.2 percentage points. The following draft statue, therefore, follows a similar pattern.

B. Draft Statute

In order to evaluate the viability of a permanent increase in the FMAP, it is necessary to describe the proposed amendment to the Social Security Act which would provide a permanent increase in the FMAP. The proposed amendment is described below.

42 U.S.C. § 1396d[115] is amended by adding subsection:

"(jj) Ensuring Medicaid Spending Security

(1) Definitions

(A) 'Federal Medical Assistance Percentage' as defined in 42 U.S.C. section 1396d subsection (b)

(2) The Federal Medical Assistance Percentage, as determined by subsections (b), (z), (aa), (cc), and (dd) of 42 U.S.C. § 1396d, determined for each state under section 1905(b) of the Social Security Act shall be permanently increased by 6.2 percentage points starting when the temporary increase in the FMAP as designated by the FFCRA ends.

(3) This amendment shall not increase the FMAP for those newly eligible populations as designated under subsection (y)"

113. Families First Coronavirus Response Act § 6008(a).

114. Press Release, House Committee on Appropriations, House Passes Families First Coronavirus Response Act (March 14, 2020), https://appropriations.house.gov/news/press-releases/house-passes-families-first-coronavirus-response-act.

115. *See* Social Security Act, 42 U.S.C. § 1396d(b) (1935) (Supp. 2018) (defining FMAP and listing Medicaid's other funding provisions).

> (4) States will receive FMAP increase irrespective of their Medicaid expansion status as it relates to the PPACA.

C. Explanation of Draft Statute

This Amendment, which for ease of reference shall be called the Medicaid Spending Security Act (MSSA), consists of one comprehensive amendment that would increase the FMAP by 6.2 percentage points[116] as it is determined for each state. The "Ensuring Medicaid Spending Security" part is divided among four parts. The first section defines the Federal Medical Assistance Percentage[117] as it is defined in the Social Security Act to maintain consistency of terminology of previous legislation that concerned the FMAP. This ensures additional FMAP spending will be a mere addition to the existing funding appropriated to states by the federal government.

The second paragraph increases the FMAP by 6.2 percentage points as it is determined among states. This paragraph predicates the increase upon the existing FMAP structure as it is presently determined in the existing statute because it is merely an addition to the amount states receive as opposed to a substantive amendment of the existing statute itself.[118] Furthermore, this paragraph also stipulates that the permanent increase takes effect when the present, temporary increase in the FMAP, as legislated by the FFCRA, ends.[119] This provision is to ensure there is not a lapse in

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116. Three previous legislative efforts to increase the FMAP did so by increasing the FMAP by 6.2 percentage points. Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108–27, § 401(a)(3), 117 Stat. 752, 765 (codified as amended at 42 U.S.C. § 1396); American Recovery and Reinvestment Act of 2009, Pub. L. No. 111–5, § 5001(b), 123 Stat. 115, 496 (codified as amended at 42 U.S.C. § 1396); Families First Coronavirus Response Act, Pub. L. No. 116–127, § 6008, 134 Stat. 208 (2020) (codified as amended at 42 U.S.C § 1396). This proposed legislation seeks to merely make the most recent increase in the FMAP permanent; thus, I suggest maintaining the original percentage.

117. The FMAP is most commonly referred to as the Federal "Medicaid" Assistance Percentage in common publications. *Commonly Used Abbreviations and Acronyms*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/reference-materials/reference-guide-to-federal-medicaid-statute-and-regulations/macpac-acronyms-list/ (last visited Dec. 3, 2022). For ease of reference, I maintain the usage of the Federal "Medical" Assistance Percentage in keeping with how it is referenced in the original statue.

118. These sections of the statute were included because these sections concern the ways in which the FMAP is specifically calculated among states with different per capita incomes, the FMAP as it relates to the PPACA, and the FMAP as it relates to Native Alaskan territory. *See* 42 U.S.C. § 1396(d)(b) (Supp. 2018) (defining FMAP).

119. Elizabeth Williams et al., *Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends*, KAISER FAM. FOUND. (May 10, 2022), https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuous-coverage-requirement-during-and-after-the-phe-ends/.

spending between the point at which the emergency-health crisis ends and the permanent increase in the FMAP begins.[120]

The third and fourth subsections may be thought of as provisions that remove ambiguities in the statute. The third section just explicitly states that the amendment does not affect the expansion population under the PPACA; states shall continue to be reimbursed for their expansion populations as described in subsection (y).[121] Moreover, the fourth section provides states with an increase in the FMAP regardless of whether the state expanded coverage under the PPACA.[122] This is due to two reasons. First, the FFCRA increased the FMAP consistent in such a way to aid states during the public-health crisis because the additional aid was conceived as assistance that was not to be contingent upon the expansion population—the additional aid was merely intended to help states. Second, and in keeping with the previous point, the increase in the FMAP is not to affect the reimbursement rates for the expansion population. Thus, the fourth section precisely describes what is implicitly alluded to—permanently increasing the FMAP by 6.2 percentage points is basic financial assistance to help certify that states do not reduce Medicaid spending after the economic fallout resulting from the public-health crisis.

