William & Mary Law Review

Volume 62 (2020-2021)
Issue 5

Article 3

4-1-2021

Fiscal Waivers and State "Innovation" in Health Care

Matthew B. Lawrence

FISCAL WAIVERS AND STATE "INNOVATION" IN HEALTH CARE

MATTHEW B. LAWRENCE*

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 policy making 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).

This 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 share federal

* Associate Professor of Law, Emory Law; Affiliate Faculty, Harvard Law School, Petrie-Flom Center for Health Law Policy, Bioethics, and Biotechnology. Thanks to Erin Fuse Brown, Martha Fineman, Barry Friedman, A. Lawrence, Kristin Madison, Medha Makhlouf, Liz McCuskey, Gillian Metzger, Jonathan Nash, Eloise Pasachoff, Bill Sage, Robert Schapiro, Fred Smith, Raquel Spencer, David Super, Susannah Tahk, Sydney Watson, and Lindsay Wiley. Thanks also to audiences at Dickinson Law, Emory Law, the Beazley Institute for Health Law and Policy at Loyola University Chicago School of Law, the Federal Funding Issues Workshop, Hall Center for Health Law at Indiana University McKinney School of Law, and the AALS Virtual Poverty Law Workshop.

savings, using delegated scorekeeping to overcome the "tyranny of the budget" and its adverse effects on health reform. But the informality currently surrounding the agency's use of executive conditions on waiver approvals makes fiscal waiver authorities ripe for leveraging and abuse, raising health policy, federalism, and administrative law concerns.

This 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. It recommends that HHS bring greater formality to its process for approving, denying, or negotiating state waiver requests and cautions that if the agency does not do so then courts may force such formality on it by way of nondelegation, federalism, or administrative law doctrine. It also suggests the development of a pioneer pathway program with greater predictability and fiscal flexibility to facilitate health-promoting state innovations.

TABLE OF CONTENTS

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 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. This 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; to draw general implications for law and legal scholarship; and to develop specific prescriptions for courts, HHS, and Congress.

This 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 policy making 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

---

1. *See* Robert A. Schapiro, *States of Inequality: Fiscal Federalism, Unequal States, and Unequal People*, 108 CALIF. L. REV. 1531, 1536 (2020) ("We have concentrated too much attention on constitutional doctrine and not enough on money."); David A. Super, *Rethinking Fiscal Federalism*, 118 HARV. L. REV. 2544, 2549, 2652 (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*

and valuable tool in health policy because they reduce these score-keeping 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 score-keepers 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 and eligibility by molding their incentives; the Trump administration 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. 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, nondelegation, and administrative law grounds.

Ultimately, this 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

---

Dysfunctional Democracy, HEALTH AFFS. BLOG (Dec. 19, 2018) [hereinafter Sage, *Ends and Means*], https://www.healthaffairs.org/do/10.1377/hblog20181219.912615/full/ [https://perma.cc/URC6-UP2E] (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*, 48 J.L. MED. & ETHICS 434 (2020); Timothy Westmoreland, *Invisible Forces at Work: Health Legislation and Budget Processes*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW 873 (I. Glenn Cohen et al. eds., 2017) (arguing that budget process rules have shaped health reform); William M. Sage, Adding Principles to Pragmatism: The Transformative Potential of "Medicare-for-All" 14-15, 23-24 (Feb. 2020) (unpublished manuscript) [hereinafter Sage, Adding Principles to Pragmatism], https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3387120 [https://perma.cc/TT5D-FSBT] (describing importance of tyranny of the budget in shaping health reform).

of 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 $1.28 trillion in health care spending annually represents 36 percent of costs nationwide.[3] (This share will only grow, and the federal government would pay 100 percent of Americans' health care costs (accounting for 18 percent of GDP) under prominent "Medicare for All" proposals.)[4] The Trump administration 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]

---

3. *See infra* notes 166-73 and accompanying text (breaking down federal role in health-care spending); *infra* Table 1. This number reflects an average because the federal government shoulders a much larger fraction of medical costs in some states than others. *See* Schapiro, *supra* note 1, at 1579 (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); Matej Mikulic, *U.S. Health Care Expenditure as a Percentage of GDP 1960-2020*, STATISTA (June 8, 2020), https://www.statista.com/statistics/184968/us-health-expenditure-as-percent-of-gdp-since-1960/ [https://perma.cc/45UZ-736U] (describing health care as share of gross domestic product).

