FISCAL WAIVERS AND STATE "INNOVATION" IN HEALTH CARE

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ABSTRACT

This Article describes how the Department of Health and Human Services (HHS) has used fiscal waiver authorities—delegated power to alter federal payments to states under Medicaid and the Affordable Care Act (ACA)—to influence state health policy choices. It highlights how the agency uses its fiscal waiver authorities to shape which reforms states choose to pursue, in some cases inspiring genuine state innovation and in others encouraging states to adopt reforms favored by HHS or discouraging states from adopting disfavored reforms. Moreover, while HHS has sometimes influenced state policymaking in ways that further the substantive goals of the ACA and Medicaid (such as by facilitating reinsurance programs that make coverage more affordable), at other times it has done so in ways that undermine those goals (such as by incentivizing states to cut benefits and eligibility or by stifling state single payer and public option experiments).

The Article theorizes fiscal waiver authorities as a double-edged tool from the perspectives of health policy, federalism, and administrative law. Fiscal waiver authorities are a distinctively valuable tool from the standpoint of health policy because they use delegated scorekeeping to overcome the "tyranny of the budget" and its adverse effects on health reform, and these authorities further the core federalism value of experimentation when used to inspire states. But the lack of transparency currently surrounding the agency's use of hidden executive conditions on waiver approvals makes fiscal waiver authorities ripe for leveraging and abuse, raising health policy, federalism, and administrative law concerns.

The Article concludes by offering concrete prescriptions for the next phase of health reform, which is poised to rely heavily on either existing fiscal waivers or new ones. The Article recommends that HHS bring greater transparency to its use of fiscal waiver authorities in Medicaid and the ACA and cautions that if the agency does not do so then courts may force such transparency on it by way of non-delegation, federalism, or administrative law doctrine. The Article also suggests that fiscal waiver authorities in future federal health reform legislation be structured as "Accountable Innovation Grants," tailored in ways the Article suggests to unleash health-promoting state innovation while resisting abuse.

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INTRODUCTION

The interaction between fiscal federalism and state innovation has received insufficient attention in prior scholarship.[1] This Article is the first to focus on a particularly important legal tool in this interaction that is reshaping both federalism and health policy in the real world today: fiscal waiver authorities in health care. Fiscal waiver authorities are statutory delegations of discretion to agencies to alter the terms of the fiscal relationship between the federal government and states from a legislative baseline. The Article describes how the Department of Health and Human Services (HHS) has used fiscal waiver authorities in Medicaid and the Affordable Care Act (ACA) to influence state health policy choices, draws general implications for law and legal scholarship, and develops specific prescriptions for courts, HHS, and Congress.

The Article's study of fiscal waiver authorities in health care demonstrates that an agency can use such authorities to influence which reforms states pursue in two distinct but overlapping ways: inspiring and steering. Inspiration entails an agency incentivizing state development of novel reforms, spurring the "laboratories of democracy." Steering entails an agency directing state behavior through implicit or explicit conditions on fiscal waiver approvals, just as Congress steers states when it creates legislative conditions on spending awards for states.

Fiscal waivers' use to inspire and induce state policymaking in health care implicates two primary sets of issues. The first set of issues stems from the way the delegation of discretion over spending from Congress to HHS impacts how the federal government decides whether to invest in health and health care. Here fiscal waivers appear in a positive light. Scholars increasingly appreciate how scorekeeping rules in the congressional budget process have held back and warped health reform.[2] Fiscal waivers are a distinctive and valuable tool in health policy because they reduce these scorekeeping barriers. They delegate the task of measuring a state reform's financial costs and benefits to the agency at the time it considers the waiver request, rather than to congressional scorekeepers at the time legislation is considered, making it easier to identify and unlock federal funds for worthwhile health investments.

Delegating discretion over spending on states from Congress to HHS raises a second set of issues relating to the way HHS exercises that discretion. HHS can use its power to deny lawful waivers or sculpt payments to states through waivers, thereby shaping states' financial incentives. Such steering can be fraught. HHS can encourage states to cut benefits

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[1] *See* Robert Schapiro, *States of Inequality: Fiscal Federalism, Unequal States, and Unequal People*, 108 CALIF. L. REV. ____ (forthcoming 2020) ("We have concentrated too much on constitutional doctrine and not enough on money."); David Super, *Rethinking Fiscal Federalism*, 118 HARV. L. REV. 2544, 2629 (2005) (calling for greater attention in federalism scholarship to fiscal issues).

[2] William M. Sage, *No, the ACA Isn't "Unconstitutional": Ends and Means In A Dysfunctional Democracy*, Health Affairs Blog, December 19, 2018 (using "tyranny of the budget" as shorthand for stifling effect of budget rules on health reform); William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, J. L. Med. & Ethics 434 (2020); Timothy M. Westmoreland, *Invisible Forces at Work: Health Legislation and Budget Processes,* in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 873 (I. GLENN COHEN, ALLISON K. HOFFMAN & WILLIAM M. SAGE EDS. 2017) (budget process rules have shaped health reform); William M. Sage, *Adding Principle to Pragmatism: The Transformative Potential of 'Medicare for All'*, 2 n.5, 5–9 (October 2019) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3387120 (describing importance of "tyranny of the budget" in shaping health reform).

and eligibility by molding their incentives; the Trump Administration has sought to use fiscal waivers in this way.

Moreover, the agency can influence states through hidden conditions on waiver awards, that is, conditions that are not necessarily public and not necessarily written that a state must satisfy in order to obtain approval of its waiver application. While only one state to date has challenged the use of hidden conditions on fiscal waivers in a lawsuit it eventually dropped, the threat of future such challenges leaves current fiscal waiver practice legally vulnerable on federalism, non-delegation, and administrative law grounds.

Ultimately, the Article endorses fiscal waivers in theory for their distinctive ability to circumvent the tyranny of the budget but calls for close scrutiny of their use to influence state policy choices in practice. This means scrutiny not just of agency decisions approving states' fiscal waiver requests but also, and especially, scrutiny on agency decisions denying such requests (including conditions the agency puts on approval).

Fiscal waiver authorities are not just an abstract concept. They are already a driving force in health care. The federal government's $1.38 trillion in health care spending annually represents 38% of costs nationwide.[3] (This share will only grow, and the federal government would pay 100% of Americans' health care costs (accounting for 18% of GDP) under prominent "Medicare for All" proposals.)[4] The Trump Administration has leveraged this fact to use fiscal waiver authorities to drive its agenda, pressuring states to cut benefits and eligibility in Medicaid and the ACA with the promise of a share of the resulting federal savings.[5] Indeed, all but one "state innovation waiver" granted to states under the ACA to date has been stimulated by states' desire for increased federal funding.[6] Yet fiscal waiver authorities have been ignored in legal scholarship on the very "big waiver" provisions in which they play a load-bearing part, which has continued an unfortunate trend in legal scholarship to focus on regulatory matters to the exclusion of fiscal matters.[7]

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[3] *See infra* nn. 162 to 169 and accompanying text (breaking down federal role in health care spending). This number reflects an average because the federal government shoulders a much larger fraction of medical costs in some states than others. *See* Schapiro, *States of Inequality*, *supra* note 1 (problematizing this fact).

[4] *See* Medicare for All Act of 2019, S. 1129, 116th Cong. (2019) (universal national coverage bill proposed by Senator Sanders); Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019) (universal national coverage bill proposed by Representative Jayapal); U.S. National Health Expenditure as Percent of GDP from 1960 to 2019, STATISTA, https://www.statista.com/statistics/184968/us-health-expenditure-as -percent-of-gdp-since-1960/ (describing health care as share of gross domestic product).

[5] E.g. Abby Goodnough, *Trump Administration Unveils a Major Shift in Medicaid*, NY Times at A21 (Jan. 30, 2020); Robert Pear, *Trump Administration Approves Work Requirements in Utah*, NY Times at A20 (Mar. 21, 2019). On the legal authorities and reforms behind these headlines, *see infra* Part II.A.2 & II.B.2.

[6] *See infra* nn. 36 to 39 and accompanying text (explaining role of fiscal waiver authority in state reforms under ACA). The fiscal waiver authority has been a driving force in Medicaid as well. *See infra* Part I.B (explaining significance of Medicaid's fiscal waiver authority).

[7] The leading article on "big waiver" is illustrative in that it offers a careful, detailed description of the ACA's "State Innovation Waiver" provision, 42 U.S.C. § 18052 ("section 1332"), that does not mention the fiscal waiver authority included in that provision. David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L. REV. 265, 281–84 (2013); *see also id.* at 281 (defining "big waiver" as "the power to waive requirements that Congress itself has passed"). Critiques of Barron & Rakoff's analysis follow their regulatory focus. *E.g.* Yair Sagy, *A Better Defense of Big Waiver: From James Landis to Louis Jaffe*, 98 Marq. L. Rev. 697, 698–99 n.1 (2014) (adopting Barron & Rakoff's understanding of "big waiver" authorities as granting agencies the "power to displace the *regulatory* baseline set by Congress" (emphasis added)); Edward Stiglitz, *Forces of*

The coronavirus pandemic has underscored the need for greater understanding of legal tools that facilitate investment in health and health care despite a (rightly or wrongly) constrained fiscal environment. It has laid bare the spillovers and fragmentation associated with overlapping federal and state responsibility in health and health care,[8] the resulting lack of investment in public health and the social determinants of health,[9] and the disparate impact of this lack of investment on people of color.[10] The Article's proposed Accountable Innovation Grants, a fiscal waiver tailored to promote transparency and avoid abuse, could begin to restore accountability while inspiring health and health care investment by breaking down fiscal barriers.

The Article proceeds in five parts. Part I introduces fiscal waiver authorities in health care. It summarizes the focus of "big waiver" scholarship on regulatory waiver authorities—which permit an agency to alter the rules set by Congress—in the ACA, Medicaid, and other intra-statutory federalism programs.[11] It then explains that the ACA and the Medicaid statute also include fiscal waiver authorities —which permit an agency to alter the payments to states from a default set by Congress—and describes the paramount role such authorities play in health reform.

Part II distinguishes two uses of fiscal waiver authorities to influence state policy choices. HHS has used fiscal waiver authorities to inspire state innovation and also to steer states to adopt federally-selected reforms and abandon federally-disfavored reforms. Part II explains that this use of fiscal waiver authorities under the Trump Administration raises concerns from both substantive and structural perspectives. The Administration has used fiscal waiver authorities to inspire states to cut benefits and eligibility and also to coerce states to adopt particular agency-selected reforms that further that end rather than other reforms, such as state-based single payer, which could create federal savings by improving health or health care.

Federalism, Safety Nets, and Waivers, 18 THEORETICAL INQUIRIES IN L. 125, 127 (2017) (focusing on regulatory waiver authorities); Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 Ohio St. L. J. 1100, 1129–1133 (2017) (same); Jessica Bulman-Pozen, *Executive Federalism Comes to America*, 102 VA. L. REV. 953, 977–79 (2016) (same); Bruce P. Frohen, *Waivers, Federalism, and the Rule of Law*, 45 Persp. Pol. Sci. 59, 60 (2016) (same); Samuel R. Bagenstos, *Federalism by Waiver after the Health Care Case* n.5 in THE HEALTH CARE CASE: THE SUPREME COURT'S DECISION AND ITS IMPLICATIONS (GILLIAN METZGER, TREVOR MORRISON & NATHANIEL PERSILY, EDS., 2013) (same). That is not to say that the analyses in these treatments are not invaluable in evaluating fiscal waiver authorities (they are); the Article discusses ways that the distinction between regulatory and fiscal authorities makes a difference *infra* Part III. Meanwhile, another important line of health law centered scholarship has analyzed aspects of Medicaid and/or ACA waiver authorities, including their fiscal components, but not focused on these fiscal components or sought to put them in conversation with more general "big waiver" scholarship. *E.g.* Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Health Care For?*, 70 STAN. L. REV. 1689, 1796 (2018) (federal government's negotiating levers include "regulatory policy and budget generosity"); Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 89 OHIO ST. L. J. 842, 878 (2018) (noting importance of funding mechanisms to the viability of state single payer efforts but taking existing funding flows as largely a given); Kristin Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPP. L. REV. 765, 791 (2014) (describing role of ACA funding flexibility in nurturing state experimentation).

[8] *See infra* Part II.A.1, II.B.1, and II.C.1 (describing spillovers and fragmentation).

[9] *See infra* nn. 114–115 and accompanying text (describing underinvestment), nn. 171–81 (same).

[10] Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J. L. & Biosciences (2020).

[11] *See* Abbe R. Gluck, *Intra-Statutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L. J. 470 (2011) (describing intra-statutory federalism as state flexibility within federal statutory programs).

Part III discusses implications for several threads of legal scholarship. Health and fiscal law scholars have lamented that scorekeeping rules distort and depress health reform; fiscal waivers delegate scorekeeping and thereby circumvent this barrier to new investment. But this perk does not make fiscal waivers simply another argument in favor of "big waivers." The use of fiscal waivers to inspire and steer state policy raises distinctive federalism, administrative law, and substantive concerns that complicate the normative analysis developed in this literature. In particular, this use underscores the necessity of scrutinizing waiver denials and threatened denials, not just waiver approvals.

Part IV turns to the potential for legal controversy surrounding agency-imposed conditions on waiver approval. It explains that the lack of transparency surrounding fiscal waiver deliberations might lead courts to scrutinize executive conditions under federalism, non-delegation, and administrative law doctrines. It then recommends HHS bring greater transparency to its administration of fiscal waivers to reduce that risk.

Part V concludes on an upbeat note, addressing the possibility of new fiscal waiver authorities in future health reform legislation. It explains that an expanded federal role in health care would in some ways deepen the problem that budget rules pose for health investment, because states would retain primary responsibility for their public's health but have reduced financial incentive and fiscal capability to invest therein. It therefore derives from the Article's discussion statutory constraints that could frame "Accountable Innovation Grants" in future health reform legislation that would empower agencies to share federal savings from state health investments with states as a bridge to transformative state investment, without risking abuse.

A note about generalizability. The Article builds on health law, federalism, and administrative law scholars' converging insight that "structural" matters should not necessarily be understood in isolation from substance.[12] Its core subject matter is the fiscal components of two of the "big waiver" provisions described above, which provisions are explicitly described as "waivers" by statute and by scholars. By focusing on these particular authorities the Article aspires to offer concrete substantive takeaways for health law and also derive theoretical insights for broader issues of federalism and administrative law.[13] A conclusion summarizes this contribution.

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[12] Because normative commitments and operational realities differ from one area of regulation to another, a legal structure that works well in one domain, such as in regulating immigration, may not necessarily work well in another, such as health, the environment, or national security. Both federalism and administrative law theory can helpfully be drawn from analysis of particular policy domains, and normative insights may well be limited to such domains. *See, e.g.*, Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Health Care For?*, 70 STAN. L. REV. 1689, 1704–06, 1719–24 (2018) (discussing need to focus on particular subject matter areas in assessing federalism arrangements); Andrew Hammond, *Welfare and Federalism's Peril*, 92 WASH. L. REV. 1721, 1724–27 (Dec. 20, 2017) (describing "need for case-specific federalism"); Heather K. Gerken, *Our Federalism(s)*, 53 WM. & MARY L. REV. 1549, 1550 (2012) ("Such debates . . . can only be hashed out in context-domain by domain, policymaking arena by policymaking arena").

[13] Some of what the Article draws from its study of fiscal waivers in health care could apply to other broad delegations to agencies of authority over spending, especially grants to states. The potential for an agency to wield discretion over funding to inspire or induce states developed in Part II may theoretically be present anywhere an executive agency has broad discretion over such grants. This category presumably overlaps closely with the category of cases that present the "*Pennhurst*/*Chevron* problem," *i.e.*, cases presenting the statutory interpretation question whether the *Pennhurst* clear statement rule for conditions on federal spending or *Chevron*

I. BIG WAIVER IS BIG MONEY

A growing body of scholarship has discussed administrative "big waiver" authorities.[14] These are statutory provisions that permit states to request, and federal agencies to grant, changes in the default operation of major federal statutory programs. Health law waivers in the Affordable Care Act and Medicaid are core authorities evaluated in such scholarship.[15]

This scholarship has focused on regulatory components of waiver authorities, *i.e.*, provisions delegating to agencies the power to depart from mandatory rules set by federal law.[16] At least in health care, this focus misses a big part of the story: money and its influence on state policy choices. The "big waiver" provisions in health care do more than delegate to agencies the power to change the default statutory requirements set out in federal law. They also delegate the power to change federal funding flows to states from the statutory default.

Indeed, in health care the most important thing about "big waiver" has arguably been the power to change the fiscal relationship between the federal government and states, not the power to change legal requirements, because of the extent to which fiscal authorities permit HHS to influence state policy choices. It's not just big waiver, it's big money. Subpart A explains that the ACA's waiver includes not only a regulatory authority (to change federal law), but a fiscal authority as well (to change federal spending).[17] Subpart B explains that the same is true of Medicaid's waiver; it includes not only a regulatory authority (to change federal law), but a fiscal authority as well (to change federal spending).[18] The Article then turns to unpacking these authorities in Part II, discussing their theoretical implications in Part III, and offering prescriptions for looming legal controversies relating to fiscal waivers in Parts IV and V.

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deference rule for agency interpretations of statutes should apply. David Freeman Engstrom, *Drawing Lines Between Chevron and Pennhurst: A Functional Analysis of the Spending Power, Federalism, and the Administrative State*, 82 TEX. L. REV. 197 (2004). Courts and scholars might consider whether the risk that agencies could leverage any interpretive discretion they have over federal spending flows to states as described here counsels against *Chevron* deference, because such deference expands the range of executive discretion. I take up a closely related argument drawing on themes from this Article in *Congress' Domain: Appropriations, Time, and Chevron*, ___ DUKE L. J. ____ (forthcoming 2021). Moreover, the potential of delegated scorekeeping to overcome fiscal obstacles to reform developed in Part III.B may be present anywhere that statutes constrain a delegation of authority in permanent law to an agency to alter federal spending by requiring the agency not wield the power in any way that increases the federal deficit.

[14] *See supra* nn. 7 (collecting sources).

[15] Edward Stiglitz, *Forces of Federalism, Safety Nets, and Waivers*, 18 THEORETICAL INQUIRIES IN L. 125, 131–39 (2017) (Medicaid waivers); Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO ST. L. J. 1100, 1129-1133 (2017) (ACA waivers); Jessica Bulman-Pozen, *Executive Federalism Comes to America*, 102 VA. L. REV. 953, 977–79 (2016) (ACA and Medicaid waivers); Bruce P. Frohen, *Waivers, Federalism, and the Rule of Law*, 45 PERSP. POL. SCI. 59, 60 (2016) (ACA waivers); Barron & Rakoff, *supra* note 7, at 265 (ACA and Medicaid waivers); Samuel R. Bagenstos, *Federalism by Waiver after the Health Care Case* n.5 in THE HEALTH CARE CASE: THE SUPREME COURT'S DECISION AND ITS IMPLICATIONS (GILLIAN METZGER, TREVOR MORRISON & NATHANIEL PERSILY, EDS., 2013) (Medicaid waivers).

[16] *Supra* note 7.

[17] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1332(b)(3), 124 Stat. 119 (2010) (2012).

[18] *See* 42 U.S.C. § 1315 ("Section 1115").

A. Affordable Care Act Pass Through

Ten years after the ACA's enactment, the law's fiscal waiver authority is proving key in state innovation. As anyone who has had the pleasure of reading *NFIB v. Sebelius* or *King v. Burwell* knows well, the ACA seeks to breath life into the "individual marketplace" where people go to buy health insurance if they do not have it through Medicare (old aged and disabled), Medicaid (low income), their employer, or some other source.[19] It prohibits pre-existing condition exclusions in the individual market and heavily limits premium rating, among other requirements.[20]

Federal dollars are the lifeblood of the ACA's individual markets. The law creates income-based subsidies (available for those who make less than 400% of the federal poverty level, or $103,000 for a family of four in 2020) for those who do not have insurance from another source.[21] For such individuals, the federal government pays a share of their premiums on individual market coverage through a premium tax credit payable to their insurer.[22] Moreover, for a subset of such individuals (those making less than 250% of the federal poverty level), the federal government makes "cost sharing reduction" payments directly to insurers to compensate the insurers for reducing their copays, deductibles, and coinsurance.[23] Through the ACA the federal government paid $54 billion in medical costs to subsidize coverage for 87% of enrollees in 2018.[24]

Section 1332 of the Affordable Care Act is the law's "big waiver" provision; it allows HHS to grant states' requests for "innovation waivers" to reform their individual markets.[25] This provision's regulatory waiver authority permits changes to certain requirements in the individual market.[26] This provision's fiscal waiver authority has been used to "pass through" to states savings to the federal government associated with reforms that reduce federal subsidy costs.[27] The statute explicitly caps pass through payments at the amount of predicted federal spending absent a waiver.[28]

The fiscal waiver authority in section 1332, not the provisions' regulatory waiver authority, has driven all but one ACA state innovation waiver to date. Such waivers have built on an idea first proposed and successfully implemented by Alaska. Alaska received shared federal savings through section 1332 to set up a "reinsurance"-type program, in which the state agrees to take on financial responsibility for the highest-cost insureds who enroll

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[19] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 539–41 (2012) (discussing purposes of ACA); 42 U.S.C. § 18091(2)(C) (same); Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1908–11 (2011) (discussing financial security as one of three conceptual purposes of ACA's insurance expansion).

[20] 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a), 300gg.

[21] 26 U.S.C. § 36B. *See* Federal Poverty Level, https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ (in 2020, the federal poverty level is $25,750 for a family of four).

[22] Patient Protection & Affordable Care Act, Pub. L. 111–148 § 1401, 124 Stat. 119, 120 (2012).

[23] *Id.* § 1402.

[24] Centers for Medicare & Medicaid Services, Early 2019 Effectuated Enrollment Snapshot (Aug. 12, 2019), https://www.cms.gov/newsroom/fact-sheets/early-2019-effectuated-enrollment-snapshot.

[25] ACA § 1332, codified at 42 U.S.C. § 18052.

[26] *Id.* § 1332(a)(1).