The intentional result of the MSSA is to provide states with needed aid during a time in which many states have signaled they are facing precipitous budgetary shortfalls and risk reductions in Medicaid spending. This is to ensure that the federal government takes responsibility for guaranteeing that states will have the financial resources required to ensure healthcare for their most vulnerable populations. Since the additional aid is not to be coercive by any means, there should be little to say regarding Medicaid's status as a federal-state partnership. Part III presents an analysis of Medicaid's history as a federal-state partnership. This section will examine previous legislation related to Medicaid spending and Medicaid expansion, concluding with an explanation for the support to permanently increase the FMAP.

IV. MEDICAID AND FEDERALISM

A. Medicaid as a Federal-State Partnership

Considering the unique nature of the structure of the U.S. government, each citizen is both a citizen of the state in which they reside and a citizen of

120. *Id.*

121. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 2001, 124 Stat. 119, 271–272 (2010) (codified as amended at 42 U.S.C. § 1396(a).

122. *See id.*

the national government.[123] The implications of this dichotomy have posed interesting social-policy questions with respect to Medicaid. Policymakers often struggle with federalism's enhancing and impeding mechanisms when forming social policy.[124] Advocates for federalism view it as a means to protect states from political tyranny; opponents of federalism view it as a cumbersome system that hinders policymaking during the times in which a rapid policy response is most needed.[125]

Differing views regarding healthcare policy and Medicaid have been no different. A comprehensive national healthcare strategy faced strong headwinds among those who believed that heavily subsidized healthcare at the national level was an overreach of federal power.[126] The unsuccessful efforts to ameliorate the strident resistance to nationally subsidized healthcare resulted in a health insurance program that adhered strictly to the ideals of federalism.[127] From its inception, Medicaid was designed to be administered by both the state and federal government[128] as a means of cost control and size containment.[129] While Medicaid was initially conceived as the caboose to the Kerr-Mills program,[130] Medicaid was unique in that it addressed the latent inadequacies that were present in existing state-administered medical-assistance programs in a way that was more inclusive of state sovereignty.[131]

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123. K.C. WHEARE, FEDERAL GOVERNMENT 2 (4th ed. 1964).

124. *See* Richard P. Nathan, *Federalism and Health Policy*, 24 HEALTH AFFS. 1458, 1460–61 (2005).

125. *Id.* at 1458.

126. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 217 (1982) (stating that the National Health Insurance faced opposition from conservative factions and special-interest groups. Specifically, the American Medical Association rejected Medicaid in face of its financial interests. Therefore, a health insurance program that was only quasi-national was the next best alternative for policymakers who favored government subsidized health insurance).

127. Nathan, *supra* note 124, at 1459.

128. Medicaid's federal-state partnership would be apt to prevent outrageous growth in the program due to the communal fiscal due diligence that was imparted on states. Medicaid's federal-state financing mechanism did not prove to be as restrictive as designed, and Wilbur Mills later described Medicaid as the most expensive mistake of his career. *See* OLSON, *supra* note 18, at 56.

129. *See* Ralph A. Rossum, *The Politics of Medicare*, AM. POL. Q. 363, 364–65 (1973) for a detailed account of Medicare's influence regarding the origins of Medicaid. Wilbur Mills, the chairman of the House Ways and Means Committee in 1965, envisioned that Medicaid could be used to curtail Medicare costs by obviating from the need to potentially expand Medicare to include additional beneficiaries besides those over age 65.

130. The Kerr-Mills Program of Medical Assistance to the aged was meant to extend the Vendor Payments Program that provided matching grants to indirectly subsidize the healthcare of welfare recipients. Medicaid was conceived as an improved, more feasible extension of the Kerr-Mills program because it was a federal-state fiscal partnership that included nonelderly welfare recipients. *See* ROSE, *supra* note 23, at 15.

131. *See* DEP'T OF HEALTH, EDUC., & WELFARE, MEDICAL RESOURCES AVAILABLE TO MEET THE NEEDS OF PUBLIC ASSISTANCE RECIPIENTS 31 (1961).