5. *E.g.*, Abby Goodnough, *Trump Administration Unveils a Major Shift in Medicaid*, N.Y. TIMES (Jan. 30, 2020), https://www.nytimes.com/2020/01/30/health/medicaid-block-grant-trump.html [https://perma.cc/KJ24-JTMJ]; Robert Pear, *Trump Administration Approves Medicaid Work Requirements in Utah*, N.Y. TIMES (Mar. 29, 2019), https://www.nytimes.com/2019/03/29/us/politics/medicaid-trump-utah.html [https://perma.cc/PRS5-4XXR]. On the legal authorities and reforms behind these headlines, see *infra* Parts II.A.2, II.B.2.

6. *See infra* notes 37-40 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, 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, 281-82 (2013); *see also id.* at 291

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] This Article's proposed pioneer pathway, 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.

This Article proceeds in five parts. Part I introduces fiscal waiver authorities in health care. It summarizes the focus of "big waiver"

(defining "big waiver" as the power "to displace a regulatory baseline that Congress itself has established"). Critiques of Barron and 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 and Rakoff's understanding of big waiver authorities as granting agencies the "power to displace the *regulatory* baseline set by Congress" (emphasis added)); Edward H. Stiglitz, *Forces of Federalism, Safety Nets, and Waivers*, 18 THEORETICAL INQUIRIES L. 125, 127 (2017) (focusing on regulatory waiver authorities); Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO STATE L.J. 1099, 1129-33 (2017); Jessica Bulman-Pozen, *Executive Federalism Comes to America*, 102 VA. L. REV. 953, 977-78 (2016); Bruce P. Frohnen, *Waivers, Federalism, and the Rule of Law*, 45 PERSPS. ON POL. SCI. 59, 60 (2016); Samuel R. Bagenstos, *Federalism by Waiver After the* Health Care Case, *in* THE HEALTH CARE CASE: THE SUPREME COURT'S DECISION AND ITS IMPLICATIONS 227, 228-30 (Nathaniel Persily et al. eds., 2013). That is not to say that the analyses in these treatments are not invaluable in evaluating fiscal waiver authorities (they are); this Article discusses ways that the distinction between regulatory and fiscal authorities makes a difference, *see infra* Part III. Meanwhile, another important line of health law scholarship has analyzed aspects of Medicaid and ACA waiver authorities, including their fiscal components but has 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) (stating that the federal government's "negotiating levers" include "regulatory policy and budget generosity"); Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 OHIO STATE L.J. 843, 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* Parts II.A.1, II.B.1 (describing spillovers and fragmentation).

9. *See infra* notes 152-61 and accompanying text (describing underinvestment).

10. Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J.L. & BIOSCIENCES, June 29, 2020.

scholarship on regulatory waiver authorities—which permit an agency to alter the rules set by Congress—in the ACA, Medicaid, and other intrastatutory 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 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.

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 waiver." 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 formality surrounding fiscal waiver deliberations might lead courts to scrutinize executive conditions under federalism, nondelegation, and administrative law doctrines. It then recommends

11. *See* Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 542 (2011) (describing intrastatutory federalism as state flexibility within federal statutory programs).

HHS bring greater formality 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 the health of their populations but have reduced financial incentive and fiscal capability to invest therein. Part V therefore derives from this Article's discussion a set of statutory constraints to frame a pioneer pathway 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. This 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, this 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.

---

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 be helpfully drawn from analysis of particular policy domains, and normative insights may well be limited to such domains. *See, e.g.*, Gluck & Huberfeld, *supra* note 7, at 1704-05, 1719-24 (discussing the 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 (2017) (describing the "need for case-specific federalism"); Heather K. Gerken, *Our Federalism(s)*, 53 WM. & MARY L. REV. 1549, 1552 (2012) ("Such debates ... can only be hashed out in context—domain by domain, policymaking arena by policymaking arena.").

13. Some of what this 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"—that is, cases presenting the statutory interpretation question whether the *Pennhurst* clear statement rule for conditions on federal

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 ACA and Medicaid are core authorities evaluated in such scholarship.[15]

This scholarship has focused on regulatory components of waiver authorities—that is, 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. These provisions 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 is not

---

spending or *Chevron* 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. 1197 (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, 70 DUKE L.J. 1057 (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* note 7 (collecting sources).

15. *See* Stiglitz, *supra* note 7, at 131-39 (discussing Medicaid waivers); McCuskey, *supra* note 7, at 1129-33 (discussing ACA waivers); Bulman-Pozen, *supra* note 7, at 977-79 (discussing ACA and Medicaid waivers); Frohnen, *supra* note 7, at 59-60; Barron & Rakoff, *supra* note 7, at 281-84, 299 (discussing ACA and Medicaid waivers); Bagenstos, *supra* note 7, at 228-30 (discussing Medicaid waivers).

16. *See supra* note 7 (collecting sources).

just big waiver, it is big money. Section 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] Section 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] This 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.