[27] *Id.* at § 1332(a)(3); State Relief and Empowerment Waivers, 83 Fed. Reg. 53575, 53580 (Oct. 24, 2018) (describing sharing, referred to as "pass through" of savings).

[28] *Id.*

through the exchange for that state.[29] This significantly brings down premiums in the state, because insurers have to charge enough in premiums to cover their predicted costs and the reinsurance program permits insurers to ignore the highest-cost individuals when they make that calculation.[30] By reducing premiums, the reinsurance program increases affordability and thereby increases enrollment, as people who could not afford costlier premiums are able to buy into the plan.[31] This is good for everyone; it just requires the state to find the money to cover the medical care that the highest-cost insureds incur.

Alaska's reinsurance program would not have been possible without a section 1332 waiver. This is not because the program violated federal law and so required a regulatory waiver; it did not.[32] The program would not have been possible because it cost Alaska a lot of money that Alaska could not afford, no matter how beneficial to its residents the program would be.[33] This Alaska stated in an application for a fiscal waiver that sought shared federal savings and explained that by reducing premiums the reinsurance program would reduce federal expenditures on subsidies for such premiums (received by most enrollees). Although Alaska's innovative proposal was submitted at the close of the Obama Administration, it was ultimately approved by the Trump Administration, and Alaska received millions in federal savings to fund the program.[34]

Alaska's reinsurance program has kicked off a cascade of state innovation, as state after state has proposed and requested federal dollars for their own similar programs.[35] At this writing twelve states have received waivers granting them new federal funds in an amount equal to the predicted reduction in federal subsidy payments created by such reforms, and several more are in the works.[36] States have explained that this financial reward

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[29] Letter from Governor Bill Walker to Lina Rashid, Senior Policy Advisor, CMS (July 31, 2017) (accepting final terms and conditions of waiver approval), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Alaska-STCs-signed-by-Treasury.pdf.

[30] Alaska Waiver Fact Sheet, CMS (July 11, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf.

[31] *Id.*

[32] Alaska's waiver application explicitly sought to "waive" a provision of law Alaska described in its application as not relevant to its waiver—the application states that "No section of the ACA that [sic] would be adversely affected by the proposed waiver." Alaska 1332 Waiver Application at 11 (Nov. 23, 2016), https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=105952; *see also id.* at 4 ("Alaska does not seek to waive any aspect of the ACA that would reduce access to meaningful, affordable insurance for any resident and does not contemplate changes to the Medicaid program, individual exchange, or direct purchase with this proposal."). HHS's written decision granting the waiver waived a different provision of law. Letter from Governor Bill Walker to Lina Rashid, Senior Policy Advisor, CMS at 1 (July 31, 2017) (waiving section 1312(c) of the ACA "to the extent it would otherwise require excluding total expected state reinsurance payments" in setting rates). https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Alaska-STCs-signed-by-Treasury.pdf.

[33] Alaska 1332 Waiver Application at 5 (Nov. 23, 2016).

[34] Letter from Governor Bill Walker to Lina Rashid, Senior Policy Advisor, CMS (July 31, 2017) (accepting final terms and conditions of waiver approval), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Alaska-STCs-signed-by-Treasury.pdf.

[35] Brad Wright *et al.*, *The Devolution of Health Reform? A Comparative Analysis of State Health Innovation Waiver Activity*, 44 J. HEALTH POLITIC. POL'Y L. 315 (2019) (describing series of state reinsurance reforms following Alaska example).

[36] Twelve states have implemented affordability-promoting high-risk pool reinsurance programs in order to obtain pass through of the millions of dollars of associated federal savings under section 1332. *See*

has been outcome-determinative in permitting them to adopt reinsurance reforms.[37] The numbers tell the same story. New Jersey's reinsurance program entitled it to shared savings in the form of pass through of $188 million in 2019.[38] Maryland's generated the largest savings, weighing in at $377 million.[39]

Building on the fiscal focus of the Alaska-type waivers, HHS is now encouraging and states are developing new state health reforms that also are fueled by the potential for federal fiscal flexibility—many of these reforms are problematic from the standpoint of health policy, as discussed in the next part. This next wave of reform aspires to use the ACA's fiscal waiver authority, perhaps in conjunction with the regulatory waiver authority, to bring about more sweeping change.

B. Medicaid Costs Not Otherwise Matchable

In "big waiver" through the Medicaid program, too, fiscal waiver authorities have been very influential. Medicaid is a cooperative federalism program of health insurance for the low income that in many ways is the linchpin of the United States health care system.[40] As with ACA waivers, federal funding made available through the fiscal component of Medicaid's "big waiver" authority has been a driving force behind state health reforms in an otherwise stagnant policy environment. The influence and role of fiscal waiver authorities in Medicaid is obscured, however, in part because of three complicating factors about this hard-to-understand program.

The first complication, which simply makes Medicaid difficult to study despite its importance in covering low-income Americans, is the fact that Medicaid is in some sense fifty different cooperative federalism programs. As the saying goes, "if you know one Medicaid program, you know one Medicaid program."[41] The Medicaid statute sets out a governing federal framework, but states have wide variation to make changes.[42]

The second complication is that unlike ACA subsidies, which the federal government pays in full, the federal government leaves some Medicaid costs to states to pay themselves. In operation, Medicaid benefits are technically provided to beneficiaries by states, but the

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Tracking Section 1332 State Innovation Waivers, KAISER FAMILY FOUNDATION (Nov. 6, 2019), https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/ (describing waivers in Maine, Rhode Island, New Jersey, Delaware, Maryland, Wisconsin, Minnesota, North Dakota, Colorado, Montana, Oregon, and Alaska).

[37] *E.g.* Rhode Island's 1332 Waiver Application at 5 (June 11, 2019), https://healthsourceri.com/wp-content/uploads/190708_FinalApplicationPackage.pdf; Wisconsin Health Care Stability Plan at 16 (March 2018), https://oci.wi.gov/Documents/AboutOCI/Wisconsin%20Healthcare%20Stability%20Plan%20-%20FINAL%20public%20pp.pdf

[38] *See* Ctrs. for Medicare & Medicaid Servs., Key Components of PPACA Section 1332 Tentative PAss-through Payments Reinsurance Waivers, 2019 (Feb. 28, 2019), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- (providing excel spreadsheet with data regarding several states' reinsurance waivers).

[39] *Id.*

[40] *See* Isaac D. Buck, *Managing Medicaid*, 11 St. Louis U. J. Health L. & Pol'y 107, 111 n.11 (describing importance of Medicaid).

[41] Jeanne Hearne, Congressional Research Service, *Medicaid Eligibility for Adults and Children* at 27 (Aug. 3, 2005), http://research.policyarchive.org/2518.pdf.

[42] 42 U.S.C. § 1396 *et seq.* (Grants to States for Medical Assistance Programs); *see also Nat'l Fed. Ind. Bus. v. Sebelius*, 567 U.S. 519, 584–86 (2012) (holding mandatory Medicaid expansion unconstitutional, and severing statute by rendering expansion optional).

federal government then pays states 50%-83% of those costs (and 90% for the "expansion population" added by the ACA), varying up or down based on a statutory formula that considers the relative financial resources of the state.[43] States are responsible only for their costs remaining after this contribution. Through Medicaid the federal government paid $399 billion for medical costs in 2018.

The third complication is that, again unlike the ACA waiver, the fiscal waiver authority in Medicaid is not limited by statute to "pass through" of federal savings, and there is no deficit-related cap. It is much broader than that. The Medicaid statute's "big waiver" provision, section 1115, includes both a regulatory component in section 1115(a)(1) (allowing HHS to waive compliance with certain Medicaid provisions at a state's request) and a fiscal component in section 1115(a)(2) (allowing HHS to increase federal payments to a state for the program at the state's request). Under the fiscal waiver authority the agency may treat as reimbursable expenditures "costs . . . which would not otherwise be included as expenditures" subject to matching under the statute, as long as they are part of an "experimental, pilot, or demonstration project" that the Secretary judges "is likely to assist in promoting the objectives" of the Medicaid statute.[44]

As written, Medicaid's fiscal waiver authority would allow HHS to provide federal matching payments for essentially any state expenditure that HHS thought would contribute to the health (or perhaps improve health coverage for) program beneficiaries.[45] HHS could, for example, wield its fiscal waiver authority to double the federal government's Medicaid payments to Rhode Island, authorizing federal matching for unprecedented substance use disorder treatment coverage and long term care programs, to fund a comprehensive hospital transportation network for enrollees, or even perhaps to fund medical legal partnerships.[46] HHS has not opted to exercise the authority in so expansive a manner, however.

Beginning with the Reagan Administration and as reportedly insisted by the Office of Management and Budget in the Executive Office of the President, HHS has voluntarily, as a matter of administrative discretion, converted section 1115(a)(2) from an unbounded agency power to increase state funding into a shared federal savings mechanism akin to that in the ACA.[47] In a perfect illustration of the influence of the "tyranny of the budget" over

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[43] 42 U.S.C. § 1396b. S*ee generally* Alison Mitchell et al., Cong. Research Serv., R43357, Medicaid: An Overview (2019) (explaining state Medicaid distributions).

[44] 42 U.S.C. § 1315 (2014). Some "experiments" have been going on for decades and are not subject to meaningful evaluation. *See* Sarah Rosenbaum et al., *Will Evaluations of Medicaid 1115 Demonstrations That Restrict Eligibility Tell Policymakers What They Need to Know?*, COMMONWEALTH FUND (Dec. 2018), https://www.commonwealthfund.org/publications/issue-briefs/2018/dec/evaluations-medicaid-1115-restrict-eligibility (highlighting the lack of meaningful evaluation regarding an Arkansas experiment). *See generally* Anthony Albanese, Note, *The Past, Present, and Future of Section 1115: Learning from History to Improve the Medicaid-Waiver Regime Today*, 128 Yale L. J. Forum 826 (March 25, 2019) (tracing lack of follow-through on experiments). Rrecently courts have rejected the agency's determinations that certain controversial regulatory waivers were "likely to assist in promoting the objectives" of Medicaid. *See Gresham v. Azar*, ___ F.3d ____, 2020 WL 741278 (D.C. Cir. 2020) (Feb. 14, 2020); *Stewart v. Azar*, 313 F. Supp. 3d 237, 260 (2018) (citation omitted).

[45] Griffin Schoenbaum, *Pre-Determined? The Prospect of Social Determinant-Based Section 1115 Waivers after* Stewart v. Azar, 120 DICK. L. REV. (2020).

[46] *Id.*

[47] Frank J. Thompson & Courtney Blake, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. HEALTH POLITICS, POL'Y & L. 971, 974-75 (2007) ("In 1983 [] the OMB insisted that [HHS] adhere to the principle of budget neutrality in its waiver reviews."); Judith M.

the development of health policy,[48] HHS has self-imposed a "budget neutrality" requirement to constrain its use of its fiscal waiver authority. Under this requirement, the agency will indeed reward a state with new federal matching funds for previously unmatched state expenses (or new, ineligible state expenses).[49] But the agency will only do so if the state makes changes, cuts, or investments that HHS calculates (often using fuzzy math[50]) will save the federal government amounts equivalent to the amount of the new federal expenditures.[51]

Perhaps due to these complications, Medicaid's fiscal waiver authority is poorly understood even within Medicaid circles. For example, scholarship often describes "budget neutrality" in Medicaid incorrectly as required by statute even though it is not.[52] But despite the self-imposed limitations on its use this authority has quietly played a key role in the course of health policy in the states for decades. After President Clinton's failed national health reform effort, the Medicaid fiscal waiver authority proved an essential motivating factor for state reform.[53] Indeed, the Massachusetts health expansion that inspired the Affordable Care

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Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 548 (1995) (crediting OMB with budget neutrality requirement); Alan Dobson et al., *The Role of Federal Waivers in the Health Policy Process*, 11 HEALTH AFF. 72, 85–86 (1992).

[48] *See infra* Part II.C.1.

[49] *See* Super, *supra* note 1, at 2561 ("[B]ecause money is fungible, the amount of relief provided is far more important than the specific subject matter of the intervention.").

[50] U.S. Gov't Accountability Office, GAO 17-312, Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending (2017). On abuses in this system, *see generally* DANIEL L. HATCHER, THE POVERTY INDUSTRY: THE EXPLOITATION OF AMERICA'S MOST VULNERABLE CITIZENS (NYU 2016).

[51] CTRS. FOR MEDICARE & MEDICAID SERVS., BUDGET NEUTRALITY POLICIES FOR SECTION 1115(A) MEDICAID DEMONSTRATION PROJECTS (Aug. 22, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf ("Currently, CMS will not approve a demonstration project under section 1115(a) of the Act unless the project is expected to be budget neutral to the federal government. A budget neutral demonstration project does not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration."); *Section 1115 Research and Demonstration Waivers*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (last visited Jan. 5, 2020), https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/ ("Over time, CMS has allowed states to calculate budget neutrality in multiple ways. . . . . 1115 waivers can be used to allow a state to use savings generated by one initiative to pay for other changes, such as eligibility expansions, as long as the waiver as a whole is budget neutral. The calculations of budget neutrality can be controversial.").

[52] DC Appleseed Center and Hogan & Hartson LLP, *Improving the District of Columbia's Response to a Public Health Crisis*, 13 GEO. J. ON POVERTY L. & POL'Y 465, 469–70 (2007) (citing Medicaid statute as source of budget neutrality requirement); Alissa Halperin et al., *What's So Special About Medicare Advantage Special Needs Plans*, 8 MARQ. ELDER'S ADVISOR 215, 245 (2007) ("Federal law allows states to seek a waiver . . . while remaining budget neutral."); Lisa Dubay et. al., *Advancing Toward Universal Coverage: Are States Able to Take the Lead?*, 7 J. HEALTH CARE L. & POL'Y 1, 29 (2004) ("This statutory requirement mandates that section 1115 demonstration waivers be budget neutral with respect to the federal government."); Sarah J. Donnell, *An Ill-Advised Cure? Providing Medicaid Benefits to the Medicare Population*, 98 NW. U. L. REV. 1213, 1227 (2004) ("Although the Secretary has broad authority to waive Medicaid requirements in approving demonstration projects, the Secretary cannot approve demonstration projects that cost the federal government more money than it would otherwise have expended if the program did not exist.").

[53] *See* John Holahan & Len Nichols, *State Health Policy in the 1990s*, *in* HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES 50–54 (Robert F. Rich & William D. White, eds., 1996) (describing savings to the federal government associated with either adoption of Medicaid managed care or reduced benefit packages to have been the causal mechanism behind more than a dozen state-based reforms to expand or revise Medicaid programs from 1990-1995).

Act was made possible by shared federal savings awarded through the fiscal authority.[54] The enactment of the ACA has not altered that trend; quite the opposite, the goal of generating savings and so payments under a waiver continues to be a determinative motivating factor in state-based health reform efforts.[55] By 2015, 33% of federal Medicaid expenditures were spent through this fiscal waiver authority, accounting for $109 billion in 40 states.[56]

II. AGENCY USE OF FISCAL WAIVERS TO INFLUENCE STATE POLICYMAKING

This Part theorizes and problematizes fiscal waiver authorities by abstracting the mechanism's use in health care along two dimensions, one functional and one normative. First, each subpart isolates from the messy real-world experience of health reform a distinct way that fiscal waiver authorities influence state policymaking—inspiring states (subpart A) and inducing states. These functions can be thought of as discrete "ends" to which HHS can put the "means" of fiscal waiver authorities in health care. Second, each subpart also develops implications of the function it describes from three normative perspectives: federalism (which focuses on the role of states),[57] substantive policy (which focuses on real-world outcomes in a given domain like health,[58] including compliance with statutory goals[59]),

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[54] *See* Nicole Huberfeld, *Federalism in Health Care Reform* 198 *in* HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY (MICHAEL ROSSER, ED. 2019) ("Massachusetts initiated universal health insurance coverage in 2006 with approval from the Bush Administration to use Medicaid funding"); Michael Doonan, AMERICAN FEDERALISM IN PRACTICE: THE FORMULATION AND IMPLEMENTATION OF CONTEMPORARY HEALTH POLICY 99–114 (2013) (explaining role of federal funding in Massachusetts health reform).

[55] New York's Medicaid Redesign Team plan to reform its health care system under Governor Cuomo was built around "reinvest[ing] the federal savings generated" by Medicaid payment changes "back into New York's healthcare delivery system." Josine Janus, *Financial Incentives to Change the Healthcare Landscape: A Case Study*, *in* THE LAW AND POLICY OF HEALTHCARE FINANCING: AN INTERNATIONAL COMPARISON OF MODELS AND OUTCOMES 108, 111 (Sauter et al., eds., 2019). New York achieved savings by adding a global spending cap to its Medicaid program, generating $8 billion in "federal savings." *Id.* at 116.

[56] U.S. Gov't Accountability Office, GAO 17-312, Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending (2017).

[57] The Article focuses on the core federalism value of experimentation. *See* Shapiro, *supra* note 2 at 2–11 (explaining federalism values); Barry Friedman, *Valuing Federalism*, 82 MINN. L. REV. 317, 389–404 (1997) (cataloging federalism values including public participation in democracy, experimentation, protecting health and welfare, and protecting liberty).

[58] *E.g.* Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes As A Community-Managed Social Phenomenon*, 16 HOUS. J. HEALTH L. & POL'Y 191, 218 (2016) ("I have described health justice as an emerging framework for eliminating health disparities and for securing uniquely public interests in access to affordable, high-quality health care.").

[59] Courts and some readers may prefer to evaluate the policy impacts of fiscal waivers from a statutory perspective rather than a theoretical one, that is, from the perspective of the governing statutes that create such waivers. Both the Medicaid statute and the ACA have providing access to health insurance coverage as a broad purpose. *Gresham v. Azar*, ___ F.3d ___, 2020 WL 741278 (D.C. Cir. Feb. 15, 2020) ("the principal objective of Medicaid is providing health care coverage"); 42 U.S.C. § 1396-1 (describing purpose of Medicaid state as "to furnish [] medical assistance on behalf of families"); *King v. Burwell*, 135 S. Ct. 2480, 2496 (2016) ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them."); 42 U.S.C. § 18091 (describing goal to "add millions of new consumers to the health insurance market . . . and share of Americans who are insured"). Most of the normative concerns raised in this Article surround this objective and so are the same regardless whether one employs a normative perspective such as health justice or statutory objectives in evaluating policy implications. One exception is the discussion of Medicare for All in part V, which addresses the use of fiscal waivers to fuel investment in health improvement.

and administrative law (which focuses on agency discretion and the separation of powers).[60] My goal in developing such implications is descriptive. I highlight effects of fiscal waiver authorities that are particularly salient from the standpoint of important normative approaches.

A. Inspiring

Fiscal waiver authorities have the theoretical potential, explained in subsection 1, to restore state innovation incentives otherwise distorted by federal spending. Whereas regulatory waivers free a state to engage in an experiment that would otherwise be foreclosed by law, fiscal waivers can encourage the state to experiment (or free it financially to do so). This function is particularly noteworthy because federal spending is often thought to interfere with state innovation, not inspire it.[61] That said, innovation is not always desirable from a substantive policy perspective and much about the current use of these authorities tends to inspire disentitlement (to use Professor Jost's term),[62] as explained in subsection 2.

1. Theory

a. Inter-sovereign spillovers

Fiscal waivers' capacity to inspire grows out of an underlying distortion that interferes with state innovation incentives. Where the federal government takes on some or all responsibility for costs incurred by (or benefits created by) state residents it creates an inter-sovereign spillover that predictability depresses state innovation and dilutes political

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[60] The Article's normative approach to administrative law relies on two core values implicated when agencies rather than Congress make decisions, namely, arbitrariness and accountability. *See* Lisa Schultz Bressman, *Beyond Accountability: Arbitrariness and Legitimacy in the Administrative State*, 78 N.Y.U. L. REV. 461, 464 (2004) ("a focus on the avoidance of arbitrary agency decisionmaking lies at the core of both a theoretical justification of administrative legitimacy and a practical evaluation of administrative law doctrines"); Richard J. Pierce, Jr., *Democratizing the Administrative State*, 48 WM. & MARY L. REV. 559, 562 (2006) ("Scholars have long questioned the political and constitutional legitimacy of the administrative state," and administrative law doctrine has sought to answer such questions); Rebecca L. Brown, *Accountability, Legitimacy, and the Constitution*, 98 COLUM. L. REV. 531 (1998) (describing accountability goal); Richard B. Stewart, The Reform of American Administrative Law, 88 HARV. L. REV. 1667 (1975) (describing role of accountability and legitimacy questions in development of administrative law).

[61] *See Steward Machine Co. v. Davis*, 301 U.S. 548, 589-91 (1937) (federal spending interferes by directing or even coercing state action); Andrew C. Coan, *Commandeering, Coercion, and the Deep Structureof American Federalism*, 95 B.U. L. REV. 1, 27 (2015) ("conditional spending . . . interferes with the ability of states to respond to the interests and preferences of their constituents"); Brian Galle, *Federal Grants, State Decisions*, 88 B.U. L. REV. 875 (2008) (describing this focus of coercion doctrine); *see also* Congressional Budget Office, *Federal Grants to State and Local Governments for Investment* at 11–15 (March 2013) (including promoting experimentation as a function of federal grants, but describing this function as leaving states regulatory "flexibility" to vary their reforms within a federal super-structure, not as rewarding or incentivizing experimentation). One notable example of a federal spending program focused on inspiring state and local innovation was the race to the top program, which was intended to encourage public schools to innovate in improving themselves. *See* Gillian E. Metzger, Federalism Under Obama, 53 WM. & MARY L REV. 567, 590-92 (2011) (describing Race to the Top).