Still, the federalist ideals axiomatic to Medicaid's institutional architecture have not lent it to orderly policy reform or orderly planning. Rather, the program has remained highly resistant to change.[132] While path dependence has remained a hallmark of Medicaid from the beginning, two-system pluralism has often stymied initiatives to further federalize the program.[133] Those who point to Medicaid's inability to provide the level of care that it is intended to deliver often cite the program's federalist-dependent nature as a root cause for inaction.[134] A critical point of contention has centered on the question of when the United States will join other nations in establishing a national healthcare system, but specific policies to address this dilemma remained elusive for some time.[135]

Relative opponents to federalism often highlight federalism's intricate and complex nature. Federalism is dynamic in the sense that one's power to influence policy is dependent upon where one has power. In other words, one's ability to implement change depends on whether a particular political faction is in power and whether the faction is in power at the state level, federal level, or both.

These instances of cyclicality, in which policy objectives alternate from time to time, is ubiquitous with respect to Medicaid's experience and history. The inherent feature of federalism oftentimes puts states at the forefront of

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132. Medicaid's federalist institutional architecture has created significant path dependence in the program because federalism creates a firewall by which there is a significant threat of veto power at multiple levels of government. *See* George Tsebelis, *Decision Making in Political Systems: Veto Players in Presidentialism, Parliamentarism, Multicameralism and Multipartyism*, 25 BRIT. J. POL. SCI. 289, 310, 316–17, 322 (1995).

133. There have been several efforts to further federalize and further curtail Medicaid throughout the program's legislative history. OLSON, *supra* note 18, at 48–50. Listing each legislative proposal that called for either reducing or increasing Medicaid spending throughout the program's legislative history would be too extensive of a list. A few examples of such efforts, though, are listed below.

In 1980, leading Democrats were calling for a reform of the federalist, anti-poverty system because it was deemed woefully ineffective at providing aid for the poor. Senator Daniel Patrick Moynihan of New York proposed increasing the benchmark of the minimum federal match from 50% to 90% in an effort to shift the onus of funding from the state to the federal government. 127 CONG. REC. 6102 (1981) (statement of Sen. Daniel Patrick Moynihan).

President Bush tried to resurrect Reagan-era Medicaid cuts, but his efforts were stymied by congressional Democrats. As a result, the Bush administration pushed for legislation that stipulated that medical provider donations would no longer qualify for federal matching reimbursements. The legislation met a harsh rebuke at a meeting of the National Governors' Association. Particularly, Florida Governor Florio said the Bush administration was directly trying to alter Medicaid in a way that would "cause great hardships to our people." Lisa B. Ahlburg, CSR, *National Governors' Association Plenary Session*, NAT'L GOVERNORS'ASS'N (Aug. 20, 1991) https://www.nga.org/wp-content/uploads/2021/03/1991NGAAnnualMeeting.pdf.

134. Nathan, *supra* note 124, at 1458.

135. The PPACA is often cited in the literature as being the first successful, mainstream effort to federalize Medicaid at the national level since Medicaid was first legislated in 1965. *See* Huberfeld, *supra* note 68, at 436–53.

cumulative policies that aim to make Medicaid more available and accessible for a wider scope of the population.[136] Federalism is unique because it provides states with a mechanism to take matters into their own hands when the federal government is not receptive to implementing policy changes. Such laboratories of the state were extolled by Justice O'Connor during the Rehnquist Court's revival of federalism.[137]

Nonetheless, federalism also provides a mechanism for states to obviate from embracing changes that would make Medicaid more accessible to a wider scope of the population, and these people are oftentimes worse off than their counterparts residing in states that expanded Medicaid funding and eligibility.[138] Furthermore, the federal government often has limited tools in its political toolkit to entice states to support political changes they are hesitant to adopt. The result is a constellation of programs that oftentimes are not reflective of the needs of people who are most likely to be affected by the implementation, or lack thereof, of such social policies.

Therefore, efforts to streamline the Medicaid policies of each state have often been difficult to implement.[139] A useful tool that the federal government has used, when federal policymakers are feeling proactive, has been to leverage the FMAP to entice states to adopt more generous Medicaid policies.[140] Yet, this use of the FMAP has not occurred without growing pains. The FMAP has frequently been seen by progressive policymakers as a strength of the program because of its ability to influence policy at the state level. Nevertheless, the FMAP may also be viewed as an innate weakness of the program because the federal-state partnership nearly guarantees that the depth and level of funding will be disparate among states.[141]

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136. President Reagan's tax cuts accompanied a pronounced recession that left millions unemployed and resulted in millions losing their employer-sponsored health insurance. Several states began to reverse course with respect to previous Medicaid cuts in an effort to expand coverage. Such efforts to expand Medicaid included first-time efforts to legislate health insurance programs for the indigent in Florida, Georgia, South Carolina, and Texas. *See* SOUTHERN REGIONAL TASK FORCE ON INFANT MORTALITY: AN INVESTMENT IN THE FUTURE—LEGISLATIVE STRATEGIES FOR MATERNAL AND INFANT HEALTH 21 (1985).