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 *National Federation of Independent Business v. Sebelius* or *King v. Burwell* knows well, the ACA seeks to breathe 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 percent of the federal poverty level, or $104,800 for a family of four in 2020) for those who do not have insurance from another source.[21] For such individuals, the federal government

17. *See* Patient Protection and Affordable Care Act § 1332(a)(3), 42 U.S.C. § 18052(a)(3).

18. *See* Social Security Act § 1115, 42 U.S.C. § 1315.

19. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 539-40 (2012) (discussing the purposes of ACA); King v. Burwell, 576 U.S. 473 (2015); 42 U.S.C. § 18091(2)(C) (laying out the purposes of ACA); 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, 300gg-1, 300gg-3, 300gg-4(a).

21. *See* Patient Protection and Affordable Care Act § 1401, 26 U.S.C. § 36B; Federal Poverty Level (FPL), HEALTHCARE.GOV, https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ [https://perma.cc/ASM5-4L3N] (stating that in 2020, the federal poverty level was

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 percent 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 percent of enrollees in 2018.[24]

Section 1332 of the ACA 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 provision's regulatory waiver authority,[29] 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 through the exchange for that state.[30] This significantly brings down premiums

---

$26,200 for a family of four).

22. § 1401; § 1412.

23. *Id.* § 1402.

24. *See Early 2019 Effectuated Enrollment Snapshot*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Aug. 12, 2019), https://www.cms.gov/newsroom/fact-sheets/early-2019-effectuated-enrollment-snapshot [https://perma.cc/9PHB-5PMW]; *infra* Table 1.

25. § 1332.

26. § 1332(a)(1).

27. § 1332(a)(3); *see also* State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575, 53,580 (Oct. 24, 2018) (describing sharing, referred to as "pass-through" of savings).

28. § 1332(a)(3).

29. *See infra* note 37.

30. Letter from Governor Bill Walker to Lina Rashid, Senior Pol'y Advisor, Ctrs. for Medicare & Medicaid Servs. (July 31, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Alaska-STCs-signed-by-Treasury.pdf [https://perma.cc/5VHB-2776] (accepting final terms and conditions of waiver approval).

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 making that calculation.[31] 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.[32] 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.[33] 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.[34] 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

---

31. CTRS. FOR MEDICARE & MEDICAID SERVS., ALASKA: STATE INNOVATION WAIVER UNDER SECTION 1332 OF THE PPACA (2017) [hereinafter ALASKA: STATE INNOVATION WAIVER], https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf [https://perma.cc/E9Bu-YZ8G]; § 1312(c)(1).

32. ALASKA: STATE INNOVATION WAIVER, *supra* note 31.

33. Alaska's waiver application initially sought to waive a provision of law Alaska described in its application as not relevant to its waiver. *See* Letter from Governor Bill Walker to Sylvia Mathews Burwell, HHS Secretary (Dec. 29, 2016), https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/Alaska%201332%20State%20Innovation%20Waiver%20June%2015%202017.pdf?ver=2017-06-26-091456-033 [https://perma.cc/BU9S-ATDV] ("Alaska is seeking to waive Section 1301(a)(2) of the [ACA] which would have allowed the state to establish a CO-OP or Community Health Option. The majority of CO-OPs that were created after the enactment of the ACA have failed, and it is not feasible that one will be established in Alaska. Waiving this provision will not have an impact on the healthcare market in Alaska."). The application was ultimately revised to request a waiver of a requirement that insurers consider all enrollees in the individual market to be members of the same risk pool but stated that "[n]o other section of the ACA would be affected by the proposed waiver." ALASKA DEP'T OF COM., CMTY., & ECON. DEV., DIV. OF INS., ALASKA 1332 WAIVER APPLICATION 13 (2016) [hereinafter ALASKA 1332 WAIVER APPLICATION], https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/Alaska%201332%20State%20Innovation%20Waiver%20June%2015%202017.pdf?ver=2017-06-26-091456-033 [https://perma.cc/BU9S-ATDV].

34. ALASKA 1332 WAIVER APPLICATION, *supra* note 33, at 6.

ultimately approved by the Trump administration, and Alaska received millions in federal savings to fund the program.[35]

Alaska's reinsurance program has kicked off a cascade of state innovation, as state after state has proposed and requested federal dollars for similar programs.[36] At this writing, sixteen 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.[37] States have explained that this financial reward has been outcome-determinative in permitting them to adopt reinsurance reforms.[38] The numbers tell the same story. New Jersey's reinsurance program entitled it to shared savings in the form of pass through of over $188 million in 2019.[39] Maryland's generated the largest savings, receiving $373 million.[40]

Building on the fiscal focus of the Alaska-type waivers, HHS is now encouraging and states are developing new state health reforms that are also fueled by the potential for federal fiscal

---

35. Letter from Governor Bill Walker, *supra* note 30.

36. Brad Wright, Anna Porter, Phillip M. Singer & David K. Jones, *The Devolution of Health Reform? A Comparative Analysis of State Innovation Waiver Activity*, 44 J. HEALTH POL. POL'Y & L. 315 (2019) (describing series of state reinsurance reforms following Alaska's example).