[62] *See* TIMOTHY STOLFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 23-46 (Oxford 2003) ("disentitlement" means limiting the availability and generosity of an entitlement program by impeding eligibility or access).

accountability.[63] Inter-state spillovers are well known in federalism theory, which predicts that where the costs or benefits of state activity (whether law, investment, or otherwise) are not borne by a state, that state has insufficient reason to reduce such costs (or maximize such benefits).[64] Such spillovers include not only costs and benefits from concrete activities with cross-border impacts like environmental pollution, but also costs and benefits from more abstract activities that also have cross-border impacts like law reform and experimentation.[65]

Inter-sovereign spillovers—where costs or benefits associated with a state reform are borne by the federal government rather than residents of other states—have been noted in prior scholarship as a potential problem wherever the federal government takes on significant responsibility for costs incurred by (or benefits produced by) states or their residents including sovereign bankruptcy,[66] welfare,[67] and health care.[68] Just like inter-state spillovers, such spillovers tend to depress state innovation and investment, because reforms that are worthwhile overall may not be worthwhile to the state (or affordable to the state) with the cost or benefit that spills over to the federal government subtracted.

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[63] The above discussion treats states and localities as an "it," but in fact policymaking is usually divided among a web of individuals and institutions with their own differing incentives and goals. *See* Nestor M. Davidson, *Localist Administrative Law*, 126 YALE L. J. 564, 595-603 (2017) (surveying vertical, horizontal, and internal dimensions of local administration).

[64] Economists assume that jurisdictions compete with each other for residents who will contribute to their tax base, a theory credited to Charles M. Tiebout's *A Purse Theory of Local Expenditures*, 64 J. POL. ECON. 416 (1956). *See generally* Bruce H. Kobyashi & Larry E. Ribstein, eds., Economics of Federalism (2007); Nestor M. Davidson, *Localist Administrative Law*, 126 YALE L. J. 564, 628 (2017) (explaining incentive of states and towns to avoid exit of their residents and attract influx of new residents). On this assumption inter-state spillovers are a major problem because they leave states with insufficient incentives to invest in public goods. *E.g.* Richard L. Revesz, *The Race to the Bottom and Federal Environmental Regualtion: A Response to Critics*, 82 MINN. L. REV. 535 (1997) (environmental regulation).

[65] Susan Rose-Ackerman, *Risk Taking and Reelection: Does Federalism Promote Innovation?*, 9 J. LEGAL STUD. 593 (1980) (identifying inter-state spillover problem as one barrier to state experimentation); *id.* (concluding that in light of public choice considerations "few useful experiments will be carried out" at state and local level, especially because states have incentive to "free ride" on others' innovations); Koleman S. Strumpf, *Does Government Decentralization Increase Policy Innovation*, 4 J. PUB. ECON. THEORY 207 (2002) (discussing freerider problem); Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 925 (1994) ("individual states will have no incentive to invest in experiments that involve any substantive or political risk"); Michael W. McConnell, *Federalism: Evaluating the Founders' Design*, 54 U. CHI. L. REV. 1489, 1498 (1987) (describing argument that "[a] consolidated national government . . . stifles choice and lacks the goad of competition" and that in decentralized system "there will be more innovation . . . both because there are more actors and because individual constituencies will perceive risk and reward differently"); *see also* Brian Galle & Joseph Leahy, *Laboratories of Democracy? Policy Innovation in Decentralized Governments*, 58 EMORY L. J. 1333 (2009) (revisiting Rose-Ackerman thesis and finding insufficient state investment in experimentation).

[66] Clayton P. Gillette, *Fiscal Federalism, Political Will, and Strategic Use of Municipal Bankruptcy*, 79 U. CHI. L. REV. 281, 287 (2012) (downside of federal intervention in municipal bankruptcy is that expectation of a federal backstop "induces localities to incur more and riskier debts than would otherwise be the case, hence increasing the likelihood [of] that fiscal distress[] and the need for centralized intervention.").

[67] DAVID A. SUPER, PUBLIC WELFARE LAW 781–82 (2017) ("Moral hazard is . . . an extremely important policy issue in public welfare law.").

[68] Abigail Moncrief, *Federalization Snowballs: The Need for National Action in Malpractice Reform*, 109 COLUM. L. REV. (2009); Abigail Moncrieff, *A Closer Look at the Federalization Snowball*, 109 COLUM. L. REV. SIDEBAR 73, 77 (2009) (predicting that the federal government's significant share of responsibility for health care costs depresses medical malpractice reform because states bear the full costs of investment but share the benefits with the federal government). Moncrieff's insight is a launching-off point for this discussion. Moncrieff referred to such spillovers as "snowballs" based on her conclusion that where present, inter-sovereign spillovers force total federalization because sharing federal savings is practically impossible. *Id.*.

b. Fiscal waiver authorities as a pigouvian subsidy and innovation incentive

Economic thinking offers a simple theoretical solution to the inter-sovereign spillover problem: provide the state an offsetting subsidy or liability equal to the amount of the spillover. This method of correcting spillovers is known in economics as a "pigouvian subsidy" (or Pigouvian tax).[69] A pigouvian subsidy could be used to "cure" inter-sovereign spillovers by sharing with a state the benefit to the federal government of state investments that create savings for the federal government due to its economic role in residents' education, health care, employment, and so on.[70]

According to this economic thinking, then, it makes some sense that HHS uses fiscal waiver authorities to share federal savings. Doing so tends to restore state innovation incentives otherwise depressed by the inter-sovereign spillover associated with federal responsibility for state residents' health care costs.

Moreover, federal dollars offered to states through fiscal waivers can be understood to inspire even if we relax the assumptions of economic theory. Experimentalist scholars have called for the federal government to take an active role in stimulating state and local experimentation as part of a recursive process of continual adaptation, evaluation, and improvement.[71] Rewarding novel or productive state programs with fiscal waiver dollars can do just this, acting as an innovation incentive that is strikingly similar to the federal role Dorf and Sabel initially called for in advocating democratic experimentalism.[72]

This reward may be particularly pivotal in stimulating state investment because states are highly liquidity constrained, and so may be unable to make even worthwhile investments

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[69] WALLACE E. OATES, FISCAL FEDERALISM 66 (1972) (describing A.C. Pigou's proposed subsidy to counteract positive externalities); Wallace E. Oates, *An Essay on Fiscal Federalism*, 37 J. ECON. LIT. 1120, 1127 (1999) (describing theoretical potential of pigouvian subsidy to correct inter-state spillovers).

[70] *See* OATES, FISCAL FEDERALISM at 66 ("[I]n the case of external benefits, the economic unit generating the spillover should receive a unit subsidy equal to the value at the margin of the spillover benefits it creates.").

[71] *See* Hannah J. Wiseman and Dave Owen, *Federal Laboratories of Democracy*, 52 U.C. DAVIS L. REV. 1119, 1137–45 (2018) (describing considerations that influence the choice of forum—congress, agency, state, county, and so on—in which to stimulate policy experimentation); Charles F. Sabel & William H. Simon, *Minimalism and Experimentalism in the Administrative State*, 100 GEO. L. J. 53, 93 (2011) ("In experimentalist regimes, central institutions . . . monitor[]local performance, pool[] information in disciplined comparisons, and creates pressures and opportunities for continuous improvement at all levels.").

[72] Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267, 340 (1998) ("The task of the legislature is to authorize [] deliberations and finance the ensuring experiments where local resources are insufficient to do so."); *see also id.* at 346 ("The agencies are thus the continuing organized link between the national and the local, helping to create through national action the local conditions for experimentation, and changing national arrangements accordingly."). As David Super pointed out in *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541 (2009), Dorf and Sabel were imprecise about how the federal government would calculate its fiscal transfers or set guardrails for those transfers, saying only "Congress can authorize the provision of funds to administrative agencies or to local governments to be distributed in turn to groups (of citizen users, local governments, and providers) able to present promising plans for continuing collaboration (including long-term consultation with others." Dorf & Sabel, *supra* at 343. This Article's example and analysis of HHS's use of fiscal waiver authorities to share federal savings can be understood as elaborating on some of the questions left open by Dorf and Sabel. It also illustrates Super's broader concern that not all experimentation is good experimentation, or real experimentation.

that require expenditures upfront.[73] If, for example, a state invests in housing for individuals in recovery from substance use disorder and thereby reduces relapse rates, its investment will reduce Medicaid costs and Medicare hospitalization costs while increasing federal and state tax revenues.[74] But states do not have the luxury of considering all those savings in deciding whether they can afford the reform; they must balance their budget within existing, narrow budgetary categories. Promising the state the federal savings associated with such a reform can stimulate investment that the state might have wanted to make otherwise, but could not afford.

2. Practice

Despite the theoretical promise of sharing with states federal savings associated with state reforms as a way to inspire state innovation, legal scholarship has not delved into this possibility. Although two scholars have explicitly acknowledged the possibility of rewarding a state for the external benefits of state investments, these scholars have thought of the idea as a practical non-starter, and so have not explored the possibility or its broader implications.[75]

The experience of fiscal waivers in health care demonstrates that while these scholars correctly predicted that estimating the savings to the federal government flowing from a state reform is very hard to do accurately, that does not mean that sharing federal savings cannot be done. A key reason that sharing federal savings is possible despite the challenge of accurate prediction: a subsidy need not accurately predict the future in order to impact a state's innovation incentives. Actuaries can and do readily estimate costs or benefits associated with state changes, indeed doing so is essential in pricing insurance and scoring legislation.[76] As long as the subsidy aligns with the states' predictions about the cost or

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[73] Michael S. Sparer & Lawrence D. Brown, States and the Health Care Crisis: Limits and Lessons of Laboratory Federalism at 185, *in* HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES (Robert F. Rich & William D. White, eds. 1996) (offering as first barrier to state-based health investment "money . . . finding dollars for reform is difficult"). *See* David Super, *Rethinking Fiscal Federalism*, 118 HARV. L. REV. 2544, 2629 (2005) (discussing constitutional and fiscal constraints on state budgets that require balanced budgets and limit ability to raise revenue through bonds or other forms of borrowing).

[74] *Compare* Anthony T. Lasso et al., *Benefits and Costs Associated with Mutual-Help Community-Based Recovery Homes: The Oxford House Model*, 35 EVAL. & PROGRAM PLAN. 47 (2012) (estimating significant per person savings from particular recovery home model as compared to standard treatment), *with supra*, Table 1 (explaining the federal government's share in medical costs).

[75] Matthew C. Stephenson, *Information Acquisition and Institutional Design*, 124 HARV. L. REV. 1422, 1431 n.20 (2011) (addressing possibility in specific context of state incentives to develop, test, and report on innovative policies, finding reward "would seem to face formidable practical difficulties); Moncrieff, *supra* note 64, at 879 (raising and rejecting possibility of a grant-based solution in medical malpractice); *id.* at 886 (describing "prohibitive practical problem . . . [t]he real dollar level of the grant would be nearly impossible to determine.").

[76] *E.g.*, Marshall Allen & ProPublica, *Why Health Insurers Track When You Buy Plus-size Clothes or Binge-watch TV,* PBS (July 17, 2018, 10:18 AM), https://www.pbs.org/newshour/health/why-health-insurers-track-when-you-buy-plus-size-clothes-or-binge-watch-tv (explaining that insurers collect information on insureds to make "predictions about how much your health care could cost them"); OMB Circular A-11 (describing predictions in scoring legislation and developing baselines).

benefit of a state reform it will tend to mitigate or eliminate the effect of the spillover on state incentives, even if there is uncertainty about the estimate.[77]

ACA waivers also illustrate an important obstacle noted by Professor Stephenson—that of pre-commitment[78]—is not insurmountable but simply depends on the funding mechanism that backs up the commitment of increased federal dollars. The ACA funded premium tax credits through a permanent, indefinite appropriation.[79] This has proven important, as it has permitted the government to honor its commitments in the waiver "terms and conditions" to make fiscal waiver payments to states from that appropriation and has permitted states to rely on such commitments even as appropriations for other ACA programs have proven problematic.[80]

Fiscal waivers' inspiration function is a positive from the standpoint of federalism values, as experimentation is a core such value.[81] They therefore represent an additional means by which the federal government can spur state innovation.[82] That said, Gluck and Huberfeld have argued forcefully and in the author's view persuasively that the desirability of federalism arrangements cannot be evaluated purely in the abstract, without reference to underlying policy goals.[83] In short, from the standpoint of a substantive field like health policy, our federalism is a means that cannot be evaluated without reference to our ends.

From the standpoint of leading normative perspectives on health and welfare policy, including the goals underlying the ACA and the Medicaid statute,[84] the innovation that fiscal waivers inspire can be valuable indeed. The Massachusetts universal coverage plan on which the ACA was based is certainly the most momentous example of a successful experiment made possible by a fiscal waiver.[85] Alaska's reinsurance waiver is a clear recent example. Although states showed a surprising lack of interest in running their own ACA marketplaces even during the Obama Administration,[86] and the Trump Administration has taken steps that are inconsistent with the law's approach to health reform,[87] Alaska proposed and the Trump Administration approved the reinsurance waiver. And it has now proven a success,

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[77] *See* CMS, Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects, (Aug. 22, 2018), medicaid.gov. (describing actuarial calculation of savings by comparing hypothetical with-waiver costs to without-waiver costs). Uncertainty surrounding a prediction may tend to dilute but not eliminate the innovation incentive associated with shared federal savings, though assessing the degree to which this is the case requires further study.

[78] Stephenson, *supra* note 75, at 1432–33.

[79] 31 U.S.C. § 1324 (2014) (as amended by ACA § 1401)

[80] *See generally* Lawrence, *supra* note 23.

[81] *See supra* nn. 57 (describing federalism values).

[82] *Cf.* Kristin Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimenation*, 41 Pepp. L. Rev. 765 (2014) (describing other efforts in ACA to spur experimentation).

[83] Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Health Care For?*, 70 STAN. L. REV. 1689, 1802 (2018) ("The ACA's architecture challenges whether any [] goals and values are unique to federalism . . . [i]t illustrates how federalism is a proxy for many ideas and challenges us to ask what we are really fighting over.").

[84] *See supra* nn. 57–58 (describing health justice approach to health policy as well as statutory goals of Medicaid statute and ACA).

[85] Michael Doonan, AMERICAN FEDERALISM IN PRACTICE: THE FORMULATION AND IMPLEMENTATION OF CONTEMPORARY HEALTH POLICY 99–114 (2013) (explaining role of federal funding in Massachusetts health reform).

[86] Gluck & Huberfeld, *supra* note 83, at 1759–66.

[87] *E.g.*, *Texas v. Azar*, No. 19-10011, 2019 WL 6888446, at *25, 28 (5th Cir. Dec. 18, 2019) (highlighting the DOJ's decision not to defend the constitutionality of the Affordable Care Act).

furthering the access and cost goals of health policy while inspiring eleven additional states to adopt analogous reforms.[88]

That said, HHS's current approach to fiscal waivers also demonstrates the wisdom of Gluck and Huberfeld's insight that inspiration for inspiration's sake is not necessarily a good thing. Recent HHS guidance documents lay out the agency's approach.[89] That approach artificially circumscribes savings calculations in four ways that individually and collectively reward states for saving the federal government by cutting benefits and eligibility (for disentitlement)[90] but not for saving the federal government by investing in their residents' health or their health care systems.[91] The agency's contemporary approach is thus problematic in similar ways to "block grants" (which simply transfer all federal funds to states in a lump sum) in programs like the Temporary Assistance for Needy Families program, which ultimately facilitated massive disentitlement in many states.[92]

First, savings are limited narrowly to particular federal programs—for ACA waivers to savings through federal ACA subsidies, and for Medicaid waivers to savings through federal Medicaid expenditures.[93] Savings created by a state reform through lower federal spending in other programs such as Medicare do not count, and neither do increased federal tax revenues or changes in tax subsidies.[94] Second, the agency limits its calculation of savings to a 5-year window, refusing to consider federal savings that accrue over the long term.[95] Third, the incentive mechanism shares savings annually only as they accrue, which leaves

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[88] *See* Brad Wright, Anne Porter, Philip M. Singer, & David K. Jones, *The Devolution of Health Reform? A Comparative Analysis of State Innovation Waiver Activity*, 44 J. HEALTH POLITICS, POLICY AND LAW 315 (2019); Katie Keith, *CMS Announces 2019 Pass-Through Funding for State Waivers*, HEALTH AFFAIRS BLOG (December 10, 2018) (describing waivers); *supra* Part I.B.1 (describing states that have followed Alaska's waiver).

[89] CTRS. FOR MEDICARE & MEDICAID SERVS., BUDGET NEUTRALITY POLICIES FOR SECTION 1115(A) MEDICAID DEMONSTRATION PROJECTS (Aug. 22, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf (hereinafter "CMS Budget Neutrality Policy").

[90] JOST, *supra* note **Error! Bookmark not defined.** (defining disentitlement).

[91] *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 483 (2011) (noting that in past Administrations "most states . . . use waivers to cut costs by cutting benefits").

[92] E.g. Andrew Hammond, *Welfare and Federalism's Peril*, 92 WASH. L. REV. 1721 (Dec. 20, 2017) (describing erosion of Temporary Assistance for Needy Families block grant program); *see* Michael S. Greve, *Bloc Party Federalism*, 42 HARV. J. L. & PUB. POL'Y 279, 298 (2019) ("In 2017, Congress considered . . . a Medicaid 'block grant' reform"). On prior reforms block granting significant health and welfare programs, *see generally* Cheryl D. Cassin, *Federalism, Welfare Reform, and the Minority Poor: Accounting for the Tyranny of State Majorities*, 99 COLUM. L. REV. 552 (1999); David Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541 (2009).

[93] ACA waiver pass through is limited by the statute to ACA subsidy amounts. ACA § 1332(b)(2). Medicaid savings are not so limited by statute, § 1115(a)(2), but the agency's guidance and concepts choose to impose such a limitation. CMS Adult Opportunity Initiative at 18 (limiting to "savings [from] spending less on Medicaid expenditures"); CMS Budget Neutrality Policy at 3–5 (explaining formula that takes into account only changes in Medicaid spending). For a discussion of related restrictions in prior administrations' approach to calculating shared federal savings in Medicaid, *see The Role of Section 114 Waivers in Medicaid and Chip: Looking Back and Looking Forward*, KAISER FAMILY FOUND, March 2009, at 3, https://www.kff.org/wp-content/uploads/2013/01/7874.pdf.

[94] State Relief and Empowerment Waivers, 83 Fed. Reg. 53575, 53580 (Oct. 24, 2018) ("The amount of federal pass-through funding equals the Secretaries' annual estimate of the federal financial assistance, including PTC, small business tax credits, or cost-sharing reductions, provided pursuant to the PPACA that would have been paid . . . in the absence of the waiver.").

[95] CMS Budget Neutrality Policy at 8; *cf.* Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS UNIV. J. OF HEALTH L. & POL'Y 127, 147 n.94 (2011) (asserting that "OMB has used longer term windows in the past in approving Medicaid section 1115 demonstrations")

cash-strapped states unable to adopt reforms that require front-loaded investments.[96] Fourth, states are liable if the federal government's costs unexpectedly go up rather than down as a result of the state investment,[97] discouraging states from making risky but worthwhile bets—unless they rely on a private contractor to administer the investment.[98]

Individually and collectively, these limitations bias state innovation toward disentitlement and privatization and away from investment in improving residents' health or health care. Disentitlement requires little upfront investment and brings reliable short-term program-specific savings, which are fully rewarded by the current cramped approach to calculating savings. Such changes include adding cost-sharing (which reduces utilization), privatizing to a managed care approach (which brings tighter utilization review that further reduces utilization, and so cost), and adding paperwork or other impediments to program participation.[99] The "savings" associated with such cuts are immediate and derived entirely within the program.

Meanwhile, savings associated with improvements in the quality of health care or residents' health require upfront expenditures, accrue across numerous fiscal categories touched by patients, may take several years to accrue, and may carry some downside risk—all features the current approach either ignores or penalizes. For example, studies have repeatedly shown a huge average return on investment across multiple programmatic domains in vaccination, communicable disease prevention, and other public health initiatives, but that return takes more than five years to accrue.[100] So too with sustained investments in the social determinants of health such as workforce or housing development.[101]

Even relatively modest, targeted reforms carry cross-program benefits and so are left out. A state that made badly-needed investments in preventive care for the near-elderly would gain no benefit because the benefits of spending on preventive care for a 60-65 year old are largely borne not by Medicaid (or another payer) but by Medicare, which picks up nearly total responsibility for medical costs at age 65 but is ignored in HHS's contemporary

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[96] CMS Adult Opportunity Initiative at 20 (agency will approve reward payments "for the next demonstration year"); CMS Budget Neutrality Policy at 1–4 (shared savings through enhanced expenditure authorities awarded only in a year for which savings are expected to accrue).

[97] CMS Budget Neutrality Policy at 3 (state is "at risk" for "increases" in per-member, per-month costs).

[98] Many states have chosen to privatize their Medicaid programs, which frees them of this uncertainty. John Jacobi, *The Tools at Hand: Medicaid Payment Reform for People with Complex Medical Needs*, 28 ANN. HEALTH LAW & LIFE SCIENCES 135, 154 (2019). The desirability or undesirability of privatization is hotly debated by scholars, making this consequence of the current approach to fiscal waivers in health care a fraught one. *Compare* JON D. MICHAELS, CONSTITUTIONAL COUP: PRIVATIZATION'S THREAT TO THE AMERICAN REPUBLIC (2017) (providing overarching critique of privatization) *with* Eugene Volokh, *Prison Vouchers*, 160 U. PENN. L. REV. 779 (2012) (exploring potential of privatization of prison system).

[99] *See, e.g.*, Andy Schneider, *Weaponizing Medicaid Paperwork*, Georgetown University Health Policy Institute (Jan. 23, 2018) (describing waivers and collecting sources), https://ccf.georgetown.edu/2018/01/23/weaponizing-medicaid-paperwork/.

[100] *See* Rebecca Masters *et al.*, *Return on Investment of Public Health Interventions: A Systematic Review*, 71 J. EPIDEMIOL. COMMUNITY HEALTH 827 (2017) (surveying literature and finding median ROI of 14.3:1 but noting that benefits are usually observed over a 10-20 year time horizon, not 3-5 years).