137. *Gregory* is often cited as a case that initiated the efforts of the Rehnquist Court to hear cases concerning issues as they related to federalism. In this case, Justice O'Connor famously described federalism as espousing principles of "dual-sovereignty." Gregory v. Ashcroft, 501 U.S. 452, 457–58 (1991); United States v. Lopez, 514 U.S. 549, 581 (1995) (Kennedy, J., concurring) (writing that "[s]tates may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear").

138. *See* Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KFF (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

139. *See* Tsebelis, *supra* note 132, at 318.

140. *See* OLSON, *supra* note 18, at 53.

141. Since the percentage of funds expended by the FMAP is directly related to the per capita income of each state, and each state theoretically has a different per capita income, states receive disparate

Given the complexity of Medicaid's origins in federalism, efforts to expand Medicaid have been at best contentious. The individualistic preferences endemic to the cultural makeup of the United States and the derivative jurisprudential approach that oftentimes follows has resulted in several legal challenges that concern Medicaid and the FMAP. The success of such efforts is varied, but their respective effects on Medicaid's legal chronology remains a reminder of the distinct role federalism occupies in Medicaid's discourse and the funding states receive.

B. Federalism and the Legislative History of Medicaid

While the Rehnquist Court made federalism a cornerstone of its jurisprudential agenda,[142] the Roberts Court for some time had been relatively nontransparent with respect to its feelings towards federalism. A prominent instance in which the Roberts Court decided on a case concerning an issue of federalism was in *Bond v. United States*.[143] In *Bond*, it was decided that a criminal defendant indeed had the right to question the constitutionality of the law under which one is charged through posing Tenth Amendment concerns.[144] Justice Kennedy, writing the majority opinion, reiterated the dicta of the Rehnquist Court's federalist ideals.[145] The Court's decision in *Bond* was indicative of its attitude towards federalism because it highlighted federalism as a system that could protect individual rights, in addition to states' rights.

In conjunction, another case decided by the Roberts Court, *Arlington Central School District Board of Education v. Murphy* further illustrates the Roberts Court's view of federalism, specifically with respect to the spending power. The majority in *Arlington* found that it was necessary for the *Dole* test to provide clear notice of the conditions of funding so that states could

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funding. *How Do States Pay for Medicaid?*, PETER G. PETERSON FOUND. (Apr. 26, 2022), https://www.pgpf.org/budget-basics/budget-explainer-how-do-states-pay-for-medicaid#:~:text=Each%20state's%20Medicaid%20expenditures%20for,medical%20assistance%20percentages%20(FMAP).

142. In addition to numerous noteworthy cases that reasserted the ideals of federalism, and the court striking down 24 federal laws and 25 state and local laws between 1994 and 2000, the Rehnquist Court initiated a movement that sought to reform normative jurisprudential views regarding the role of federalism in ensuring state sovereignty. *See* Huberfeld*, supra* note 68, at 455–57. Specifically, the Rehnquist Court viewed federalism as a judicial safeguard that serves as a check against congressional and executive power. *Id.*at 457.

143. Bond v. United States, 564 U.S. 211, 214 (2011).

144. *Id.* at 225–26.

145. *Id.* at 221 (noting that "[f]ederalism has more than one dynamic . . . [and] preserves the integrity, dignity, and residual sovereignty of the States").

wholly understand the implications of accepting the funds.[146] Redefining the interpretation of the *Dole* test language in this way narrowed the scope of the spending power's perceived ambiguity, which resulted in states' rights being more protected than originally conceived.[147]

While both *Bond* and *Arlington* provide context with respect to the Roberts Court's interpretation of federalism, the prominent legal challenge in *NFIB v. Sebelius* specifically concerned Medicaid. Though *NFIB v. Sebelius* challenged more than the constitutionality of Medicaid's expansion,[148] the most notable legal challenge Medicaid faced as it relates to the FMAP concerned the spending power.[149] Chief Justice Robert's Medicaid ruling narrowed the scope of the PPACA by changing the Medicaid expansion's mandate to an opt-in, a triumphant success among those who championed the extolled virtues of federalism with respect to policymaking. Nevertheless, the ruling was much more significant than a repudiation of an incentive system intended to universally expand Medicaid coverage.[150] Rather, the defeat of the federal government's plan to further federalize Medicaid was rejected as being incongruent with Medicaid's original scheme as a health insurance program that offered states immense autonomy with respect to its administration.[151]

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146. Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy, 548 U.S. 291, 296 (2006) (citing Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17 (1984)).