[101] *E.g.* Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 89 OHIO ST. L. J. 842, 879 (2018) (noting that "Vermont officials initially anticipated that federal funds would be available [for their single-payer effort] from an ACA section 1332 waiver pass-through" and that limitations on such funding were influential in failure of proposal).

savings calculations.[102] Similarly, a state that made desperately-needed investments in long-term care would be left out, even insofar as state investment might "save" the federal government the six months of "rehabilitation" care that is the extent of Medicare's long-term care benefit, because of the limitation to in-program savings under the agency's current fiscal waiver practice.[103]

B. Steering

1. Theory

A second function of fiscal waiver authorities is to steer states to adopt federally-selected reforms and not federally-disfavored ones. Unlike regulatory waiver authorities, which impact which policies that differ from the legislative default states *may* nonetheless adopt, fiscal waiver authorities influence which actions from the broad range of permissible state actions states *choose* to pursue by changing state's monetary calculus. Where federal payments are available for any state reform that saves the federal government money the result is to restore state innovation incentives as described in the last section. But where the agency makes federal funds available only for particular reforms or subsets of reforms that it selects the result is more compliance than innovation.

To use a metaphor, regulatory authorities shape which reforms are "on the menu" for states to choose and which are not. But fiscal authorities set the "price" the state can expect to pay (or be paid) if it pursues particular reforms. And states' fiscal constraints push them to be highly cost-conscious in choosing which reforms to pursue.[104]

The potential for federal spending to steer state policymaking is not unique to fiscal waiver authorities. Scholars have previously noted this steering function in evaluating other forms of federal spending such as ordinary grant programs.[105] And, of course, a longstanding body of legislative coercion doctrine limits the ability of Congress to influence state action by imposing conditions on spending.[106]

2. Practice

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[102] Such reforms with cross-program benefits are not difficult to identify. *E.g.* Kenneth Thorpe, *Estimated Federal Savings Associated with Care Coordination Models or Medicare-Medicaid Dual Eligibles* 2 (Sept. 2011), https://healthandwelfare.idaho.gov/Portals/0/Medical/Managed%20Care/Estimated%20Saviings%20from%20Care%20Coordination.pdf ("Well managed team based care results in lower rates of emergency room, clinic, and hospital days—services financed largely by Medicare and not Medicaid, so States are not rewarded for more efficient use of these services.").

[103] *See* Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL'Y, L., & ETHICS 239, 270 (2016) (describing gaps left in home- and community-based long-term care programs in order to satisfy budget neutrality).

[104] John Kincaid, The Constitutional Frameworks of State and Local Government Finance 64-68, 74-77 *in* The Oxford Handbook of State and Local Government Finance (Ebel & Petersen, Eds. 2012) (describing financial constraints on states).

[105] Super, *supra* note 1 at 2571–74 (describing role of federal funding in leading states); Eloise Pasachoff, *Agency Enforcement of Spending Clause Statutes: A Defense of the Funding Cut-Off*, 2 YALE L. J. 248, nn. 110-124 and accompanying text (2014) (same);

[106] *See infra* Part IV.B.

HHS has for decades steered state reform by inviting states to apply for fiscal waiver funding for agency-favored reforms, and by setting out conditions waivers must satisfy, beyond those in the statute, to garner approval.[107] Indeed, even the requirement that waivers be budget neutral to the federal government is an agency-created condition on approval. And as a controversial particular example, the Obama Administration was in one case sued by the state of Florida for allegedly conditioning renewal of the state's high-dollar fiscal waiver on the state's agreement to expand Medicaid through telephone hints and a cryptic letter.[108]

Fiscal waiver authorities' steering function has been an emphasis of the Trump Administration's health care agenda. In traditional grant programs the question which state reforms to direct through grant awards is largely decided in advance by Congress; agencies may then make grant awards subject to elaborate, congressionally-specified procedures designed to prevent arbitrariness or abuse and make sure that grants are used to encourage adoption of the reforms that Congress decided to favor.[109] That is not the case as to the fiscal waiver authorities discussed here, which leave the agency apparently broad discretion to choose which reforms to favor with an award of federal dollars.[110]

The Trump Administration has invited states to adopt specific reforms that further its market-focused reform agenda (a substantively good thing for supporters of that agenda, a substantively bad thing for opponents). Specifically, HHS has released guidance documents announcing waiver concepts through which it indicates its willingness to fast-track waiver approval and funding for particular insurance market reforms.[111] These reforms

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[107] Frank J. Thompson & Courtney Blake, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. HEALTH POLITICS, POL'Y & L. 971, 997 (2007) ("The [W] Bush administration held strong views on how to improve Medicaid . . . The administration invited states to submit waivers targeted toward these ends . . . "); *id.* at 977 ("The George W. Bush Administration "articulated 1115 waiver themes that it would welcome," such as providing health insurance for the uninsured and covering pharmaceuticals."); Samuel R. Bagenstos, *Federalism by Waiver after the Health Care Case* 3-5, *in* THE HEALTH CARE CASE: THE SUPREME COURT'S DECISION AND ITS IMPLICATIONS (GILLIAN METZGER, TREVOR MORRISON & NATHANIEL PERSILY, EDS., 2013) (describing historical use of waivers); *see also See* John Dinan, *Implementing Health Reform: Intergovernmental Bargaining and the Affordable Care Act*, 44 PUBLIUS 399, 418 (2014) (describing influence of federal regulators over states in health care). Bruce P. Frohen, *Waivers, Federalism, and the Rule of Law*, 45 PERSP. POL. SCI. 59, 60 (2016) (expressing rule of law concern about power agency officials exert over states through health care waivers).

[108] *See Scott v. HHS*, Pls.' Mem. in Support of Mot. Prelim. Inj., ECF No. 15-1; *Scott v.* HHS, Defs.' Mem. Opp. Pls.' Mot. Prelim. Inj., ECF No. 30, N.D. Fla. 2015 (3:15-00193).

[109] Such programs certainly present opportunities for agency discretion, especially surrounding whether and how to sanction states that fail to comply with grant requirements. Eloise Pasachoff, *Agency Enforcement of Spending Clause Statutes: A Defense of the Funding Cutoff*, 124 YALE L. J. 248 (2014).

[110] *See* § 1115(a)(2); § 1332(a)(3). For a discussion of the precise bounds of this discretion, *see infra* Part IV.A.

[111] *See* State Relief and Empowerment Waivers, 83 Fed. Reg. 53575 (2018) (guidance); CTRS. FOR MEDICARE & MEDICAID SERVS., SECTION 1332 STATE RELIEF AND EMPOWERMENT WAIVER CONCEPTS (Nov. 29, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF (providing guidance regarding waivers) (hearinafter "CMS Waiver Concepts"); CTRS. FOR MEDICARE & MEDICAID SERVS., TAKING ACTION USING SECTION 1332 WAIVERS (Oct. 4, 2019), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Take-Action-Using-1332-Waivers.pdf ("If a state's waiver is approved and results in savings to the federal government for PTC or small business tax credits, the state can receive those savings

include recalibrated subsidies based on age rather than income,[112] relaxed insurance protections that allow greater discrimination against those with pre-existing conditions,[113] and increased cost sharing coupled with health savings accounts.[114] Similarly, in Medicaid, HHS has taken the same approach, announcing in a 2018 "Dear Medicaid Director" letter a new "policy" to favor "community engagement" (aka work requirements) in state waivers.[115] More recently, the agency in January 2020 invited states to adopt "aggregate caps" (which cap the potential federal expenditure, creating an incentive structure analogous to block grants)[116] as part of "healthy adult opportunity" reforms, which states have begun to do.[117] To facilitate state adoption of the federal proposals, HHS has issued checklists and an FAQ focused specifically on the state reforms it proposes to reward with fiscal waiver flexibilities.[118]

Crucially, focusing on the specific reforms that HHS has invited misses a huge part of the story. It misses the state reforms never tried because of states' expectation that a fiscal waiver award would not be forthcoming from HHS, which might be thought of as null waivers.

Most prominently, HHS has indicated its lack of interest in waivers associated with "single-payer" state reforms.[119] Opponents of an expanded government role in health

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(pass-through funding)."); *see also* Press Release*, Fact Sheet: State Empowerment and Relief Waiver Concepts*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Nov. 29, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf (providing overview of several waiver concepts).

[112] CMS Waiver Concepts at 8.

[113] CMS Waiver Concepts at 13 ("states would have the flexibility to provide state financial assistance" for insurance plans that do not qualify as "qualified health plans" because they do not satisfy ACA consumer protections).

[114] *Id.* at 20 ("the consumer's overall cost for premiums and out of pocket expenses would increase").

[115] Dear Medicaid Director Letter at 1, SMD 18-002 (Jan. 11, 2018) https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18002.pdf ("CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility.").

[116] CMS Adult Opportunity Initiative at 1–3.

[117] The agency has trumpeted the healthy adult opportunity initiative, which explicitly makes states "eligible to access shared savings," as "transformative." CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY ADULT OPPORTUNITY, SMD # 20-001 (Jan. 30, 2020) (hereinafter "CMS Adult Opportunity Initiative"); *Section 1115 Research and Demonstration Waivers*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (last visited Jan. 5, 2020), https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/; CMS Adult Opportunity Initiative at 2, 16; Centers for Medicare & Medicaid Services, *Trump Administration Announces Transformative Medicaid Healthy Adult Opportunity* (Jan. 30, 2020). *See* Edward Allen Miller, Nicole Huberfeld, & David K. Jones, *Pursuing Medicaid Block Grants with the Healthy Adult Opportunity Initiative: Dressing Up Old Ideas in New Clothes* at 16, J. Health Politics, Policy and Law at 16-17 (2020) (describing Oklahoma and Tennessee efforts to adopt healthy adult opportunity reforms).

[118] CENTER FOR MEDICARE AND MEDICAID SERVICES, CHECKLIST FOR SECTION 1332 STATE INNOVATION WAIVER APPLICATIONS, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf (accessed Feb. 1, 2020); Section 1332 State Relief and Empowerment Waiver Pass-Through Funding Frequently Asked Questions (Feb. 28, 2019) https://www.cms.gov/files/document/section1332-pass-through-funding-faq.pdf ("the savings are paid from the federal government to the state").

[119] *See* Virgil Dickson, *Verma will reject any single-payer state waivers*, Modern Healthcare (July 25, 2018) (quoting Verma as stating ""it doesn't make sense to waste time on something that's not going to work" and

insurance have cited that lack of interest in advocating against state-based reforms that would if successful rely on a waiver,[120] and they are right that federal resistance effectively precludes state innovation along these lines for as long as current leadership is in power.[121] Administrator Verma has also spoken out against public option proposals.[122] And as another example, Massachusetts' recent effort to redesign its health care system to bring down drug prices was foreclosed by HHS's rejection of its waiver application.[123]

We can only speculate what health- or quality-improving state innovations might have been pioneered in the past if HHS approved all waiver requests it believed met the statutory criteria. The Massachusetts health reform expansion on which the ACA was based was approved by the Republican Bush Administration—what reforms in recent years might have been? Rejections of waiver applications that states have taken the time and effort to submit presumably represent a small fraction of potential state reforms stifled by HHS's practice of denying statutorily-eligible requests that its leadership does not support as a policy matter.

HHS's use of fiscal waivers' steering function raises concerns from all three normative perspectives addressed here: federalism, health policy, and administrative law. Incentivizing states to adopt agency-selected reforms, and discouraging adoption of agency-disfavored reforms, raises the same concerns of political accountability and sovereignty underlying the legislative coercion doctrine, albeit not to the same extreme.[124] Moreover, this use of fiscal waiver authorities also raises federalism concerns insofar as it risks connecting states' ability to obtain federal financial support for state reforms with political

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as indicating that CMS would "likely deny waivers to launch single payer systems"); Nathaniel Weixel, *Top Trump Health Official Slams 'Medicare for All'*, The Hill (July 25, 2018) ("Verma [] said the *CMS would likely deny waivers* from states that seek to implement their own single-payer systems.") (emphasis added), https://thehill.com/policy/healthcare/398871-top-trump-health-official-slams-Medicare for All.

[120] *See* New York Health Plan Association, Memorandum in Opposition of New York Health Act, Feb. 27, 2019, https://realitiesofsinglepayer.com/wp-content/uploads/2019/02/HPA-MIO-A5248-NY-Health-Act.pdf (citing Verma's statement as reason New York should not attempt to pursue state-based single payer).

[121] *See* Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 89 OHIO ST. L. J. 842, 876 (2018) ("starting point for single-payer financing at the state level is to repurpose [] federal funds already committed to covering the state's residents."); *id.*, *passim* (in analysis of potential for state-based single payer, revealing repeatedly how availability of federal funding through fiscal waiver authorities constrains such efforts).

[122] *See* Paige Minemeyer, *Verma: Public Option Like 'Sending Your Referees to Compete in the Game'*, Fierce Health Care Oct. 27, 2019, https://www.fiercehealthcare.com/payer/verma-bashes-public-option-says-it-s-like-sending-your-referees-to-compete-game.

[123]Letter from Angela D. Garner, Director, Division of System Reform Demonstrations to Daniel Tsai (June 26, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf (denying Massachusetts' effort to develop a drug formulary for its Medicaid program).

[124] *See infra* Part III.A (describing line between inspiration and coercion).

alignment, thereby both exacerbating fiscal inequity between states lamented by Shapiro,[125] and also creating a tool for partisan weaponization.[126]

As for health policy, HHS's recent approach shows how fiscal waivers' steering function can be problematic. The Administration has used this function to solicit state reforms likely to cut benefits or eligibility (like its waiver concepts) while simultaneously stifling major state reforms designed to improve quality or resident health or at least offered valuable lessons for future reform (like state single payer or public option reforms).

Finally, HHS's recent utilization of fiscal waiver authorities' steering function is also concerning from the standpoint of administrative law. A fundamental challenge of administrative law is how to legitimate the exercise of power over significant national policies by unelected bureaucrats. The procedures of the APA, including notice-and-comment rulemaking, provide an essential curb on arbitrariness and source of public participation.[127] But by threatening to deny waivers, setting implicit or explicit conditions on waiver approvals, or promising to favor certain waivers, HHS is able to steer national health policy without providing any such process.[128]

Yes, once a state chooses to pursue a reform the ultimate approval of the state's waiver and associated financial award is subject to a rulemaking-like process.[129] But by then, the really important policy decision—about which waivers to encourage by promising federal dollars and which to stifle by signaling denial—has already been made. The public might comment upon and courts might scrutinize the reforms that states, prompted by the promise of federal dollars, choose to pursue, if the agency grants them. But there is no such opportunity for participation or review in the agency's decision to encourage those reforms in the first place, or to discourage others.

III. BIG MONEY INCREASES THE BENEFITS AND RISKS OF BIG WAIVER

What should we make of the contemporary influence of fiscal waivers on state policymaking in health care? Or to make the question concrete, suppose you are a federal judge asked by a state or resident to review an agency's decision to deny an agency's fiscal waiver request, as occurred in *Scott v. HHS*.[130] What legal questions do such decisions raise and how should those questions be resolved? Or suppose you are counsel to a Senator writing new health reform legislation, or legislation in another area with significant federal

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[125] On the problem of unequal fiscal treatment of states generally, *see* Schapiro, *supra* note 1; *see also* Paul Bernd Spahn, Equity and Efficiency Aspects of Interagency Transfers in a Multigovernment Framework 76-77, *in* INTERGOVERNMENTAL FISCAL TRANSFERS: PRINCIPLES AND PRACTICE (Robin Broadway & Anward Shah Eds. 2007) (describing equalization of transfers to regional governments in various countries and considerations underlying equalization).

[126] *See* Michael S. Greve, *Block Party Federalism*, 42 HARV. J. LAW & PUB. POL'Y 1 (2019) (describing risk of partisanship in agency exercise of authority over states); Michael A. Livermore, *The Perils of Experimentation*, 126 YALE L. J. 636 (2017) (noting risk that local experiments will be tailored to support partisan narratives rather than discover genuinely better policies).

[127] *See supra* note 60 (collecting sources regarding normative considerations in administrative law).

[128] *See* Bruce P. Frohen, *Waivers, Federalism, and the Rule of Law*, 45 PERSP. POL. SCI. 59, 60 (2016) (expressing rule of law concern about power agency officials exert over states through health care waivers).

[129] 42 U.S.C. § 1315(d) (requiring notice and comment for waiver approvals); 42 C.F.R. § § 431.400 *et seq.* (implementing statutory notice and comment requirements).

[130] *See Scott v. HHS*, Pls.' Mem. in Support of Mot. Prelim. Inj., ECF No. 15-1; *Scott v.* HHS, Defs.' Mem. Opp. Pls.' Mot. Prelim. Inj., ECF No. 30, N.D. Fla. 2015 (3:15-00193).

spending.[131] Should you include a fiscal waiver authority empowering an agency to alter payments to states like that in the ACA or Medicaid?

Subpart A briefly canvases benefits and risks of waiver authorities developed in prior scholarship. The remainder of the Part then explains how fiscal waiver authorities add to the benefits of big waiver, but also add to the risks. Subpart A isolates and elaborates on a previously-unexplored substantive benefit of fiscal waivers that weighs in their favor, namely, they overcome the "tyranny of the budget." Subpart B isolates and elaborates on a previously-underexplored risk exacerbated by fiscal waivers, namely, agency use of waiver denials (as opposed to approvals) to discourage substantively beneficial reforms, aggrandize executive power, and stifle experimentation. Parts IV and V then turn to the concrete questions of the legality of waiver conditions and the design of any fiscal waiver authority in future health reform legislation, respectively.

A. Theoretical Background

In theorizing and evaluating statutory delegations that give an agency power to grant a state's request to depart from a congressionally-specified default, prior scholars have considered substantive, federalism, and administrative law values like those teased out in Part II. From the standpoint of substance, Professor Stiglitz worries that states' fiscal constraints and policy tendencies may tend to bias any policy variation under a waiver in favor of disentitlements—that states will be inclined predominantly toward changes that cut benefits and eligibility.[132] Professors Jones, Miller, and Huberfeld offer specific evidence in support of that concern in the context of the "Healthy Adult Opportunities" waiver concept.[133] On the other hand, Professor Bagenstos sees a substantive benefit of waivers if they give the federal government a chance to induce states to sign on to a cooperative federalism program (like Medicaid) that they'd otherwise opt out of,[134] and Professors Gluck and Huberfeld see this playing out in the ACA's implementation.[135] Moreover, Professors Gluck and Huberfeld and Professor Bulman-Pozen each identify another substantive benefit of waivers, namely,

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[131] In 2019 the federal government spent $4.45 trillion, an amount equal to about 21% of gross domestic product. *See Your Guide to America's Finances: How Much Money Did The Federal Government Collect and Spend in 2019?,* DATALAB, https://datalab.usaspending.gov/americas-finance-guide/ (last visited Jan. 5, 2020) (explaining 2019 federal spending). States and localities in the United States spent approximately $3.6 trillion combined, for a total of 17% of GDP. *Id.*; *State and Local Expenditures*, URBAN INST., https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/state-and-local-backgrounders/state-and-local-expenditures (last visited Jan. 5, 2020). With the arguable exception of national security (12% of federal spending), OFF. OF MGMT. & BUDGET, PRESIDENT'S BUDGET, https://www.whitehouse.gov/omb/budget/ (last visited Jan. 5, 2020), it is difficult to identify something the federal government spends money on over which states and localities do not exert significant or even primary influence. *See* OFF. OF MGMT. & BUDGET, PRESIDENT'S BUDGET, *passim*, https://www.whitehouse.gov/omb/budget/ (last visited Jan. 5, 2020). *See also infra* nn. 66–68 (collecting scholarship discussing inter-sovereign spillovers in municipal bankruptcy, welfare, and health care).

[132] Stiglitz, *supra* note 7, at 152 ("[t]he forces that operate at the level of state implementation tend to work toward cuts").

[133] Edward Allen Miller, Nicole Huberfeld, & David K. Jones, *Pursuing Medicaid Block Grants with the Healthy Adult Opportunity Initiative: Dressing Up Old Ideas in New Clothes* at 16, J. Health Politics, Policy and Law (2020).

[134] Bagenstos, *supra* note 7, at 10-11.

[135] Gluck & Huberfeld, *supra* note 12, at 1737-40 (describing this dynamic in promoting Medicaid expansion).

that the complexity (and, often, lack of transparency) surrounding waiver decisionmaking may allow agency and state experts to develop and implement substantively-desirable but politically-unpopular policies by making it unclear which government and which officials are actually responsible for the policy or by circumventing political officials.[136]

Meanwhile, Professors Barron and Rakoff counter arbitrariness concerns surrounding waivers by arguing that they are *more* accountable than what they see as the alternative, "big delegation."[137] Barron and Rakoff explain that in a world in which broad delegations are the norm, having Congress specify a default from which states and agencies may depart (an "opt out" approach to agency discretion) is preferable to a blank slate delegation (an "active choice" approach to agency discretion).[138] In a similar vein, Professor Bagenstos explains that waivers in health care are preferable to the alternative of agency non-enforcement; because agencies generally have broad discretion to decline to enforce grant conditions, an agency without "big waiver" authority might simply refuse to enforce a provision that it would prefer explicitly to waive.[139]

As discussed *supra*, this prior scholarship has focused on the regulatory components of "big waiver"; agency power to waive a rule created by statute.[140] Focusing on fiscal components of "big waiver"—agency power to alter a state's funding from a baseline set in statute—complicates the story, because regulatory requirements and financial grants are different.[141] The remainder of this subpart addresses two ways that fiscal waivers in health care show the difference matters, but there are surely others that might be uncovered and unpacked in future scholarship.

B. Delegated Scorekeeping

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[136] *Id.* at 1768-71 (describing "secret girlfriend" model of collaboration between lower-level state and federal officials); Bulman-Pozen, *supra* note 7, at 979 ("discrete negotiations" make health care waivers "particularly agile at differentiating federal schemes").

[137] Barron & Rakoff, *supra* note 7, at 310.

[138] *See* Barron & Rakoff, *supra* note 7, at 311 ("it can be said that the combination of a specified statute and a strong power to waive is less to be feared, and more to be welcomed, than the more direct delegations we now accept as a matter of course"); *see also id.* ("It might well be thought that the power to waive, however great it is, is less conducive to creating unchecked rule by administration than broad undifferentiated grants of regulatory power per se").

[139] Bagenstos, *supra* note 7, at 9 (even where agency lacks statutory waiver authority, "regime of *de facto* waivers" may emerge from agency non-enforcement).

[140] *See supra* note 7.