147. In *Arlington*, Justice Alito wrote for the majority and indicated that the *Dole* test required "clear notice" for the implications of a spending decision so that states fully understood the terms of the agreement when states opt to accept federal funds. *Id.*

148. In addition to claiming that the PPACA's Medicaid expansion was unduly coercive, *National Federation of Independent Business v. Sebelius* also challenged that the individual mandate exceeded Congress's authority under the Commerce Clause and that the employer mandate unnecessarily interfered with state sovereignty. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 540 (2012).

149. The Spending Power is listed in Article I, Section 8 of the Constitution and provides that "Congress shall have Power To . . . provide for the common Defence and general Welfare of the United States; . . . ." *See* U.S. CONST. art. I, § 8, cl. 1.

The PPACA's Medicaid expansion cited the Spending Power as providing the basis for its efforts to unilaterally expand Medicaid as helping to ensure the "general Welfare" of the states. Given that Medicaid's expansion was to be funded through increasing the federal match that states received, the FMAP was exercised as a use of Congress's authority under the spending power. While Medicaid's expansion was eventually deemed to be coercive and unconstitutional, the court's decision nevertheless posed important implications with respect to the federal government's efforts to further subsidize Medicaid via increasing the FMAP. *See* Huberfeld, *supra* note 68, at 465.

150. Chief Justice Roberts, writing for the majority, emphasized that states must be provided with a "genuine choice" with respect to accepting or rejecting federal funding for a given purpose. *Nat'l Fed'n. Indep. Bus*., 567 U.S. at 588. In *National Federation of Independent Business v. Sebelius*, it was argued that states did not have such a choice because the PPACA was mandating that states would lose all federal funding associated with Medicaid in the event that the state in question refused to expand Medicaid. *Id.*

151. *See generally Medicaid*, *supra* note 13 (providing an overview of the health insurance program).

Specifically, opponents to Medicaid's expansion cited that expansion mandates were unconstitutionally coercive as written.[152] It was decided that under the spending power, Congress did not have the ability to withhold Medicaid funding from states that did not expand coverage.[153] Many found this ruling surprising[154] given the cooperative nature of federalism had been conceived for some time as a shared partnership between states and the federal government whereby policy goals could be achieved through additional spending or possible preemption.[155] Thus, *NFIB v. Sebelius* identified coercion linked to the spending power as being a means for the federal government to essentially circumvent the limit on its power.

The implications of this decision were far reaching with respect to Medicaid but also set an undertone concerning what the federal government could achieve in regard to healthcare policy.

As a result, states that were not interested in expanding Medicaid prevailed in their desire for limited interference in their respective Medicaid programs but not without a cost. States that did not expand coverage likewise did not receive an enhanced federal match. The derivative financial effects of receiving less federal funding from the FMAP have become more pronounced following the onset and aftermath of Covid-19. Considering the precarious financial situation in which many states currently find themselves, increasing the federal match is now more necessary than ever. Moreover, while the most recent issue concerning the FMAP was litigated at length in *NFIB v. Sebelius*, a permanent increase in the FMAP to address worsening state budgets is altogether different given the context of the public-health crisis.

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152. *Nat'l Fed'n Indep. Bus.*, 567 U.S. at 542, 575.

153. The ruling in *National Federation of Independent Business v. Sebelius* was the first time in which the Supreme Court found an instance in which the Spending Power was unduly coercive and was a significant shift in Spending Power jurisprudence. In her dissenting opinion, Justice Ginsburg highlighted the novelty of the decision as being the first instance the Spending Power was deemed to be coercive. *Id.* at 625.

154. Aside from being the first instance that the Spending Power was deemed unduly coercive, the decision in *National Federation of Independent Business v. Sebelius* was furthermore surprising to some for the reasoning behind the decision. In his majority opinion, Justice Roberts interprets the PPACA's proposed Medicaid expansion as a new federally funded grant program as opposed to an amendment of an existing Medicaid program. The implications of this interpretation result in the explication that the federal government sought to withhold funds from an existing program to entice states to adopt a new program. Yet, contenders to this interpretation cite that the PPACA's Medicaid expansion was merely an amendment to the existing program, and therefore well within the scope of the Spending Power's ability to provide for, or withhold, funding based on states' willingness to comply with new regulations. *See id.* at 625–26.

155. New York v. United States, 505 U.S. 142, 167 (1992) (citing Arkansas v. Oklahoma, 503 U.S. 91, 101 (1992)).

C. Legal Basis for a Permanent Increase in the FMAP

Given temporarily increasing the FMAP has longstanding precedent in statutory law,[156] permanently increasing the FMAP, while different in longevity, is none together very different with respect to its legality. Here, permanently increasing the FMAP would be constitutional under the spending power,[157] more specifically under the *Dole* framework*,* despite the decision following *NFIB v. Sebelius* concerning the PPACA's Medicaid expansion.

The determinative question following *NFIB v. Sebelius* that would call into question the constitutionally of MSSA concerns whether permanently increasing the FMAP is in any way too coercive for states. More specifically, whether the conditions under which a permanent increase in the FMAP is predicated results in states feeling as though they must accept the proposed terms of the statute without a true choice in the matter.

Under the FFCRA, states receiving a temporary increase in the FMAP may not implement new eligibility restrictions nor could states rescind coverage of Medicaid enrollees in the middle of the pandemic.[158] In other words, maintenance of effort restrictions were applied to ensure that states did not accept the temporary funding provided by the FMAP and henceforth use the funding for an altogether different purpose than ensuring that states had the wherewithal to fund their respective Medicaid programs.

Likewise, the MSSA would include similar maintenance of effort requirements that would ensure that states did not implement new policies that would be incrementally more restrictive following their acceptance of the federal funding pursuant to the permanent increase in the FMAP. Given the MSSA does not contain any provisions requiring states to further expand eligibility, as was legislated under the PPACA's ill-fated Medicaid expansion, including maintenance of effort requirements would not be deemed unduly coercive. This conclusion is reached due to not only the longstanding record of maintenance of effort requirements endemic to Medicaid's legislative history,[159] but also due to significant differences

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156. *See* Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108–27, § 401(a), 117 Stat. 752, 764 (codified as amended at 42 U.S.C. § 1396); American Recovery and Reinvestment Act of 2009, Pub. L. No. 111–5, § 5001, 123 Stat. 115, 496 (codified as amended at 42 U.S.C. § 1396); Families First Coronavirus Response Act, Pub. L. No. 116–127, § 6008, 123 Stat. 178, 208 (2020) (codified as amended at 42 U.S.C § 1396).

157. *See New York*, 505 U.S. at 158 (quoting U.S. CONST. art. I, § 8, cl. 1).

158. Families First Coronavirus Response Act § 6008(b)(1).

159. Maintenance of effort requirements were implemented each time states received additional funding via the FMAP. *See* Jobs and Growth Tax Relief Reconciliation Act § 401(a); American Recovery and Reinvestment Act § 5001(f)(1)(A); Families First Coronavirus Response Act § 6008(b).

between the application of the spending power in this instance compared to the spending power as applied under the PPACA's original Medicaid expansion.[160] Specifically, the MSSA fulfills all four limitations imposed under the *Dole* framework.

1. The General Welfare

The General Welfare Clause in Article I of the Constitution, has been interpreted differently since its conception as first written,[161] but its established interpretation has been conceived as a broad authority that provides deference to Congress to expend public funding for the public benefit. This view was cemented in the ruling following *United States v. Butler*.[162] In *Butler*, the principal question was whether provisions of the Agricultural Adjustment Act of 1933 clashed with the U.S. Constitution. The Court reasoned that the tax imposed on processors of farm products was not a true tax, but nevertheless the Court viewed the subject of taxation and derivative expenditures in a positive light.[163]

The Court later applied its holding in *Butler* to *Helvering v. Davis*.[164] Here, the Court went even further by defining its understanding of "Welfare"

160. The majority opinion in *National Federal of Independent Business v. Sebelius* found the exercise of the spending power unduly coercive because Medicaid's expansion was, first, essentially conceived as an additional grant program instead of an amendment to the existing Medicaid program. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 625 (2012) (Ginsburg, J., dissenting in part). Second, Medicaid's expansion was deemed unforeseeable by states when they accepted the terms of the original conditional funding agreement. *Id.* Third, the potential loss of funding was so large that it posed to irrevocably harm states' financial interests. *Id.* Due to these reasons, the spending power was deemed unduly coercive, and therefore Medicaid's expansion was invalidated. *Id.* MSSA applies the spending power in the way that it has been applied in legislation that temporarily increased the FMAP whereas funding is contingent upon maintenance of effort requirements. Here, the Medicaid program itself is not being amended in any significant way. Rather, the amount of funding that states receive is being amended, and it is being amended in states' favor. Considering that states have agreed to the contractual terms of temporary increases in the FMAP without claims of coercion, it is hardly reasonable that states would now object to maintenance of effort requirements in exchange for a permanent increase in federal funding via the FMAP. *See generally* Shane Hoffmann, *Individual Mandates, Take Two: Incentivizing State-Based Individual Health Insurance Mandates Under the Spending Power*, 2011 WIS. L. REV. 827, 852 (2011) (addressing the constitutionality of a proposed draft statute that would provide states with the option under PPACA).