[141] The difference between legal requirements that prohibit (or compel) and fiscal inducements that discourage (or encourage) is fundamental to American law and legal scholarship. *See generally* Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089 (1972) (contrasting property rules that compel and liability rules that incentivize); *compare, e.g.*, *Nat'l Fed. Ind. Bus. v. Sebelius*, 567 U.S. 519, 562–574 (2012) (Constitution gives federal government power to tax Americans who fail to purchase health care), *with id.* at 548–557 (Constitution does not give federal government power to compel Americans to purchase health care). That said, the line between these categories can blur, especially when "rules" are themselves merely legislative preconditions to grant eligibilty. *See* Brooks, Galle, & Maher, *Cross-Subsidies, Government's Hidden Pocketbook*, 106 Geo. L.J. 1229 (2018); David Freeman Engstrom, *Drawing Lines Between Chevron and Pennhurst: A Functional Analysis of the Spending Power, Federalism, and the Administrative State*, 82 Tex. L. Rev. 197 (2004) (describing potential for overlap between regulatory mandates and spending provisions). The discussion in subparts A and B offers two ways in which, blurry though it may be, the distinction between fiscal and regulatory authorities is a useful one.

One clear difference between fiscal and regulatory waivers is that fiscal waivers present fiscal questions, *i.e.*, questions about the role of waivers within the federal system for accounting for and regulating resource allocation. Another, more subtle difference is that the alternative to fiscal waiver is different than the alternative to regulatory waiver.

The alternative to regulatory waiver as Barron and Rakoff describe it is "big delegation"—broad congressional delegation without even a default set out in statute.[142] This is not true in the fiscal realm. The alternative to fiscal waiver in health care has been congressional specification (what might be called "small delegation"), not big delegation.

Congress generally oversees federal spending closely, either leaving spending dependent on the annual appropriations process or specifying the terms of permanent spending in statute.[143] Thus, arguments in favor of "big waiver" that rely on ways that it is better than "big delegation" do not apply when it comes to fiscal waiver,[144] because the question is not whether fiscal waiver is better than "big delegation," it is whether fiscal waiver is better than congressional specification.

At the same time, comparing fiscal waiver to congressional specification reveals a distinctive benefit associated with flexibility in federal spending. The fiscal flexibility afforded by fiscal waivers in health care mitigates a big substantive problem in health policy. The problem, described in section 1, is that legislative scorekeeping rules combine with fiscal fragmentation to impede desirable federal investment in health-related public goods. The solution presented by fiscal waivers, described in section 2, is to delegate the responsibility for scorekeeping from congressional scorekeepers at the time legislation is considered to agency officials at the time administrative action is implemented.

1. The "tyranny of the budget"

Statutes and congressional rules make it difficult to pass legislation that scorekeepers predict will increase expenditures more than it increases revenues.[145] These include PAYGO requirements and discretionary caps that impede Congress' ability to create new costly programs in the mandatory or discretionary categories of the federal budget without simultaneously eliminating or cutting existing programs in these fiscal categories.[146]

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[142] *Supra* note 137.

[143] That the alternative to fiscal waiver in health care is congressional specification, not broad delegation, is evident in the legislative history of health care waiver provisions themselves. Medicaid's waiver authority was added *after* the underlying program, including detailed congressional specifications to cabin agency discretion, was already enacted. *See* Gluck and Huberfeld at 1729 n. 197 (explaining history of section 1115). And the Affordable Care Act's waiver authority was added at the last minute at the insistence of one senator, again after a detailed statutory scheme was well on its way to passage. *See* John E. McDonough, *Wyden's Waiver: State Innovation on Steroids*, 39 J. HEALTH POLIT., POL'Y L. 1099, 1102–06 (2014) (describing legislative history of ACA waiver).

[144] *See* sources cited *supra*, note 7.

[145] ALLEN SCHICK, THE FEDERAL BUDGET: POLITICS, POLICY, PROCESS (3d ed. 2007); David Kamin, *Basing Budget Baselines*, 57 WM. & MARY L. REV. 143, 162–70 (2015) (explaining influence of federal budget process). *See* Budget Enforcement Act of 1990, Pub. L. No. 101-508, 104 Stat. 138 (1990); Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997); Office of Management and Budget, Appendix A: Scorekeeping Guidelines *in* Circular A-11 § 20 (June 2006) (describing scorekeeping practices);

[146] *E.g id.* 167 (describing PAYGO).

It is difficult to overstate the significance of scorekeeping considerations in the contemporary federal legislative process.[147] Such considerations impact policy choices across the board, including in infrastructure, education, emergency relief, and myriad other domains.[148]

Scorekeeping's distortions are a partial explanation for a larger underlying problem in health care, that of underinvestment.[149] Scholars have documented under-investment in health-related accessible transportation,[150] housing,[151] nutrition,[152] preventing or overcoming antibiotic resistance,[153] hospital construction and workforce development (especially in rural areas),[154] environmental protection,[155] and public health education and investment on risks like communicable disease, tobacco, safe drug use, and fall prevention.[156] And scholars, especially legal scholars, have expressed concern about under-investment in less-tangible but no-less impactful levers for promoting health including policy innovation, experimentation,

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[147] *Id.* at 72 ("As legislative ideas are bounced around, there is a lot of behind-the-scenes interaction between budget scorers and politicians. Lobbyists and federal agencies sometimes get into the act, trying to persuade budget specialists to score matters their way.); Martha Albertson Fineman, *The Nature of Dependencies and Welfare "Reform"*, 36 SANTA CLARA L. REV. 287 (1996) ("it is widely understood that the social safety net is being torn apart by the rhetoric of budget necessity and professed American moral values"); *see also* William M. Sage, *Adding Principle to Pragmatism: The Transformative Potential of 'Medicare for All'*, 2 n.5, 5-9 (October 2019) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3387120 (surveying various proposals for expanded or universal federal health care coverage); *e.g.* Steven D. Gold, Health Care and the Fiscal Crisis of the States 97-126, *in* HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES (Robert F. Rich & William D. White, eds. 1996) (describing at granular level impact of fiscal crisis on state health policy).

[148] *See* George K. Yin, *Temporary Effect Legislation, Political Accountability, and Fiscal Restraint*, 84 N.Y.U. L. REV. 174, 188-92 (2009) ("Supporters of legislation have long used various techniques to reduce the official cost of legislation and thereby enhance its likelihood of approval.").

[149] In addition to the fiscal considerations described above, other structural pathologies including public choice failures and interest group capture are also understood to play a role in underinvestment in health and health care. *See, e.g.* Paul A. Diller, *Why Do Cities Innovate in Public Health? Implications of Scale and Structure*, 91 WASH. U. L. REV. 1219 (2014) (collecting sources).

[150] *E.g.* Len M. Nichols & Lauren A. Taylor, *Social Determinants as Public Goods: A New Approach to Financing Key Investments in Healthy Communities*, 37 HEALTH AFFAIRS 1223 (2018) (focusing on transportation as example of underinvestment; "[t]here is growing awareness that funding for interventions related to social determinants of health has long been inadequate").

[151] Lo Sasso et al., *Benefits and Costs Associated with Mutual-Help Community-Based Recovery Homes: The Oxford House Model*, 35 EVALUATION AND PROGRAM PLANNING 47 (2012); L.A. Jason et al., *The Need for Substance Abuse After-Care: Longitudinal Analysis of Oxford House*, 32 ADDICTIVE BEHAVIORS 803 (2007).

[152] *E.g.* Paul A. Diller, *Why Do Cities Innovate in Public Health? Implications of Scale and Structure*, 91 WASH. U. L. REV. 1219 (2014) 1243-48 (documenting adverse impacts of federal and state failure to invest in obesity and tobacco regulation).

[153] E.g. Kevin Outterson, *The Legal Ecology of Resistance: The Role of Antibiotic Resistance in Pharmaceutical Innovation*, 31 CARDOZO L. REV. 613 (2009).

[154] E.g. Elizabeth Weeks, *Medicalization of Rural Poverty: Challenges for Access*, 46 J. L. MED. & ETHICS 651 (2018); Thomas C. Ricketts, *Workforce Issues in Rural Areas: A Focus on Policy Equity*, 95 AM. J. PUB. HEALTH 42 (2005).

[155] Elise Gould, *Childhood Lead Poisoning: Conservative Estimates of the Social and Economic Benefits of Lead Hazard Control*, 117 ENV. HEALTH PERSP. 1162, 1166 (2009) ("For every dollar spent on controlling lead hazards, $17-$221 would be returned in health benefits, increased IQ, higher lifetime earnings, tax revenue, reduced spending on special education, and reduced criminal activity.").

[156] Rebecca Masters et al., *Return on Investment of Public Health Interventions: A Systematic Review*, 71 J. EPIDEMIOL. COMMUNITY HEALTH 827, 828 (2017).

and improvement.[157] (Of course, although health care is the substantive focus here, scholarly concern about underinvestment in public goods is hardly limited to health care.[158])

Professors Westmoreland and Sage document how some of this under-investment can ultimately be traced to scorekeeping rules, which distort health lawmaking and so interfere with health reform. What investments actually get made often depends on what is included as a predicted expenditure (or source of revenue), what is not, and how each is measured. Westmoreland categorizes several discrete scorekeeping rules that shape health lawmaking, such as discouraging long-term investment.[159] Sage, who describes these effects collectively as the "tyranny of the budget," persuasively presents the history of health reform at the federal level over the past several decades as a history of efforts stymied or constrained by budgetary considerations.[160] And together, Westmoreland and Sage catalogue how scorekeeping considerations shaped the Affordable Care Act, prompting design choices that ultimately made the Act vulnerable in litigation.[161]

A feature of American health care that exacerbates scorekeeping rules' impact on health programs is the fiscal fragmentation across health programs, within the federal budget and beyond.[162] At the federal level costs are categorized into two major categories, "mandatory" expenditures (like Medicare and Medicaid) and "discretionary" expenditures (like COVID relief),[163] and then further categorized into programs ("Medicare Part A" or "Medicaid"), and so on. Table 1 offers an example: while the federal government bears approximately 38% of Americans' medical costs,[164] that expenditure is spread out over

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[157] *See, e.g.*, Daniel E. Ho, *Does Peer Review Work? An Experiment of Experimentalism*, 69 STAN. L. REV. 1 (2017) (food safety); Abbe R. Gluck, *Federalism from Federal Statutes*, 81 FORDHAM L. REV. 1749 (2013) (describing "dearth of state-led policy experimentation").

[158] Lisa Larrimore Oullette, *Patent Experimentalism*, 101 VA. L. REV. 65 (2015) (describing lack of investment in experimentation in innovation policy); Zachary J. Gubler, *Experimental Rules*, 55 B.C. L. REV. 129, 140 (2014) (expressing concern about insufficient policy experimentation at the federal agency level); *id.* (explaining prediction of public choice theory that interest groups' incentive to ensure the entrenchment of the policies they achieve will tend to cause under-investment in reversability, and so experimentation); Matthew C. Stephenson, *Information Acquisition and Institutional Design*, 124 HARV. L. REV. 1422, 1427–1437 (2011) (describing under-investment in "research," broadly defined); Michael Abramowicz, *Tax Experimentation*, 71 FLA. L. REV. 65, 67 (2019) (describing "empirical deficit" about effects of tax policies and calling for greater experimentation in tax policy as a way to address this deficit).

[159] Timothy M. Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 Geo. L. J. 1555, 1590 (2006-2007).

[160] William M. Sage, *No, the ACA Isn't "Unconstitutional": Ends and Means In A Dysfunctional Democracy*, Health Affairs Blog, December 19, 2018; *see also* DAVID G. SMITH, ENTITLEMENT POLITICS: MEDICARE AND MEDICAID 1995-2001, 177–184 (2002) (describing importance of budgetary considerations in federal legislative process for health care legislation).

[161] William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, J. L. Med. & Ethics 434 (2020)

[162] *See* Erin Fuse Brown, Matthew Lawrence, Liz McCuskey, and Lindsay Wiley, *Single Payer, American Style*, J. Law, Med. & Ethics (2020) (describing fiscal fragmentation in health care). On the broader concept of fragmentation in health and disability law, *see* Ani B. Satz, *Overcoming Fragmentation in Disability and Health Law*, 60 Emory L. J. 277 (2010).

[163] Federal budgeting rules treat "mandatory" expenditures on programs like Medicare and Medicaid as distinct from "discretionary" expenditures on annual programs, requiring that increases in mandatory spending be offset by decreases in mandatory spending and that increases in discretionary spending similarly be offset by discretionary decreases. ALLEN SCHICK, THE FEDERAL BUDGET: POLITICS, POLICY, PROCESS.

[164] This point was originally highlighted in Moncrieff, *supra* note 68, at 848 ("[T]he federal government bears forty percent of the costs of U.S. healthcare spending.").

numerous distinct programs including Medicare,[165] Medicaid,[166] ACA,[167] and employer subsidies,[168] each of which is budgeted and accounted for separately.[169]

Table 1: Federal Share of Medical Costs Through Fragmented Programs[170]

Program	Who?	How?	Federal $	Federal %
Medicare	65+, disabled	Direct federal expenditure	$583 billion	90%-100%
Medicaid	Very low income (limited to "deserving" in some states)	Federal payment to states	$399 billion	53%-90%
ACA subsidies	Low income	Federal tax credit, federal payment to insurers	$54 billion	1%-100%

[165] *See generally* Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519 (2013) (explaining Medicare). The federal government is responsible (directly or through subsidies for Part C and D plans) for almost all of the medical costs of the 59.9 million Americans enrolled in Medicare. MEDICARE BD. OF TRS., 2018 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 6 (June 5, 2018), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf (stating that the Medicare trust fund will "become depleted in 2026"). Through Medicare the federal government paid a net of $583 billion in 2018 for medical costs.

[166] Medicaid is described *supra* Part I.B.2.

[167] ACA subsidies are described *supra* Part I.B.1.

[168] *See* Brendan S. Maher, *Unlocking Exchanges*, 24 CONN. INS. L. J. 125, 142 (2017) (explaining that health insurance is a federally-subsidized employment benefit through which a plurality of Americans obtain health care); John R. Brooks, *Quasi-Public Spending*, 104 GEO. L.J. 1057 (2016) (discussing similarities between tax expenditures and other forms of government spending).

[169] *Cf.* E. Weeks and P. Sanford, *Financial Impact of the Opioid Crisis on Local Government: Quantifying Costs for Litigation and Policymaking*, 67 U. KANSAS L. REV. 1061 (2019) (illustrating fiscal fragmentation within state budgets by describing many different components of states and localities that have been impacted financially by the opioid crisis).

[170] Data on federal expenditures collected from: *Estimated Federal Spending and Tax Expenditures for Health Care FY 2018*, TAX POL'Y CTR. (last visited Jan. 5. 2020), https://www.taxpolicycenter.org/briefing-book/how-much-does-federal-government-spend-health-care (citing CONG. BUDGET OFF., THE BUDGET AND ECONOMIC OUTLOOK: 2018 TO 2028 (2018)); CONG. BUDGET OFF., FEDERAL SUBSIDIES FOR HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65: 2018 TO 2028 (2018); JOINT COMM. ON TAX'N, ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2018-2022, (2018); OFF. OF MGMT. & BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2019, HISTORICAL TABLES (2018)). These report $1.1 trillion in direct spending in 2018 with an additional $280 billion in tax spending. *Id.* Data on net U.S. health care spending was reported by OECD (U.S. health care spending was 3.65 trillion in 2018); *see also* JOINT COMM. ON TAX'N, ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2018-2022 (2018) (acknowledging similar expenditures); Press Release, *CMS Office of the Actuary Releases 2018-2027 Projections of National Health Expenditures* (Feb. 20, 2019), https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2018-2027-projections-national-health-expenditures (projecting similar figures); Thomas M. Selden & Bradley M. Gray, *Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006*, 25 HEALTH AFF. 1568, 1570-71 (2006) (estimating figures); Moncrieff, *supra* note 64, at 862-63 (similar analysis); Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 474-76 (2011) (similar analysis; collecting sources).

Employer sponsored insurance	Full time employees of large- and mid-sized firms	Federal tax deduction	$280 billion	10%-40%
Other direct federal expenditures (Veterans, workers compensation, IHS)	Various	Various	$64 billion	Various
Indirect federal costs[171]	Various	Various	Unknown	Unknown
TOTAL/Average	Varies	Varies	$1.38 trillion	38.3% (of $3.6 trillion annual)

Coupled with scorekeeping constraints, the fiscal fragmentation of costs into artificial categories prevents needed investment in public goods by impeding reforms that are not cost-justified within a given narrow fiscal category or, put differently, by impeding investments that pose costs within one fiscal category but create benefits within another category.[172]

2. Delegated scorekeeping

In one sense, fiscal waiver authorities in health care illustrate the potency of budgetary considerations. HHS is forbidden by statute from using its ACA fiscal waiver authority to increase the federal deficit.[173] And while its Medicaid fiscal waiver authority includes no such requirement, HHS has self-imposed (albeit originally at OMB's insistence[174]) an analogous "budget neutrality" restriction on its use of that authority.[175]

At the same time, fiscal waivers offer a way to mitigate some of the distortions of the budget process on health policy. A "budget neutrality" requirement measured and enforced by Congress when legislation is considered is a very different mechanism from a "budget neutrality" requirement measured and enforced by an agency when a program is

[171] The chart includes a line for "indirect federal costs" to fight the invisibility of important but difficult-to-quantify costs left out of common accounting metrics, such as costs the federal government absorbs through diminished tax revenues (because sick people are less able to work) or increased payments in other programs such as the earned income tax credit. *See, e.g.*, COUNCIL OF ECON. ADVISORS, THE FULL COST OF THE OPIOID CRISIS: $2.5 TRILLION OVER FOUR YEARS (Oct. 28, 2019), https://www.whitehouse.gov/articles/full-cost-opioid-crisis-2-5-trillion-four-years/ (explaining how the federal government bears indirect costs associated with medical care); David W. Brown, et al., Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood, REV. OF ECON. STUD. 1 (May 7, 2019) (increased earnings and lower use of social supports later in life associated with childhood access to Medicaid coverage itself repays the federal government "58 cents of each dollar of its 'investment.'").

[172] Fuse Brown *et al.*, *supra* note 162.

[173] ACA § 1332.

[174] *Supra* note 47.

[175] *Supra* notes 47-51 and accompanying text.

about to be implemented. Delegating scorekeeping changes the "who" (from congressional scorekeepers to agency) and "when" (from the enactment of legislation to program implementation) of scorekeeping.

Delegated scorekeeping predictably mitigates the "tyranny of the budget" in four ways. First, program agencies naturally have a comparative advantage over congressional scorekeepers in personnel and program expertise, which gives them the time and competence it takes to predict secondary effects on revenues and expenditures associated with changes in their programs. Whereas scorekeepers generally ignore secondary effects, HHS need not do so in administering fiscal waivers.[176] Second, program agencies tend to have a vested interest in their programs, and so motivation to "count" secondary effects that make investment possible (though this presents a risk of overly optimistic agency predictions).[177] Third, scoring at the program level rather than the legislation level reduces the uncertainty surrounding predictions by closing the time gap between score and implementation, potentially reducing the impact of scorekeeping's blind spot for effects outside the budget window (often ten years from a law's enactment). Fourth, an agency tasked with ensuring deficit neutrality across federal programs may have greater flexibility to pool otherwise-fragmented fiscal categories than congressional budget rules that enforce sometimes-rigid distinctions between mandatory and discretionary, and revenues and spending.

The effects of delegated scorekeeping (increasing expertise and commitment, reducing uncertainty, and creating flexibility) combine in the specific context of spending on states to make this mechanism particularly valuable in health care. The health and cost impacts of legislation that facilitates state policy changes is difficult to predict at the time legislation is passed. At that time it is almost impossible to know what specific state changes the spending will prompt—the law must be enacted and states must respond to it first. By contrast, in assessing a particular proposed state reform HHS has the benefit of this crucial information, and so some ability to acknowledge and "count" ways that changes in state policy will ultimately increase federal revenues or reduce federal expenditures.

Furthermore, one distinctive feature of delegated scorekeeping as a partial solution to under-investment in health care is that by providing a way to "count" federal savings associated with health improvement in budgetary conversations, it offers the potential not only to overcome the "tyranny of the budget" but also to conscript it in service of reform. As the Alaska reinsurance example demonstrates,[178] this approach can show how investment can further rather than undermine the goal of fiscal control by transforming investments in health-related public goods from "costs" for budgetary purposes to "savings" for such

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[176] The reduced federal subsidy payments associated with Alaska's reinsurance waiver is an example of a "secondary effect" of federal spending on Alaska's waiver that the agency counted; congressional scorekeepers often do not consider such effects. See Scott Levy, *Spending Money to Make Money: CBO Scoring of Secondary Effects*, 127 YALE L. J. 788 (2019) (describing challenges to offsetting the "cost" of an expenditure expected to produce savings against its anticipated "benefits").

[177] One way to address the concern that the error in estimating savings might skew positive (toward overpayment) would be to limit spending permitted through delegated scorekeeping to a fraction of the actual predicted savings estimated by an agency.

[178] *Supra* Part II.A.2.

purposes. The potency of such budgetary arguments will only increase in the years to come.[179]

Future legal scholarship might build on the fiscal waiver example to explore further the potential of delegated scorekeeping, as well as the mechanism's risks. A key, of course, is assessing the circumstances under which congressional scorekeepers will be willing to "score" a payment authority as "neutral" with a delegated scorekeeping requirement in place, as CBO appears to have done with ACA programs.[180] The growth of "budget neutrality" limitations in Medicare may be one example of delegated scorekeeping to compare and contrast with the fiscal waiver examples.[181]

C. Waiver Denials as a Source of Agency Policy Control

Scholars, courts, and policymakers have focused on HHS's use of its waiver approval power, especially HHS decisions granting waivers of questionable legality.[182] On the flip side, waiver denials have largely flown under the radar, as have threatened denials and partial denials (approvals that award something less than the state asked for).[183] Shining a light on

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[179] Both the size of the deficit and the role of health care spending in that deficit are likely to increase in years to come. *See* Neel U. Sukhatame & M. Gregg Bloche, *Health Care Costs and the Arc of Innovation*, 104 MINN. L. REV. 955, 957 (2019) ("[m]edical spending is the fiscal analogue of global warming").