161. James Madison and Alexander Hamilton famously disagreed regarding the interpretation and scope of the general Welfare clause under the spending power. Madison held a relatively narrow interpretation of the clause in which Congress was authorized to spend solely when it took advantage of other powers provided in Article I of the Constitution. Conversely, Hamilton believed that spending efforts that were at least tangentially related to the powers enumerated to the Congress under Article I of the Constitution could be considered for the purpose of ensuring the general Welfare of the nation. *See* Henry St. George Tucker, *The General Welfare*, 8 VA. L. REV. 167, 168 (1922).

162. United States v. Butler, 297 U.S. 1, 64 (1936).

163. *Id.*

164. Helvering v. Davis, 301 U.S. 619, 641 (1937).

in general welfare.[165] The resultant broad interpretation of the meaning of general welfare provided Congress with the ability to discern judgment with respect to passing legislation to achieve specific objectives. Considering this framework, permanently increasing the FMAP provides for the general welfare due to Congress's longstanding jurisdiction to distribute funds in accordance with Medicaid.[166] In addition, permanently increasing the FMAP would ensure that states have the necessary funding to maintain their Medicaid programs during a time in which the funding for these programs is under threat. Considering the far-reaching necessity of healthcare among the population, permanently increasing the FMAP provides for the comprehensive well-being of all persons receiving Medicaid benefits through ensuring the vitality of the program at a time in which funding is threatened.

2. Unambiguous Conditions

Permanently increasing the FMAP under the spending power involves a quasi-contractual, conditional-funding arrangement by which the federal government would provide states with needed funding under the pretense that states fulfill some obligation as a prerequisite. An absence of ambiguity in this instance would entail that states are fully aware of the maintenance of effort requirements that would ensure that states do not rescind coverage or amend eligibility requirements after the fact of receiving aid from an increased federal match.

In *Arlington*, the Court explained unambiguous conditions as providing a "clear notice" to states concerning the proposed congressional act in question to ensure that states were forthwith aware of the implications of accepting federal funding.[167] Here, the MSSA would provide clear notice that states accepting funding pursuant to the heightened federal match is contingent upon states maintaining specific consistent eligibility levels which were in keeping with previous eligibility standards.

Moreover, the implication of accepting funding provided by the newly increased FMAP under the MSSA would not be unduly coercive as to

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165. *Id.* at 640 ("The conception of the spending power advocated by Hamilton and strongly reinforced by Story has prevailed over that of Madison, which has not been lacking in adherents. Yet difficulties are left when the power is conceded. The line must still be drawn between one welfare and another, between particular and general. Where this shall be placed cannot be known through a formula in advance of the event. There is a middle ground or certainly a penumbra in which discretion is at large. The discretion, however, is not confided to the courts. The discretion belongs to Congress, unless the choice is clearly wrong, a display of arbitrary power, not an exercise of judgment.").

166. 42 U.S.C. § 1304 (stating that "[t]he right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress").

167. Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy, 548 U.S. 291, 296 (2006).

preclude states from accepting the terms of the proposed amendment without choice.[168] Rather, the MSSA merely seeks to provide states with additional funding so long as they maintain their current eligibility levels.[169] In other words, the proposed amendment seeks from states nothing more than to maintain business as usual while providing further support to ensure states are not relegated to rescind coverage at a time when many need health insurance more than ever.

Thus, MSSA satisfies the unambiguous condition limitation under the *Dole* framework. The structure of MSSA mirrors that of previous legislation that increased the FMAP in which parallel maintenance of effort requirements were implemented[170] by which no serious claims of unambiguity were advanced by the courts. Furthermore, MSSA satisfies the requirement of clear notice, as held in *Arlington*,[171] by making explicit that accepting a permanent increase in the FMAP is contingent upon states' respective maintenance of effort provisions.

3. Federal Interest

The maintenance of effort conditions linked to the proposed amendment "might be illegitimate if they are unrelated 'to the federal interest . . . .'"[172] In *Dole*, Justice Rehnquist alluded to the fact that funding mechanisms or legislation may be illegitimate if they are unrelated to the federal interest.[173] In *Dole*, the question at hand was the issue of drunk driving accidents that disproportionately affected young people. Therefore, Congress addressed the issue through means of uniformity at the national level by mandating a national drinking age to reduce instances of drunk driving accidents.[174]

Furthermore, the PPACA sought to address the federal interest with respect to healthcare through the individual mandate. Legislating that individuals insure themselves relates directly to the federal interest by

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168. This is primarily because under MSSA, states do not risk losing funding. *See* Huberfeld, *supra* note 68, at 451.

169. *See Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html (last visited Dec. 3, 2022).

170. *See supra* note 8.

171. *See Arlington Cent. Sch. Dist. Bd. of Educ.*, 548 U.S. at 296.

172. South Dakota v. Dole, 483 U.S. 203, 207–08 (1987) (quoting Massachusetts v. United States, 435 U.S. 444, 461 (1978) (plurality opinion)).