[180] For example, the ACA gave new experimental expenditure authorities to CMMI that are conditioned on the requirement that to be made nationwide such new expenditures be projected to be budget neutral in the long run by CMS's Chief Actuary. 42 U.S.C. § 1315a(c)(2) (requiring that "Chief Actuary of the Centers for Medicare & Medicaid Services certifies that [payments] would reduce (or would not result in any increase in) net program spending under applicable titles"). The Congressional Budget Office does not appear to have "scored" these new authorities as a cost of the Affordable Care Act in developing its pivotal report predicting the law's fiscal consequences. Letter from Douglas W. Elmendorf, Congressional Budget Office to Nancy Pelosi, tbl 5, p. 4 (March 20, 2010) (showing net reduction in spending as result of creation of Center for Medicare and Medicaid Innovation, section 3021 of the Affordable Care Act, which created 42 U.S.C. § 1315).

[181] *E.g.* 42 U.S.C. § 1395ww (Medicare payment provision featuring ten separate authorities to adjust rates subject to budget neutrality constraints).

[182] 42 U.S.C. § 1315(d) (requiring notice and comment for waiver approvals); *see also* Barron & Rakoff, *supra* note 7, at 331–33 (suggesting that to satisfy administrative law values agency must explain its decision to grant a waiver; not addressing whether agency should explain decision denying waiver); *id.* at 327-330 (discussing "explanatory duties of an agency that makes a change in regulatory policy by waiving a congressional requirement"); Sidney D. Watson, *Medicaid, Work, and the Courts: Reigning in HHS Overreach*, 4 J. L. MED. & ETHICS 887 (2019); David A. Super, *A Hiatus in Soft-Power Administrative Law: The Case of Medicaid Eligibility Waivers*, 65 UCLA L. REV. 1590 (2018) (discussing approval of waivers requiring "community engagement," aka work requirements); Julie Novkov, *Unclaiming and Reblaming: Medicaid Work Requirements and the Transformation of Health Care Access for the Working Poor*, 79 MD. L. REV. 145 (2019) (same); David Wasserstein, *Working 9 to 5? Equal Protection and States' Efforts to Impose Work Requirements for Medicaid Eligibility*, 69 AM. U. L. REV. 703 (2019) (same);; Frank J. Thompson & Courtney Blake, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. HEALTH POLITICS, POL'Y & L. 971, 999 (2007) (focusing on process for approvals); *Gresham v. Azar*, ___ F.3d ____, 2020 WL 741278 (D.C. Cir. 2020) (Feb. 14, 2020) (finding unreasonable agency's judgment that statutorily-required finding that waiver would further objectives of the Medicaid statute was satisfied).

[183] One exception is the discussion in prior literature of explicit conditions on waivers—which are a form of threatened denial—built upon *infra* Part IV. For other exceptions *see* Gillian Metzger, *Administrative Law as the New Federalism*, 57 DUKE L. J. 2023 (2008) (noting federalism implication of agency decisions denying state waiver applications); Nicholas Bagley & Rachel E. Sachs, *Limiting State Flexibility in Drug Pricing*, 379 N. ENGL. J. MED. 1002, 1002 (2018) (describing lack of transparency surrounding waiver denials).

waiver approvals is appropriate and important, as they police the boundaries of permissible variation set by Congress in the underlying statute. But it leaves much in the dark about the influence of waiver authorities.

Waiver denials are an important source of agency policy control. Part II described how HHS can use the power to deny fiscal waivers to shape which potential reforms states actually pursue and which potential reforms states do not pursue.[184] HHS can wield its denial power by tacitly or explicitly encouraging certain waivers and discouraging others (whether through published guidance, public statements, or private statements), by rejecting or refusing to consider waivers that states do submit, and by approving submitted waivers only in part, on funding terms that the agency sets.[185]

The fungibility of money and the variability of terms on which money can be made available through partial denials make fiscal waiver denials a potent tool of influence than regulatory waiver denials, generally speaking. To be sure, for a state that badly wants a particular regulatory waiver the threat of denial is an important tool for the agency.[186] But that threat is useless as to a state that does not want that regulatory waiver or that has already received it. Fiscal waivers are not so limited a tool of influence. Every state wants money, and in granting a fiscal waiver the agency adjusts the state's financial incentives going forward, thereby steering state policy choices made well after the "approval" letter is sent.

Critical normative questions about the desirability of fiscal waiver authorities from federalism, substantive, and administrative law perspectives depend in large part on the agency's denial power and how it is utilized. From a federalism perspective a key question is whether waiver dollars are used to inspire or to induce.[187] The point at which inspiration becomes inducement may be difficult to identify with precision,[188] but it depends on how

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[184] *Supra* notes **Error! Bookmark not defined.**–123 and accompanying text (describing importance of denials, and threat of denials, in shaping state incentives).

[185] According to one empirical study, the agency much more often lets waiver application languish until the state withdraws it or it lapses. Frank J. Thompson & Courtney Blake, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. HEALTH POLITICS, POL'Y & L. 971, 978 (2007). The agency may also punt by asking the state to elaborate upon detailed, seriatim questions. Frank J. Thompson & Courtney Blake, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. HEALTH POLITICS, POL'Y & L. 971, 996 (2007) (describing example of mid-1990s congressional committee chair having reams of letters from a state "brought into the room in a wheelbarrow" in a hearing lamenting denays in processing waiver applications).

[186] *E.g.* Derek W. Black, *Federalizing Education by Waiver?*, 68 VAND. L. REV. 607 (2015) (explain state's need for No Child Left Behind waivers).

[187] Part II explained how fiscal waivers in health care can further federalism's experimentation value by restoring state innovation incentives that are otherwise depressed by partial federalization, or undermine experimentation as well as sovereignty and accountability by inducing states to adopt particular reforms selected by the federal government.

[188] Like the associated constitutional line been inducement and coercion, drawing a clean line between inspiration and direction is difficult. It demands deep specification of the underlying federalism value (why is experimentation desired?). For example, depending on why one values state experimentation, state "experiments" that are actually designed and induced by the federal government may not be a bad thing. *See* Hannah J. Wiseman and Dave Owen, *Federal Laboratories of Democracy*, 52 U.C. DAVIS L. REV. 1119, 1137–45 (2018); Kristin Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPP. L. REV. 765 (2014). Drawing this line also demands either a fact-specific analysis of an individual case or a rich theoretical understanding of how state policy officials make decisions, and so what role the availability (or unavailability) of federal spending plays in that decision. This difficult line-drawing exercise is intimately

much freedom states have to select which reforms to pursue, and so on how states' options are circumscribed by the federal government. Once the universe of state reforms potentially eligible for federal funds is defined by statute, the toggle an agency has to shrink that universe and push the waiver authority's effect from inspiration to inducement is the power to deny or threaten to deny lawful waivers. Moreover, it is through threatened denials that the agency can impose conditions on state applications, raising a distinctive set of federalism questions discussed in the next Part.

From a substantive perspective, too, HHS's waiver denial power has proven pivotal. Denials can be substantively problematic either by skewing state incentives under approved waivers toward disentitlement or by stifling desirable experiments. It is through denials and partial denials that HHS has constrained fiscal waiver calculations to exclude long-term savings and cross-program savings, tending to bias states toward cutting benefits rather than investing in health or quality.[189] It is also through threatened denials that federal officials have discouraged more sweeping state-based reforms such as single payer,[190] and through which federal officials have the power to punish states, whether for partisan reasons, any reason, or no reason.[191]

On the other hand, denials and partial denials can be substantively desirable when they prevent states from benefiting financially by cutting benefits and eligibility. This beneficial role for denials plays a key role in the Accountable Innovation Grant proposal, *infra* Part V.

Finally, administrative law concerns raised by fiscal waivers also stem largely from the agency's power to deny lawful waivers. Waiver approvals are today subject to a notice-and-comment like process that provides some opportunity for participation and some protection against arbitrariness, two core ways administrative law legitimizes agency action.[192] But not so denials, as Bagley and Sachs point out and is elaborated upon below.[193] HHS has used fiscal waiver denials (including partial denials giving states less than hoped for) to make important judgments about the course of national health policy, without even minimal procedural safeguards like reason-giving or public participation. A statute that required an agency to grant fiscal waivers that satisfied readily-identified statutory conditions (analogous

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related to the elusive but critical point "where persuasion gives way to coercion" that separates unconstitutional federal coercion from permissible federal pressure under current constitutional doctrine, which line the Supreme Court has felt "no need to fix." *Nat'l Fed. Ind. Bus. v. Sebelius*, 567 U.S. 519, 585 (2012); *see also id.* ("The Court in *Steward Machine* did not attempt to "fix the outermost line" where persuasion gives way to coercion. . . . We have no need to fix a line either."). *See generally* Heather K. Gerken, *Our Federalism(s)*, 53 WM. & MARY L. REV. 1549 (2012). Federal spending's innovation impacts can be understood on a continuum that ranges from pure inspiration (federal spending reduces barriers to state innovation, such as partial federalization), to inducement (federal spending steers state to adopt particular federally-favored reform), to compulsion (federal spending forces state to adopt particular federally-selected reform).

[189] *See supra* Part II.A.2 & II.B.2 (describing these limitations).

[190] *See supra* Part II.B.2.

[191] *Supra* note 126 and accompanying text (discussing risk of weaponization).

[192] 42 U.S.C. § 1315(d) (requiring notice and comment for waiver approvals); 42 C.F.R. § § 431.400 *et seq.* (implementing statutory notice and comment requirements); *Gresham v. Azar*, ___ F.3d ____, 2020 WL 741278 (D.C. Cir. 2020) (describing decision granting Kentucky waiver).

[193] *See* Nicholas Bagley & Rachel E. Sachs, *Limiting State Flexibility in Drug Pricing*, 379 N. ENGL. J. MED. 1002, 1002 (2018) (decrying lack of explanation accompanying denial of Massachusetts drug pricing Medicaid waiver application); *infra* Part IV.A.1 (describing agency assertion of authority to deny waivers without explanation).

to an entitlement) would, by contrast, not raise these administrative law concerns (even if it still presented substantive and federalism concerns).[194]

IV. HIDDEN CONDITIONS

Fiscal waiver authorities have not been free of legal controversy. In *Scott v. HHS*, Florida sued HHS over the denial of its request to renew a high-dollar fiscal waiver in Medicaid.[195] The state alleged that HHS had conditioned renewal of the waiver on the state's agreement to expand Medicaid.[196] After failing to obtain emergency relief the state ultimately sought dismissal of its case as moot, so it was never litigated, and scholars have not previously addressed it. Nonetheless, the case presented an important question that seems likely to recur: what statutory and constitutional requirements apply to agency-invented conditions on federal payments to states?

A growing body of case law and scholarship addresses legislative conditions on payments to states, that is, federal statutes providing states money "if" they comply with statutory criteria.[197] But what if a condition is executive rather than legislative, that is, what if a state satisfies all the criteria set out in a statute but an administering agency refuses payment unless the state complies with further, agency-decided criteria? Does the constitutional test for legislative conditions apply whole cloth to executive conditions, or some version thereof? And when should a statute be understood to empower an agency to impose conditions on states?

Scholars previously addressed the question of executive conditions in the context of explicit conditions that the Obama Administration put on regulatory No Child Left Behind waivers. States sure to fall short of legislative conditions on funding under the statute sought waivers of such conditions, and the Obama Administration for a time imposed its own conditions on the grant of such waivers. One state sued, though the issue was not resolved in court.[198] To grossly simplify, scholars evaluating executive conditions in this context generally conclude that they should be subject to similar constraints as legislative conditions, albeit with a statutory interpretation gloss.[199]

The Article's study of fiscal waivers in health care offers an additional consideration for the question of executive conditions, with implications for HHS's use of conditions in negotiating waivers in health care. Section 1 highlights a key practical difference between legislative conditions and executive conditions. While legislative conditions are by nature written and public and so easily observed and reviewed by courts, executive conditions are

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194 *See* Jerry L. Mashaw & Dylan S. Calsyn, *Block Grants, Entitlements, and Federalism: A Conceptual Map of Contested Terrain*, 14 YALE L. & POL'Y REV. 297, 318 (1996) (through specific legislation politically-accountable actors specify policy).

195 *Scott v. HHS*, Pls.' Mem. in Support of Mot. Prelim. Inj., ECF No. 15-1 (exhibits including declarations from state officials and email and letter correspondence).

196 *Id.*

197 *E.g. NFIB v. Sebelius*; *South Dakota v. Dole*; Samuel R. Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After NFIB*, 101 Geo. L. J. 861 (2013).

198 *See Jindal v. U.S. Dep't of Educ.*, 2015 WL 854132 (M.D. La. 2015) (challenge to condition on waiver of No Child Left Behind Act requirements on federal funding).

199 Zachary S. Price, *Seeking Baselines for Negative Authority, Constitutional and Rule-of-Law Arguments Over Nonenforcement and Waiver*, 8 J. Legal Anal. 235 (2016); Barron & Rakoff, *supra* note 8. *But see* Derek W. Black, *Federalizing Education by Waiver?*, 68 VAND. L. REV. 607 (2015) (expressing legal concerns about executive conditions).

often unwritten and/or nonpublic, and their existence and terms may even be disputed. Section 2 explains that this makes hidden conditions legally vulnerable under federalism doctrines and the non-delegation doctrine. Section 3 explains that while their potential to remain hidden complicates the desirability and legality of executive conditions, their overall desirability depends on difficult value choices of the sort canvassed and developed in Part III. Section 4 recommends, nonetheless, that HHS self-impose greater procedural constraints on its denial power to reduce litigation risk and mitigate administrative law, federalism, and substantive concerns with its current practice.

A. Federalism's "Black Box"

Fiscal waivers in health care reveal an important difference between legislative conditions and executive conditions. Whereas legislative conditions are by definition memorialized publicly in statute, executive conditions may be unwritten and/or undisclosed. This impedes identification of conditions by third parties and, so, impedes enforcement of any constitutional and statutory limits.

Sidney Watson has aptly described agency/state negotiation and deliberation about fiscal waivers as a "black box."[200] Much of HHS's use of its denial power to influence states involves executive conditions of various types and levels of transparency.

The agency's current practice is to deny waivers for any reason or no reason, often without even explaining its reasons (or lack of reasons).[201] The non-partisan Government Accountability Office has repeatedly lamented the arbitrariness and secrecy of the waiver consideration process.[202] While HHS has recently published guidance explaining aspects of its approach to deciding whether to grant fiscal waivers and how much to award, for years these fundamental criteria were unwritten.[203]

The waiver decisionmaking process involves repeated "informal negotiations" between state and federal officials in which federal officials may instruct the state on the telephone, over email, or in letters what steps the state must take in order to obtain

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[200] *See* Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POLICY, L., & ETHICS 213 (2015) (explaining current "black box" in which agency waiver decisions are made).

[201] *See*, *e.g.*, Nicholas Bagley & Rachel E. Sachs, *Limiting State Flexibility in Drug Pricing*, 379 N. ENGL. J. MED. 1002, 1002 (2018) (absence of explanation for denial of Massachusetts drug pricing Medicaid waiver application); Wiley, *supra* note 101 (describing significant wait for agency to process, or ignore, waiver applications).

[202] *See* Government Accountability Office ("GAO"), Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending (April 2017); GAO, Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency (June 2013); GAO, Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns (Aug. 2014); GAO, Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns (Jan. 2008). *See also* Nicholas Bagley, *Legal Limits and the Implementation of the Affordable Care Act*, 164 U. PA. L. REV. 1715, 1741–43 (2016) (critiquing "padding" in calculation of Medicaid waiver payment for Arkansas waiver; noting tension between budget neutrality requirement and encouraging state innovation); Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POLICY, L., & ETHICS 213, 217 (2015) ("The U.S. Government Accountability Office has already called CMS to task for failing to ensure budget neutrality in the Arkansas waiver approval.").

[203] *See supra* Part II.

approval.[204] Indeed, a consulting industry has sprung up in which experts with experience in these private negotiations sell their knowledge and connections to states hoping to secure desired waiver approvals on favorable terms, and otherwise to maximize their payments through federal health care programs.[205] CMS Administrator Seema Verma was a leading consultant in this field before being tapped for a government role.[206]

The current lack of transparency surrounding the agency's decisions which waivers to deny impedes enforcement of any legal or constitutional restrictions on the agency's authority to impose conditions on waiver approvals. Take for example the constitutional limits on Congress' ability to impose conditions on funding for states. In addition to the requirement that legislative conditions not "coerce" states, the Supreme Court has instructed that conditions must promote the "general welfare," be "unambiguous[]," be relevant "to the federal interest in particular national projects or programs," and not "induce the States to engage in activities that would themselves be unconstitutional."[207] In the case of a non-public, unwritten executive condition, ensuring consistency with these boundaries is simply not possible.

A not-so-hypothetical illustrates the point. Readers will recall that in 2020 President Trump was impeached for threatening to hold up defense aid funding for Ukraine until the country agreed to investigate former Vice President Biden's son.[208] This was a nonpublic, executive condition on federal funding, and would have remained so but for a whistleblower. If the Administration made a similar threat to a state to deny or delay a fiscal waiver or waiver renewal unless the state or one of its officials took some action or did some favor for the Administration, that would be an obvious example of a likely- unconstitutional condition (because not connected to the federal interest in the underlying program, not advancing the general welfare, and perhaps violating constitutional prohibitions on commandeering state's administrative apparatus). Yet if unwritten and non-public, it would be very difficult for outsiders to identify the unconstitutional condition, let alone challenge it in court.

The dispute in *Scott v. HHS* illustrated this identification challenge. In that litigation, state officials swore under oath that they believed the agency to have conditioned renewal of the state's fiscal waiver on the state's agreement to expand Medicaid, which the state alleged was unconstitutional.[209] But in the litigation, federal officials swore under oath that they had not done so, and that the threatened denial was really about other considerations.[210] Florida

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[204] *See Scott v. HHS*, Pls.' Mem. in Support of Mot. Prelim. Inj., ECF No. 15-1 (describing waiver negotiations); Gluck & Huberfeld, *supra* note 8 at 1778-80 (describing "picket fence" relationships "between state insurance experts and their federal counterparts").

[205] *See* Daniel L. Hatcher, *Poverty Revenue: The Subversion of Fiscal Federalism*, 52 ARIZ. L. REV. 675 (2010) (describing revenue maximization consultants).

[206] Tony Cook, *Seema Verma, Powerful State Health-Care Consultant, Serves Two Bosses*, Indy Star Aug. 25, 2014 (updated Nov. 29, 2016).

[207] *South Dakota v. Dole*, 483 U.S. 203 (1987); *see also* Samuel R. Bagenstos, The Anti-Leveraging Principle and the Spending Clause after NFIB, 101 Geo. L. J. 861 (2013) (exploring potential understandings of doctrinal test post-*NFIB*); Eloise Pasachoff, *Conditional Spending After NFIB v. Sebelius: The Example of Federal Education Law*, 62 Am. U. L. Rev. 577 (2013) (describing *Dole* test).

[208] *See* GAO, Withholding of Ukraine Security Assistance, B-331564, 8 (Jan. 16, 2020) ("OMB violated the [Impoundment Control Act] when it withheld . . . funds from obligation for policy reasons.").

[209] *See Scott v. HHS*, Pls.' Mem. in Support of Mot. Prelim. Inj., ECF No. 15-1 (exhibits including declarations from state officials and email and letter correspondence).

[210] *See Scott v.* HHS, Defs.' Mem. Opp. Pls.' Mot. Prelim. Inj., ECF No. 30, N.D. Fla. 2015 (3:15-00193) (exhibits including declarations from federal officials disputing state's reading of agency letter).

eventually dismissed the case after failing to obtain emergency relief. It surely would have been a difficult one given the evidentiary dispute about whether federal officials had really conditioned funding and remedial questions about the role of the court if the federal officials had indeed imposed an unconstitutional condition but reversed course once a case was brought.[211]

It might be that the state officials' interpretation of the signals they received in the *Scott* case was correct, or it might even be that the state genuinely believed the federal government to have imposed a condition that the federal government had not intended to impose, which simply confirms that executive conditions present identification challenges that legislative conditions do not. For a state official in the midst of informal negotiations on a waiver, it may be difficult to tell which hints or suggestions about changes from federal officials are conditions on approval, and which are truly mere suggestions. For a court, telling the difference may well be impossible without a fulsome, contemporaneous record.

B. Hidden Conditions are Legally Vulnerable

Hidden conditions render fiscal waivers in health care legally vulnerable in four ways. The first source of legal vulnerability is federalism restrictions on federal conditions on spending for states. Should a future case like *Scott v. HHS* be fully litigated, it is legally possible that a court would hold that agencies must make waiver decisions through a process that ensures transparency surrounding waiver conditions in order to satisfy an executive conditions doctrine. The confusion in that case about what conditions the agency had actually imposed teed up just this sort of question. Requiring that agency reasoning be made explicit in order to permit judicial review is a familiar doctrinal "move" in administrative law.[212] And if agencies can get away with imposing conditions that Congress could not, then that would create an incentive, problematic from the standpoint of federalism doctrine, for Congress to maximize federal power to influence states by delegating conditional funding authority to agencies to be wielded away from the eyes of the courts and the public.

An executive conditions doctrine requiring transparency in waiver deliberation would represent a judicial innovation. But recent Supreme Court attention to federalism limitations on federal authority coupled with the novelty of executive conditions and their potential for abuse may embolden courts to recognize new doctrines to meet the new modes of governance in this area.[213] Courts may be concerned that insofar as constitutional guarantees are a blend of the underlying standard and the likelihood of enforcement and remediation,[214] subjecting executive conditions to the same standard as legislative conditions would produce a very different constitutional rule.

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[211] *See Scott v.* HHS, Defs.' Mem. Opp. Pls.' Mot. Prelim. Inj., ECF No. 30, N.D. Fla. 2015 (3:15-00193) (offering these considerations as reasons to deny Florida's motion for relief).

[212] *See Citizens to Preserve Overton Park v. Slope*, 401 U.S. 402, 420 (1971) (agency must create contemporaneous written explanation to facilitate judicial review).

[213] Brian Galle has argued that motivated as it is by concerns for political accountability and experimentation, federalism doctrine should take account of the actual impact of a particular form of federal spending on states as part of coercion doctrine analysis. Brian Galle, *Federal Grants, State Decisions*, 88 B.U. L. REV. 875 (2008); *see also* Brian Galle, *Does Federal Spending 'Coerce' States? Evidence from State Budgets*, 108 NW. U. L. REV. 989 (2013-2014) (measuring crowding out of state budgets by federal taxation). Courts that accept this argument might particularly scrutinize fiscal waivers when used to induce, but not when used to inspire.

[214] Daryl J. Levinson, *Rights Essentialism and Remedial Equilibration*, 99 COLUM. L. REV. 857 (1999).

A second source of legal vulnerability for hidden conditions is the legal question of the agency's authority. Scholars have noted the difficult interpretive question of whether a statute gives an agency authority to condition waiver approvals.[215] By writing out conditions on approval publicly and in advance an agency can bolster its interpretive case, connecting conditions to underlying statutory purposes. This possibility is absent, however, with an unwritten or undeveloped condition expressed in the course of state-agency negotiation.

A third source of legal vulnerability is the non-delegation doctrine. This doctrine limits Congress' ability to empower agencies to make policy, though the standard courts use to judge non-delegation claims is notoriously vague and currently up for grabs.[216] Professor Black has argued that executive conditions can violate the non-delegation doctrine, because they permit an agency to shape policy without guidance from Congress.[217] Black's concern is exacerbated by the practice of nonpublic unwritten conditions. Through both the inspiration and direction functions of fiscal waivers, HHS may use denials and threatened denials (aka conditions on approval) to influence which policy changes states seek to make.[218] Because both approvals and denials thus shape the course of national health policy both entail policy discretion, the non-delegation argument would go, and so both must be subject to an intelligible principle set by Congress.

The fourth source of legal vulnerability is the Administrative Procedure Act. Litigants might challenge either waiver denials or waiver approvals under the APA if the administrative record fails to include communications between states and HHS about the formulation of the state's waiver, and thereby permit judicial review. Waiver approvals are subject to ordinary arbitrary and capricious review, and denials likely would be too.[219] DOJ has argued that denials are committed to agency discretion by law,[220] and the courts have

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[215] Price, *supra* note 199; Barron & Rakoff, *supra* note 7, at 325-27.

[216] Under the non-delegation doctrine, Congress may not delegate authority to an agency without providing an "intelligible principle" to guide the agency's exercise of discretion. *.W. Hampton, Jr. & Co. v. United States*, 276 U.S. 394, 406 (1928) (legislative action delegating authority is permissible as long as Congress "shall lay down by legislative act an intelligible principle to which the person or body authorized to [exercise the delegated authority] is directed to conform"). Five justices of the Supreme Court have recently expressed interest in tightening this standard, with Justice Kavanaugh suggesting the Court will heavily scrutinize delegations giving agencies authority to make inherently policy judgments. *See Gundy v. United States*, 119 S. Ct. 2116, 2121, 2137 (2019) (Gorsuch, J., dissenting, joined by Justices Roberts and Thomas) (would have held statute unconstitutional delegation, reviving doctrine); *id.* at 2131 (Alito, J., concurring in the judgment) ("If a majority of this court were willing to reconsider the approach we have taken for the past 84 years, I would support that effort."); *Paul v. United States*, 589 U.S. ____ (2019) (statement of Kavanaugh, J., respecting denial of certiorari). See *generally* Aditya Bamzai, *Delegation and Interpretive Discretion:* Gundy, Kisor, *and the Formation and Future of Administrative Law*, 133 HARV. L. REV. 164 (2019). Thus, existing fiscal waiver authorities may face constitutional scrutiny under a renewed non-delegation doctrine in the near future.

[217] Derek W. Black, *Federalizing Education by Waiver?*, 68 VAND. L. REV. 607 (2015). *But see* Price (doubting this concern).

[218] Part II.B.2, *supra.*

[219] *See* Gillian Metzger, *Administrative Law as the New Federalism*, 57 DUKE L. J. 2023 (2008) (suggesting that more stringent judicial review of waiver denials may be warranted because of the federalism implication of denials).

[220] *See* Brief of Defendants-Appellants, *Gresham v. Azar*, ___ F.3d ____, 2019 WL 338260, *19 ("Consistent with the broad grant of discretion and the nature of a demonstration project, Section 1115 does not require that HHS provide an explanation for its decisions. Nor does the Administrative Procedure Act (APA)."); *id.* at *22 ("Section 1115 similarly commits to the Secretary's discretion - and thus makes unreviewable - the judgment that a demonstration project is likely to promote the Medicaid program's purposes, and that waiving particular requirements is necessary to facilitate the project.").

remained agnostic on that argument even while asserting authority to review waiver approvals.[221] But courts might well reject the "committed to agency discretion" argument as not only inconsistent with the statute but also as raising avoidable constitutional concerns.[222]

An important feature of APA review is the obligation on the agency to compile an administrative record including materials considered either directly or indirectly by the agency in rendering its decision in order to form a basis for review and to articulate reasons for its decision.[223] In recent years courts have been increasingly assertive in requiring fulsome records and permitting discovery, including depositions of agency officials, where it appears that important communications relevant to the agency's decision were not included in the record.[224] It is therefore possible to speculate that a court would do the same in a challenge by a state to a waiver denial, or even a challenge by a third party to a waiver approval, that argued that the waiver formulation and decisionmaking process featured agency conditions that were not memorialized in the administrative record.

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[221] *See Gresham v. Azar*, ___ F.3d ____, 2020 WL 741278 (D.C. Cir. Feb. 14, 2020) (rejecting argument that waiver approvals are committed to agency discretion by law in carefully-worded language that avoids opining on whether denials are also committed to agency discretion by law); *id.* at *3 ("Section 1315 *approvals* are not among the rare 'categories of administrative decisions that courts have traditionally regarded as committed to agency discretion.'").

[222] Under the "committed to agency discretion" exception to judicial review under the APA, no judicial review is available (and so no agency explanation of reasons is necessary) for certain narrow categories of agency judgments, such as where an agency exercises enforcement discretion or there is "no law to apply." See *Abbott Labs. v. Gardner*, 387 U.S. 136 (1967); Hickman & Pierce, *supra* at 1591 (describing presumption of reviewability); 1648-61 (describing committed to agency discretion by law exception to APA review). DOJ argues that waiver denials are such a judgment, because while the Medicaid statute and the ACA unambiguously set out standards to constrain the circumstances when the agency may alter federal funding flows to states, these authorities can be read to provide "no law to apply" on the question whether, when the agency has authority to grant a waiver sharing federal savings, it should do so. Brief of Defendants, *supra* note 211 at *22. The DOJ's reading of the relevant statutory authorities is a plausible one, but it is not the only one. While the Medicaid statute's grant of fiscal waiver authority to HHS is permissive—HHS is not compelled to grant a state's eligible request but simply "may" do so—it is nonetheless reasonable to read the statute as setting out the factors that the agency should consider in making its decision (especially whether granting a waiver promotes the purposes of the Medicaid statute), and therefore as requiring the agency to limit its consideration to such factors and to explain its reasons in a contemporaneous, written decision reviewable under the APA. *See Gundy v. United States*, 119 S. Ct. 2116, 2121 (2019) (plurality op.) (reading statutory purposes as constraint on decisionmaking in order to save it from non-delegation doctrine challenge); *Gresham v. Azar*, ___ F.3d ____, 2020 WL 741278 (D.C. Cir. 2020) (Feb. 14, 2020) (finding required considerations in authorization of appropriations). The same is true of the ACA. 42 U.S.C. § 18091 (describing purposes of ACA); *King v. Burwell*, 135 S. Ct. 2480, 2496 (2016) (same). Thus, the statutes need not be read as precluding review of denials altogether; they can readily be read to do what many delegations do in administrative law: leave the agency ultimate discretion but require the agency consider factors consistent with the statute in wielding its discretion and provide a contemporaneous written explanation of its decision susceptible to judicial review. *State Farm*, 463 U.S. at 43 (agency action is arbitrary and capricious if agency, among other things, "relied on factors which Congress has not intended it to consider"); *Whitman v. Am. Trucking Ass'n*, 531 U.S. 457 (2001) (agency action was arbitrary and capricious because agency considered cost in setting air quality standard, but cost was not a permissible consideration under the statute).

[223] *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Ins. Co.*, 463 U.S. 29 (1983); *see* KRISTIN E. HICKMAN & RICHARD J. PIERCE, JR., ADMINISTRATIVE LAW TREATISE at 1018-34 (5th ed. 2014) (describing arbitrary and capricious test).

[224] *E.g. Department of Commerce v. New York*, 139 S. Ct. 2551 (2019) (holding agency's stated reasons for decision were pretextual based in part on evidence obtained through discovery to supplement administrative record filed by agency).

To be sure, these potential legal vulnerabilities are just that, potential vulnerabilities. To date, litigation surrounding waiver denials has been rare, perhaps because the agency's power over states' revenues through its fiscal waiver authorities discourages states from suing for fear of retaliation.[225]

The fact that HHS's denial power has avoided judicial scrutiny for many years is a reason to be cautious about overstating its legal vulnerabilities, but not a reason to ignore those vulnerabilities. The recent history of health reform has been a history of litigation, with the party holding the presidency being besieged (rightly or wrongly) by novel but successful attacks that have unseated assumptions about the law long taken for granted.[226] At this writing, it seems possible if not likely that the next President will rely heavily on health care waivers to pursue his or her health reform agenda, and that this use will become subject to political polarization that draws public interest litigation.[227] Furthermore, given the increasing reliance on waivers, a future change in administration could see an administration rejecting, refusing to renew, or even terminating a waiver solicited by its predecessor, again increasing the likelihood of judicial scrutiny on the denial. In light of these possibilities the legal vulnerabilities of HHS's denial power in general, and of hidden conditions in particular, may well be tested in court.

C. Hidden Conditions Complicate the Desirability of Informal Waiver Negotiation

The desirability of fiscal waiver authorities in health care is itself a subtle question, as discussed *supra* Part III. The desirability of hidden conditions in the agency's exercise of such authorities is more subtle still.

Scholars have identified several potential substantive benefits to informal waiver negotiations between states and the federal government that greater transparency might wreck. One such potential benefit is that negotiation may permit the agency to entice a state into adopting a beneficial reform it would not have pursued if the agency could not negotiate over waiver terms, *i.e.*, if the agency could not threaten to deny waivers absent the state's

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[225] Fiscal waivers in health care, and federal cooperative health care programs generally, present many repeated interactions between states and the federal government in which federal officials have discretion over payments to states. This discretion is present not only when the agency decides whether to grant a fiscal waiver or calculate payment formulae under that waiver, but also year-in and year-out as states actually apply for and receive their matching fund payments under the waivers. In most of these interactions HHS not only wields discretion, but does so in ways insulated from judicial review because unwritten and unregulated. This repeated interaction creates a dynamic surrounding executive conditions not present with legislative conditions. State officials have a vested interest in maintaining positive relationships with their federal counterparts—a healthy "picket fence" connecting players to one another. This predictably discourages state officials from seeking relief through litigation even when faced with an unconstitutional condition, because an offended federal official might have many future opportunities to retaliate in subtle and unenforceable ways. By contrast, states need not fear congressional retaliation in the same way (which is not the same as saying they need never fear it), because congressional conditions are often set in permanent legislation that is not easily susceptible to change.

[226] Abbe R. Gluck, Mark Regan, and Erica Turrett, *The Affordable Care Act's Litigation Decade*, 108 GEO. L. J. 1471 (2020).

[227] Biden-Sanders Unity Task Force Recommendations, July 13, 2020 at 93 ("Democrats will also empower the states, as laboratories of democracy, to use Affordable Care Act innovation waivers to develop locally tailored approaches to health coverage, including by removing barriers to states that seek to experiment with statewide universal health care approaches.").

agreement to modify their application or comply with some other agency-created condition.[228] Another such potential benefit of negotiation is that it might provide an opportunity for state/federal compromise that overcomes partisan gridlock to obtain policy improvements.[229] And another is the possibility that the obscurity about who is actually responsible for waiver-related reforms (the state or federal government, and which actors in each?) permits the adoption of desirable reforms that are politically unpopular for some or all actors involved,[230] as well as the formation of "picket-fence" relationships in which state policy officials have close working relationships not only with other state officials but also with their federal counterparts.[231]

Yet it is not clear that the agency's ability to impose unwritten and/or nonpublic conditions on funding for states is actually beneficial from a substantive standpoint. One risk is that the informality of negotiations may facilitate "hold out" behavior by states; such behavior can impede beneficial agreement.[232] Another risk is that rather than inducing beneficial state reforms, the agency will use conditions to induce states to adopt undesirable reforms. It stands to reason that the ability to make conditions non-public and unwritten facilitates agency-imposed conditions that are themselves inconsistent with statutory goals to a greater extent than it facilitates agency-imposed conditions that advance the goals of the underlying statute.

Moreover, an agency that wants to maximize its substantive influence may do so by limiting the waivers it is willing to consider and thereby stifling experimentation. It is intuitively possible that the leverage an agency's power to deny state requests gives the agency increases with the agency's general reluctance to grant eligible waiver requests. An agency that frequently denies eligible waivers has more credibility in threatening to deny any particular waiver, and no particular denial stands out as particularly unfair or arbitrary when denials are routine. An agency that usually approves eligible waivers, on the other hand, has less credibility in threatening denial and may face greater scrutiny for any particular denial. If this dynamic plays out in practice, then the agency's desire to maximize its steering power would give it reason to close the door to true state experiments, reserving approvals only for state adoption of federally-desired reforms. The result would be less experimentation and less policy learning overall.

It is not apparent how to resolve these competing substantive considerations for and against hidden conditions. Moreover, even if hidden conditions are substantively beneficial, it is not apparent how to resolve tensions that may result between that benefit and the

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[228] Bagenstos, *supra* note 7.

[229] Jessica Bulman-Pozen, *Executive Federalism Comes to America*, 102 VA. L. REV. 953, 955-56, 976 (2016) ("lack of transparency" in negotiation between state and federal officials about waivers "may be an asset"); *id.* at 1002-03 (fact that negotiation occurs "in greater secrecy than legislative deliberation" is an "advantage" of waiver negotiation in that it may help overcome political polarization).

[230] *See* Gluck & Huberfeld, *supra* note 83, at 1700 ("hybrids [] gave red-state officials cover to entrench the ACA but arguably came at a steep price when it comes to accountability"); *id.* at 1700-01 (reporting state official who "colorfully called it the 'secret boyfriend model' of state-federal relations—a relationship coveted by the states, but one that states were unwilling to admit publicly for political reasons").

[231] *See* Roderick M. Hills, Jr., *The Eleventh Amendment as Curb on Bureaucratic Power*, 53 STAN. L. REV. 1225, 1227 (2001) (describing picket "fence" federalism but noting concerns about such relationships).

[232] Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and "Dual Sovereignty" Doesn't*, 96 MICH. L. REV. 813, 855-56 (downsides of letting states "hold out" for more generous terms).

concerns that hidden conditions present from administrative law and federalism perspectives.

Future scholarship might usefully delve more deeply into these values disputes about the desirability of hidden conditions. Depending how one comes out, a blunt rule for or against hidden conditions may be in order, such as forbidding such conditions through legislation or one of the doctrinal pathways discussed above or, alternatively, blessing them through legislation immunizing waiver deliberations from judicial review.

D. HHS Should Not Hide Conditions

For present purposes, it is possible to draw this one specific takeaway for the administration of fiscal waivers: HHS should endeavor to reduce the legal vulnerability of its process for deliberating on waivers by bringing greater transparency to that process. Doing so would preserve the agency's power, for if the agency does not shore up its processes itself then courts may do so—and judicial scrutiny is sure to create not just controversy (and potentially unwelcome discovery) but a less predictable standard than the agency would adopt for itself.[233]

How should HHS improve the transparency of waiver deliberation? First, the agency should resolve state applications promptly and provide a denial letter that articulates the reasoning for the denial, connecting the factors it has considered to its statutory authority. This would guard against arbitrary and capricious challenges (by providing reasoning) and non-delegation claims (by connecting the agency's judgment to statutory criteria).[234]

Second, the agency should track communications with states regarding potential waivers and include these communications in the administrative record of any ultimate waiver approval or denial.[235] This would mitigate federalism concerns by providing a basis for judicial review of any conditions articulated by the agency, and also mitigate statutory concerns by allowing the agency subsequently to explain how any conditions it did impose were consistent with its statutory authority. Moreover, having a system for tracking communications as they happen would protect the agency against invasive discovery in any litigation that might arise. Absent such materials in *Scott v. HHS* the agency was forced hastily to put together declarations by agency officials recounting (and sometimes disputing the state's version of) informal and formal communications between agency staff and states.[236]

Third, the agency might consider putting its guidance documents articulating its waiver priorities and practice through notice and comment rulemaking.[237] This would help

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[233] *See supra* note 212-226 and accompanying text (describing possibility of litigation).

[234] *Cf. Citizens to Preserve Overton Park v. Slope*, 401 U.S. 402, 420 (1971) (to permit judicial review, agency officials must either testify to their reasons or prepare contemporaneous written explanation).

[235] *Cf. Sierra Club v. Costle*, 657 F.2d 298 (D.C. Cir. 1981) (addressing situations in which agency should include *ex parte* communications relevant to its ultimate decision in the administrative record).

[236] *See Scott v.* HHS, Defs.' Mem. Opp. Pls.' Mot. Prelim. Inj., ECF No. 30, N.D. Fla. 2015 (3:15-00193) (declarations included in exhibits, along with emails and letters exchanged between state and agency officials).

[237] Miller, Huberfeld, and Jones suggest that agency invitations for waiver applications fitting specific agency-defined criteria are "substantive rules" for purposes of the Administrative Procedure Act, and so the agency does not have the legal authority to avoid notice and comment rulemaking in issuing such guidance. Edward Allen Miller, Nicole Huberfeld, & David K. Jones, *Pursuing Medicaid Block Grants with the Healthy Adult*

ensure the agency's interpretations of its statutory authorities receive *Chevron* deference,[238] and provide a vehicle for judicial resolution of any disputes about invited waiver concepts *ex ante*, without forcing a state first to apply for a waiver and receive it only to have it overturned in court after much time and effort, as happened with work requirements.[239]

Process skeptics might object that adding the constraint of additional transparency on the agency's use of its fiscal waiver authorities would undermine their usefulness in inspiring innovation and linking fiscal categories to promote beneficial investment.[240] This concern is misplaced when it comes to transparency surrounding fiscal waiver denials, however. The rationales for experimentalists' skepticism that procedure will discourage innovation—the increased uncertainty and disruption for new innovations if invalidated by a court[241]—apply only to judicial review of federal agency waiver approvals. Describing denials poses little risk of disrupting approved projects; to the contrary such review merely creates a possibility that reforms stifled by the federal government might be revived, increasing the predicted payoffs to a state of time and resources devoted to developing a proposal.[242]

V. ACCOUNTABLE INNOVATION GRANTS

A second real-world scenario in which the question of fiscal waivers is concrete and pressing is that of health reform. The ACA did not include any kind of waiver (whether fiscal or regulatory) until the last minute, when Senator Ron Wyden pushed for one.[243] Thus while prominent current health reform proposals such as Medicare for All do not include

Opportunity Initiative: Dressing Up Old Ideas in New Clothes at 16, J. Health Politics, Policy and Law (2020). This is a challenging argument because such invitations are styled as non-binding guidance, and guidance is not ordinarily subject to notice and comment requirements. 5 U.S.C. § 553.

[238] *U.S. v. Mead*, 533 U.S. 218 (2001).

[239] *Gresham v. Azar*, ___ F.3d ____, 2020 WL 741278 (D.C. Cir. 2020) (Feb. 14, 2020); *Stewart v. Azar*, 313 F. Supp. 3d 237, 260 (2018) (citation omitted).

[240] *See* Dorf & Sabel, *supra* note 72, at 356; *id.* at 398–99 (expressing concern about the potential of judicial review to stifle innovation); Michael Abramowicz, Ian Ayres, & Yair Listokin, *Randomizing Law*, 159 U. PA. L. REV. 929, 981 (2011) ("an administrative agency should receive broader latitude to create an experiment than to create a new administrative regime without an experiment"); Nicholas Bagley, *The Procedure Fetish*, 118 MICH. L. REV. 345, 400–01 (2019) (arguing that broad agency discretion is often worth the risks of abuse because it facilitates progressive reform).

[241] Robin Kundis Craig & J.B. Ruhl, *Designing Administrative Law for Adaptive Management*, 67 VAND. L. REV. 1, 33-35 (2014) (describing as downsides of judicial review the uncertainty and intrusion of review itself and the stringent standards currently used by courts to review agency action); *see also* William H. Simon, *The Organizational Premises of Administrative Law*, 78 LAW & CONTEMP. Prob. 61 (2015) (critiquing traditional administrative law doctrine as out of touch with performance-based regulation).

[242] One might worry that states would use the courts to force through waivers over the objection of the administering agency. This concern is mitigated by the fact that any such waivers would need to satisfy statutory eligibility requirements, and so necessarily would be within the range of permissible waivers specified by Congress. It is a concern, then, that the statutory scope of potential waivers might be too broad.

[243] *See* John E. McDonough, *Wyden's Waiver: State Innovation on Steroids*, 39 J. HEALTH POLIT., POL'Y L. 1099, 1102–06 (2014) (describing legislative history of ACA waiver).

waiver authorities,[244] the questions whether they should—and if so, how such authorities should be designed—are bound to come up. This Part addresses these looming questions.

Subsection 1 explains that expansion of federal health care coverage (through Medicare for All or otherwise) would sharpen the need for fiscal waivers, deepening the fiscal fragmentation problem that makes delegated scorekeeping particularly valuable. Subsection 2 proposes that future fiscal waivers in health reform legislation be structured as tightly-constrained "Accountable Innovation Grants" and describes how constraints on such grants could mitigate the risks posed by fiscal waivers.