173. *Id.* ("[C]onditions on federal grants might be illegitimate if they are unrelated 'to the federal interest in particular national projects or programs.'") (quoting *Massachusetts,* 435 U.S. at 461).

174. *Id.* at 208 (noting federal funding for highways was predicated upon states adopting the new drinking age to address the interstate aspects of drunk driving).

minimizing the burden that the uninsured have on the economy.[175] Mitigating negative externalities for the purpose of promoting economic prosperity at the national level was a direct federal interest envisioned in the passage of the PPACA and with respect to securing health insurance through Medicaid, more specifically. Although Medicaid's expansion was struck down by the Court, the negative effects of vast numbers of persons being uninsured has at least tangential economic ramifications at the national level. Thus, securing additional funding for states to use to bolster state Medicaid programs fulfills a national interest by mitigating the economic risks associated with numerous persons being uninsured.

4. Constitutionality of Proposed Amendment

The final limitation of the *Dole* framework relates to the constitutionality of the conditions of funding imposed on the states. The question at hand is whether the Tenth Amendment limits Congress's ability to permanently increase the FMAP pursuant to maintenance of effort requirements.[176] Determining an underlying violation of state sovereignty gets at the crux of the question of whether stipulating funding on maintenance of effort requirements raises Tenth Amendment concerns. Here, the Tenth Amendment does not preclude Congress from stipulating funding on maintenance of effort requirements because, as in *Oklahoma v. Civil Service Commission*, there is "no violation of the State's sovereignty because the [s]tate could . . . adopt 'the simple expedient' of not yielding to what she urges is federal coercion."[177] In other words, relatively mild encouragement of adopting maintenance of effort requirements in exchange for increased federal funding from the FMAP does not necessitate coercion to accept the funding. Merely, MSSA seeks to help states in their time of need as opposed to urging states to amend their Medicaid programs in some way pursuant to receiving funding.

Challenging MSSA would most likely rely on some theory of coercion. Though the only time the Court applied a theory of coercion was in its ruling in *NFIB v. Sebelius*, a potential claim of coercion theory may follow that states may not safely reject federal funding at a time in which state budgets are facing precipitous funding challenges. However, this line of thinking is

175. *See generally* 42 U.S.C. § 18091 (2018) (noting Congress's findings regarding the uninsured and the economy).

176. 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.").

177. *Dole*, 483 U.S. at 210 (quoting Oklahoma v. Civ. Serv. Comm'n, 330 U.S. 127, 143–44 (1947).

plagued for a significant reason: Medicaid already functions as a conditional funding arrangement[178] under given current maintenance of efforts. Considering that it has not been coercive for states to condition temporary increases in the FMAP to maintenance of effort requirements, it can hardly be so coercive as to predicate maintenance of effort requirements on a permanent increase in the FMAP.

Furthermore, MSSA provides states with a significantly less dire decision than the Medicaid expansion of the PPACA proposed because states are not at risk of forfeiting any funding for their Medicaid programs. In addition, states are not being asked to relax nor strengthen eligibility requirements. Instead, states are merely being asked to maintain current eligibility standards in view of receiving additional funding. For these reasons listed, the Medicaid Spending Security Act cannot be considered to encroach on states' Tenth Amendment rights, nor could the proposed amendment be considered to require states to adopt an unconstitutional amendment.

CONCLUSION

One of the most important lessons the United States can learn from Covid-19 is the necessity for a well-funded health insurance safety net and a realization of the derivative financial implications of public-health funding at the state level. Indeed, the unprecedented pandemic has resulted in people losing their employer-sponsored health insurance, has exacerbated the healthcare inequality between those with means and those without, and relegated states to make difficult decisions between programs that will continue to be fully funded and those that will not. This Article proposes a solution to mitigate the repercussions Covid-19 has had on state budgets while ensuring the security of the country's principal health insurance safety net at a time in which such security has never been more critical. Congress should act swiftly to pass a new statute, like MSSA, that will permanently increase the FMAP to provide states with desperately needed fiscal relief.

MSSA is modeled after previous temporary increases in the FMAP that were passed to provide states with similar relief. Moreover, permanently increasing the FMAP does not impose unambiguous, coercive conditions upon states as states are not mandated to expand coverage. Rather, states are simply being provided with additional aid predicated upon their ability to sustain maintenance of effort provisions, which are present in previous

178. 42 U.S.C. § 1396–1 ("The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.").

versions of Medicaid legislation that temporarily increased the FMAP. So too, this comment finds that a permanent increase in the FMAP is constitutional under the *Dole* framework. Congress need not let states reach the point at which reductions in state Medicaid spending are imminent. Rather, Congress should act decisively to ensure the health security of low-income individuals and the stability of state budgets amid a national convalescence following Covid-19.