A. Medicare for All would Deepen Fragmentation and Exacerbate the Tyranny of the Budget

In one important way, expanded federal responsibility for health care would consolidate disparate fiscal categories and thereby lessen the harms of fiscal fragmentation. Rather than shared among state, local, public, and private actors, the health care costs incurred by Americans would be borne entirely (or almost entirely) by the federal government.

Although prior scholarship has assumed that total federalization as through Medicare for All would eliminate fiscal fragmentation concerns,[245] it would in some ways deepen them. Constitutional, practical, and political constraints on the federal government's regulatory and spending powers limit the federal government's ability to influence upstream determinants of the cost of health care itself, namely, regulation of health care and of the social determinants of health.

The 2020 coronavirus pandemic provides a stark and tragic reminder that health outcomes in the United States are a function of a broad range of inter-related determinants. The medical care actually provided by one's doctor when she is sick is of course the most visible such determinant.[246] But there are many less-visible but important determinants that influence the cost, quality, and availability of medical care. Innovation policy (including but not limited to intellectual property) determines what technologies and drugs medical

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[244] *See* Medicare for All Act of 2019, S. 1129, 116th Cong. (2019) (universal national coverage bill proposed by Senator Sanders); Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019) (universal national coverage bill proposed by Representative Jayapal); William M. Sage, *Adding Principle to Pragmatism: The Transformative Potential of 'Medicare for All'*, 2 n.5, 5-9 (October 2019) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3387120 (surveying various proposals for expanded or universal federal health care coverage); Nicole Huberfeld, *Is Medicare for All the Answer? Assessing the Health Reform Gestalt as the ACA Turns* 10 at 11, Hous. J. of Health Law & Poly (forthcoming 2020) (Sanders bill "does not address whether HHS would retain demonstration waiver authority"). Fuse Brown and McCuskey offer an ERISA waiver as a way to solve ERISA's tendency to inhibit state reform, explicitly taking as inspiration Medicaid and ACA waivers. Erin Fuse Brown & Liz McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. ___, 209 (2020); *see also* Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255 (1990) (early treatment addressing how ERISA impedes state innovation). Their proposed waiver does not include a fiscal waiver authority. *See id.* at 64 n. 278 (treating as separate question beyond paper's scope implications of "federal tax preference given to employer-sponsored health insurance").

[245] As Professor Moncrieff understood it, significant inter-sovereign spillovers leave the federal government with "a decision between federalizing . . . and devolving healthcare spending." *See* Moncrieff, *supra* note 68, at 876–77.

[246] *E.g.* Michelle M. Mello, David M. Studdert, & Troyen A. Brennan, *The New Medical Malpractice Crisis*, 348 N. ENGL. J. MED. 2281 (2003).

professionals might have at their disposal and what they cost.[247] Scholars have repeatedly described how regulations and infrastructure policies—including professional licensure rules, the corporate practice of medicine doctrine, accreditation standards, and certificate of need laws—determine whether providers will be available, in what form, what they will cost, how much wasteful care they will provide, and where and when innovation happens.[248] And health insurance itself influences at what stage of illness patients seek medical help and what treatments and services their providers recommend when they do.[249]

Moreover, medicine is only a piece of the puzzle. Public health scholars have been emphasizing for some time that while the cost, quality, and availability of medical care is itself an important determinant of health outcomes in the United States, health outcomes have numerous other important, upstream determinants.[250] Vulnerability theory has developed an analogous but more general insight about the importance of state-influenced structures in promoting resilience.[251] Social, environmental, and behavioral factors—like marital or family status, income, nutrition, air quality, housing, employment, education, and racism—all contribute in significant and predictable ways to a person's health (her odds of getting sick), the care from medical providers and loved ones she receives if she does become sick, and her ability to remain well again if treated successfully.[252]

In fact, these "social determinants of health" are collectively more influential than medical care itself in determining health care costs and outcomes.[253] Relatedly, many in health policy believe the reason the United States spends much more on health care than other developed countries but gets comparatively worse health outcomes (what Bradley and

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[247] Rachel Sachs, *Prizing Insurance: Prescription Drug Insurance as Innovation Incentive*, 30 HARV. J. L. & TECH. 154 (2016).

[248] *See* Allison K. Hoffman, *What Health Reform Reveals about Health Law, in* THE OXFORD HANDBOOK OF U.S. HEALTH L. 61 (I. Glenn Cohen, et al. eds., 2017) ("Healthcare regulation can have paralyzing effects on innovation, especially in healthcare delivery."); William M. Sage, *Fracking Health Care: How to Safely De-Medicalize American and Recover Trapped Value for Its People*, 11 N.Y.U. J. L. & Lib. 635, 652 (2017) ("an astonishing amount of health care spending is plausibly unnecessary"); *see also* Gabe Scheffler, *The Dynamism of Health Law: Expanded Insurance Coverage as the Engine of Regulatory Reform*, U.C. IRVINE L. REV. (forthcoming 2020) (summarizing the significant extent to which health care cost, quality, and access are held back by outdated laws regulating health care providers including licensing, corporate practice, and certificate of need laws); William M. Sage, Explaining America's spendthrift healthcare system: the enduring effects of public regulation on private competition at 34, *in* THE LAW AND POLICY OF HEALTHCARE FINANCING: AN INTERNATIONAL COMPARISON OF MODELS AND OUTCOMES (Sauter et al. 2019) (calling for new turn in health policy to "the task of facilitating decentralized, incremental improvement" in order to "liberat[e] resources that are currently trapped in America's grossly inefficient healthcare system by accreted health law"); *Cf.* Inst. Of Med., Best Care At Lower Cost: The Path to Continuously Learning Health Care In America (2012) (estimating $750,000,000,000 annual waste in U.S. health care system).

[249] Matthew B. Lawrence, *The Social Consequences Problem in Health Insurance and How to Solve It*, 13 HARV. L. & POL'Y REV. 593 (2019) (describing impacts of health insurance on health care quality and access).

[250] LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 5 (3d ed. 2016); Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 U. PA. L. REV. 1649, 1652–54 (2011).

[251] E.g. Martha A. Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 Yale J. L. & Feminism 1, 13 (2008) ("state facilitated institutions . . . provide resilience in the face of vulnerability").

[252] Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J. L. & Biosciences (2020); Elizabeth Y. McCuskey, The Body Politic: Federalism as Feminism in Health Reform, 11 St. Louis U. J. Health L. & Pol'y 303, 311–13 (2018); Lindsay F. Wiley, From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care, 37 CARDOZO L. REV. 833 (2016).

[253] ELIZABETH BRADLEY & LAUREN A. TAYLOR, THE AMERICAN HEALTH CARE PARADOX: WHY SPENDING MORE IS GETTING US LESS (2013).

Taylor call the "American Health Care Paradox"[254]) is that the U.S. spends too little on social services to prevent illness and too much on health care to cure the illnesses it failed to prevent.[255] As one concrete example, "an additional $4.2 billion in health care costs per year [] is attributable to" the obesity epidemic in Mississippi alone."[256]

Medicare for All proposals do not, and constitutionally could not, propose federal takeover of all professional regulation or the provision of social services in the United States.[257] Therefore, even if such proposals were adopted, the states would continue to play a lead role in regulation of their health care systems and of the social determinants of health. Medicare for All would thus deepen the problem even as it limited it. One entity, the federal government, would now bear total responsibility for Americans' medical costs. Another entity, the states, would continue to hold either exclusive or substantial regulatory authority over the myriad determinants beyond health care coverage itself that ultimately influence both residents' likelihood of needing medical care and the cost of that care. Absent some mechanism to link federal costs with state investments, such as shared federal savings through fiscal waivers, the combination of high health care costs with low social services spending documented by Bradley & Taylor would be locked in place or even exacerbated as the entity responsible for paying those high health care costs would be different than the entities (the states) with primary authority over professional regulation and the social determinants of health.

B. Tailoring Accountable Innovation Grants to Inspire Investment, not Induce Disentitlement

The Article's study of fiscal waivers in the ACA and Medicaid offers guidance for how a fiscal waiver might be structured for inclusion in future health reform legislation to serve as a necessary stepping stone to greater investment in Americans' health (and the prevention of illness) while avoiding the risk of abuse and mitigating administrative law and

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[254] *Id.* at 4, 6, 15.

[255] *Id.* at 15 (United States spends much less on health-related social services *other* than medical care—like employment counseling, housing, and paid parental leave—than comparable countries); *id.* at 72 (same correlation between social services spending and health care costs repeats in the fifty states); *id.* at 173 (noting need to "share accountability" for health costs in order to overcome the "American health care paradox").

[256] Bradley & Taylor, *supra* at 173 (2013); *see also id.* (noting that these costs are ultimately borne by Medicaid, Medicare, and private insurance companies).

[257] It is conceivable that a single payer or other plan for increasing federal responsibility for health care costs would also entail federal takeover of responsibility for housing costs, transportation costs, infrastructure costs, education costs, and the regulation of medical practice. *See* Wiley, *Medicaid for All* at 891 (explaining that "Federal single-payer health care could prompt further federalization"). But no current plans propose this and constitutionally, historically, and practically considerations make it likely states will continue to have significant influence over their residents' health. *Nat'l Fed. Ind. Bus. v. Sebelius*, 567 U.S. 519, 562–574 (2012) (describing constitutional limitation of federal role to enumerated powers); *Jacobsen v. Commonwealth of Mass.*, 197 U.S. 11, 24–25 (1905) ("state[s] did not surrender" the "police power . . . when becoming a member of the Union"); Nicole Huberfeld, *Federalism in Health Care Reform* 200-205 *in* HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY (MICHAEL ROSSER, ED. 2019) (describing increasing but still limited federal role in health regulation over time from founding to present day); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (describing history of regulation of medicine in states).

federalism concerns.[258] "Accountable Innovation Grants" could foster beneficial investment while avoiding abuse by being structured as follows:

1. Carefully constrain awards

First, and foremost from a health policy perspective, payments through a fiscal waiver must not reward states for reducing utilization of health care. Increasing states' financial interest in reducing utilization, as the Trump Administration has sought to do,[259] undesirably encourages states to cut benefits and eligibility despite adverse health and equality impacts of such cuts.[260] On the other hand, rewarding investments in health-related public goods or quality, as in the Alaska reinsurance program financed through the ACA's pass-through provision, desirably encourages states to make such investments while circumventing budgetary constraints.

This substantive focus on risk shared is analogous to other cutting-edge health care financing tools. Health Maintenance Organizations ("HMOs") were a relatively early effort to share health care costs (and so savings) between health insurers and providers by having providers work directly for insurers that came to the fore in the 1990s,[261] because of the acknowledged benefit of encouraging coordination. HMOs inspired widespread backlash due to significant concerns that physicians' new financial interest in their patients' care costs was leading them to reduce costs by avoiding *necessary* treatment rather than merely by avoiding unnecessary treatments or promoting patient health.[262]

The difficulties that arose from HMOs' complete commingling of professional and financial incentives did not foreclose forever the promise of sharing savings between providers and payers to promote better health care. Scholars and policymakers realized that careful attention must be paid to which risks are shared, which determines how the recipient exercises its discretion in order to attempt to reduce costs.[263] The lesson in health care was to share risks related to the quality of care and patient health outcomes, but not to share risks related to utilization (how many patients are eligible for and seek care, and how much they seek), while setting quality criteria that an entity must continue to satisfy in order to receive payment.

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[258] Public health scholars have recently noted the need for some entity to coordinate community investment in social determinants of health. Len M. Nichols and Lauren A. Taylor, *Social Determinants As Public Goods: A New Appropriation to Financing Key Investments in Health Communities*, 37 HEALTH AFFAIRS 1229 (2018). Accountable Innovation Grants would empower states to play this role.

[259] *See supra* notes 115–118 (describing proposal). From the standpoint of the underlying entitlement programs and of mainstream normative perspectives that assign the government a role in ensuring the health of residents and problematize health disparities, cuts to benefits and eligibility despite adverse health impacts are bad and investments in health-related public goods are good. *See supra* notes 58–59 (explaining normative perspectives and statutory purposes on which disentitlement is undesirable).

[260] *See* David Super, *The Political Economy of Entitlement*, 104 COLUM. L. REV. 633, 650–657 (2004) (offering taxonomy of senses in which word "entitlement" is used).

[261] Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 4 (1999) (describing controversy surrounding HMOs)

[262] See David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 222 (2000) (describing laws proliferating in response to backlash).

[263] *See* Donald M. Berwick, *Launching Accountable Care Organizations—The Proposed Rule for the Medicare Shared Savings Program*, 364 N. ENGL. J. MED. 1753 (April 21, 2011) (describing how shared savings in ACO program mitigates risks of abuse).

So it is that, two decades after "HMO" became a four letter word, Accountable Care Organizations ("ACOs") are a centerpiece of the ACA's effort to reform health care. ACOs permit groups of physicians organized together to become entitled to financial reward if their patients incur reduced Medicare costs.[264] Far from unpopular, ACOs are seen as a promising model for the future of health reform and were a centerpiece of the ACA's efforts to bend the cost curve.[265] Like HMOs, the structure of ACOs gives physicians some financial stake in their patients' costs. But ACOs are not thought to carry the same potential for abuse as HMOs because federal savings are shared carefully, with a focus on ensuring ACOs are not rewarded for preventing patients from obtaining care.[266]

Fiscal waivers could do the same. Ensuring that fiscal waivers are not used to reward states for reducing utilization actually becomes easier as federal responsibility for health care costs grows, because states would have a diminished ability to interfere with their residents' utilization in the first place. Today the problem is that states receive awards through fiscal waivers in programs they administer and share financial responsibility for—like Medicaid—and so can readily tailor forms, coverage decisions, or enrollment processes to keep beneficiaries out. Prominent Medicare for All proposals do not leave states any such administrative role.

Three further steps, drawn from prior experience with ACOs and the ACA, can assure that states are not rewarded for decreased utilization. First, the statute should include judicially-enforceable guardrails that make fiscal waivers unavailable for any reform that negatively impacts the affordability of coverage, the comprehensiveness of coverage, or the generosity of coverage for any state resident. The ACA includes analogous guardrails but they are written less clearly than they could be, and the Trump Administration has interpreted them in ways that risk harm to many state residents.[267] Future legislation should instead include explicit criteria that align with the Obama Administration's (now rescinded) interpretive guidance.[268] Second, the statute should provide for close federal oversight of and reporting on a state's compliance with these guardrails during the life of a fiscal waiver, a step that Miller, Huberfeld, and Jones explain helped Vermont's and Rhode Island's

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[264] Some ACOs also take on the risk of increases in Medicare costs. *See* David Newman, Congressional Research Service, R41474, *Accountable Care Organizations and the Medicare Shared Savings Program* (2010).

[265] *Id. See also* Donald M. Berwick, *Launching Accountable Care Organizations—The Proposed Rule for the Medicare Shared Savings Program*, 364 N. Engl. J. Med. 1753 (April 21, 2011) (commentary by CMS Administrator explaining that by sharing savings between "physicians, hospitals, public or private players, or employers," ACO programs overcome the "[f]ragmentation" that "leads to waste and duplication"); David Newman, Cong. Research Serv., R41474, Accountable Care Organizations and the Medicare Shared Savings Program (2010) (collecting sources on shared savings between hospitals and other payers); *see also, e.g.*, Erin Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation or Cost* Control, 92 IND. L.J. 55, 63 (2016) (describing shared savings in Medicare between providers and payers); Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L. J. 519, 574 (2013) (discussing "shared savings" in ACA).

[266] *Id.*

[267] State Relief and Empowerment Waivers, 83 Fed. Reg. 53575 (Oct. 24, 2018); *see* Katie Keith, *Feds Dramatically Relax Section 1332 Waiver Guardrails*, Health Affairs Blog (Oct. 23, 2018) ("the new guidance . . . significantly relaxes the standards").

[268] Waivers for State Innovation, 80 Fed. Reg. 78131 (Dec. 16, 2015).

Medicaid waivers avoid encouraging disentitlement.[269] Third, as is a common step in mitigating adverse incentives, the statute should require any federal savings shared with states be calculated on a per capita basis rather than on an overall population basis.[270]

2. Require transparency in waiver consideration

Some agency discretion in using fiscal waivers is inevitable, as fact-intensive judgments will be necessary to decide on the magnitude of awards and monitor for compliance with guardrails as well as fraud, waste, and abuse, no matter how specific the statute.[271] Nonetheless, a fiscal waiver authority in any expanded federal health care legislation should require by statute the procedural protections that Part IV.D suggested HHS adopt, above: a deadline for review of state applications, written explanations of denials with considerations connected to statutory criteria, reporting of agency/state communications regarding waiver contents, and advance promulgation of substantive requirements for waiver applications by notice and comment rulemaking.

In the analogous setting of Medicare reimbursement policy, Congress has expressly required that HHS use notice and comment rulemaking to develop the substantive criteria it will use in making individual payment decisions.[272] The Supreme Court recently reaffirmed this requirement in an opinion emphasizing Congress's judgment of the importance of notice-and-comment as a constraint on the agency's ability to shape national health policy.[273] Future health reform legislation should similarly subject agency discretion in any fiscal waiver authority to public input and judicial review by including language identical to the Medicare statute's provision requiring substantive payment standards be established by regulation.

Beyond these administrative law safeguards, future health reform legislation could include additional requirements further constraining agency discretion to limit the risk of abuse. The ACA's Center for Medicare and Medicaid Innovation waiver authorities permit the agency to reimburse providers nationwide for expenses not otherwise payable in Medicare or Medicaid, but only where the agency's actuary certifies that such payments are expected to be deficit neutral to the federal government over the long term.[274] A similar professional certification process, perhaps including peer review of award proposals as in

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[269] *See* Edward Allen Miller, Nicole Huberfeld, & David K. Jones, *Pursuing Medicaid Block Grants with the Healthy Adult Opportunity Initiative: Dressing Up Old Ideas in New Clothes* at 10-11, J. Health Politics, Policy and Law (2020) (describing limitations on Vermont and Rhode Island waivers, along with close oversight, that helped prevent these waivers from creating the problematic results associated with block grants).

[270] *Id.*

[271] *See* Michael Smart, *The Incentive Effects of Grants* at 206-207, *in* INTERGOVERNMENTAL FISCAL TRANSFERS: PRINCIPLES AND PRACTICE (Robin Broadway & Anward Shah Eds. 2007) (describing this risk that states may seek to increase federal payments through accounting tricks but also noting that "a large body of empirical literature has demonstrated that intergovernmental transfers are disproportionately spent on public services, rather than tax cuts"); DANIEL L. HATCHER, THE POVERTY INDUSTRY 112 (NYU 2016) (offering example of New Hampshire scheme); *see also* Kathryn G. Allen, U.S. Government Accountability Office, *Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight* (2014); David A. Super, Federal-State Budgetary Interactions at 376, *in* FISCAL CHALLENGES: AN INTERDISCIPLINARY APPROACH TO BUDGET POLICY (Elizabeth Garrett et al., eds. 2008) ("Medicaid 'maximization' plans allow states to draw down additional federal matching dollars without increasing their own contributions.").

[272] 42 U.S.C. § 1395hh(a)(2).

[273] *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1808 (2019).

[274]Section 1115A(b)(3).

grant review by the National Institutes of Health,[275] would further decrease the risk of arbitrariness, reassure congressional scorekeepers regarding the true budgetary effects of payments,[276] and facilitate development by states of proposals likely to qualify for innovation grants. The point at which the value of the protection provided by such additional safeguards is outweighed by the degree to which they limit the realm of potential state reforms eligible for waivers will depend on how one balances the conflicting goals of unleashing investment and preventing abuse.[277]

3. Preference for new or untested innovations

Currently, the seventh state to implement a health investment financed by a fiscal waiver is entitled to the same federal award as the first. Yet research on state policy innovation has borne out Rose Ackerman's prediction that the costs of trying a policy are the greatest for the first-moving states and that once one state shows a policy works, others will soon follow.[278] To increase the extent to which innovation grants serve an inspiration function rather than merely directing state reforms, priority in processing and grant awards should go to early adopters and novel state proposals.[279] Moreover, by publicly and ostentatiously awarding grants to pioneering states (who want the publicity), federal agencies wielding fiscal waiver authorities would give "credit" for the investment to the political actors in states whose time, effort, political capital, and state apparatus are necessary to it. It would thereby concentrate political accountability for such investments in the states rather than split such accountability between elected state policymakers and unelected agency officials or the president.

CONCLUSION

HHS can use fiscal waiver authorities in Medicaid and the ACA to influence state health policy either by inspiring state innovation or by steering the course of health policy, encouraging some state reforms with financial awards and discouraging others by refusing waivers. This influence makes these fiscal waiver authorities a double-edged tool from the perspectives of substantive policy, federalism, and administrative law. Fiscal components increase the benefits and risks of "big waiver" in health care. Fiscal waiver authorities offer a way to avoid the "tyranny of the budget" that otherwise impedes health reform, but such authorities also give the agency a power to deny funds to states (and so condition the award of such funds) in ways that can be problematic. Indeed, hidden executive conditions represent a distinctive method of governance that may be subject to future judicial scrutiny under federalism and administrative law doctrines, if and when courts are called upon to adjudicate a waiver denial or partial denial. HHS could minimize legal risk by adopting

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[275] Price, *supra* note 109 at 20–29.

[276] *See supra* Part II.C (sharing federal savings uniquely viable in constrained budget environment).

[277] *See supra* Part IV.C.

[278] Michael S. Sparer & Lawrence D. Brown, States and the Health Care Crisis: Limits and Lessons of Laboratory Federalism at 193, *in* HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES (Robert F. Rich & William D. White, eds. 1996) ("States do look at and learn from other states.")

[279] National Institutes of Health, Director's Pioneer Award, https://commonfund.nih.gov/pioneer/faq (offering pioneer award for creative and innovative biomedical researchers to fund cutting-edge research).

greater transparency in its use of its fiscal waiver authorities, and future health reform legislation including fiscal waiver authorities could make such transparency mandatory with Accountable Innovation Grants.

Finally, the Article has underscored the need for greater understanding of the interaction between fiscal federalism and state innovation and developed fiscal waivers as an example of how legal structures shape and are shaped by that interaction. Fiscal waivers are part of the problem with federalism in American health care, but they can also be part of the solution.