37. Sixteen states have received section 1332 waivers, in most cases to implement affordability-promoting high-risk pool reinsurance programs and obtain pass through of the millions of dollars of associated federal savings. *See Tracking Section 1332 State Innovation Waivers*, KAISER FAMILY FOUND. (Nov. 1, 2020), https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/ [https://perma.cc/TEY3-U8HT] (describing waivers in Alaska, Colorado, Delaware, Georgia, Hawaii, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, and Wisconsin, all of which are reinsurance-type programs with the exception of Hawaii).

38. *E.g.*, ZACHARY W. SHERMAN & MARIE GANIM, OFF. OF THE HEALTH INS. COMM'R, RHODE ISLAND'S 1332 WAIVER APPLICATION 5 (2019), https://healthsourceri.com/wp-content/uploads/190708_FinalApplicationPackage.pdf [https://perma.cc/46D5-S2WY]; J.P. WIESKE, OFF. OF THE COMM'R OF INS., WISCONSIN HEALTHCARE STABILITY PLAN 16 (2018), https://oci.wi.gov/Documents/AboutOCI/Wisconsin%20Healthcare%20Stability%20Plan%20-%20FINAL%20public%20pp.pdf [https://perma.cc/H598-XZDA].

39. *See Section 1332: State Innovation Waivers*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- [https://perma.cc/B79H-DNUP] (navigate down to "Pass-through Funding Tools and Resources," and then "2019 Pass-through Funding," to select "Key Components of PPACA Section 1332 Tentative Pass-through Payments Reinsurance Waivers, 2019 (XLSX)") (providing excel spreadsheet with data regarding several states' reinsurance waivers).

40. *Id.*

flexibility; some 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 low-income Americans that in many ways is the linchpin of the United States health care system.[41] 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."[42] The Medicaid statute sets out a governing federal framework, but states have wide latitude to make changes.[43]

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 federal government then pays states 50-83 percent of those costs (and 90 percent for the "expansion population" added by the ACA),

---

41. Isaac D. Buck, *Managing Medicaid*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 107, 111 n.11 (2017).

42. JEAN HEARNE, CONG. RSCH. SERV., RL33019, MEDICAID ELIGIBILITY FOR ADULTS AND CHILDREN 27 (2005), http://research.policyarchive.org/2518.pdf [https://perma.cc/DB6Y-3SNQ].

43. *See* 42 U.S.C. §§ 1396-1396w-5; *see also* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 584-86 (2012) (plurality opinion) (holding mandatory Medicaid expansion unconstitutional and severing offending provision by rendering expansion optional).

varying up or down based on a statutory formula that considers the relative financial resources of the state.[44] States are responsible only for their costs remaining after this contribution. Through Medicaid, the federal government paid $399 billion for medical costs in 2018.[45]

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.[46]

As written, Medicaid's fiscal waiver authority would allow HHS to provide federal matching payments for essentially any state

---

44. *See* 42 U.S.C. §§ 1396b, 1396d(b). *See generally* ALISON MITCHELL, EVELYNE P. BAUMRUCKER, KIRSTEN J. COLELLO, ANGELA NAPILI & CLIFF BINDER, CONG. RSCH. SERV., R43357, MEDICAID: AN OVERVIEW (2019), https://fas.org/sgp/crs/misc/R43357.pdf [https://perma.cc/3DC4-SLAN] (explaining state Medicaid distributions); ALISON MITCHELL & SARA BENCIC, CONG. RSCH. SERV., IF10399, OVERVIEW OF THE ACA MEDICAID EXPANSION (2018), https://fas.org/sgp/crs/misc/IF10399.pdf [https://perma.cc/KC25-RHRG].

45. *See infra* Table 1.

46. 42 U.S.C. § 1315. Some "experiments" have been going on for decades and are not subject to meaningful evaluation. *See* Sara Rosenbaum, Maria Velasquez, Rachel Gunsalus, Rebecca Morris & Alexander Somodevilla, *Will Evaluations of Medicaid 1115 Demonstrations that Restrict Eligibility Tell Policymakers What They Need to Know?*, COMMONWEALTH FUND (Dec. 12, 2018), https://www.commonwealthfund.org/publications/issue-briefs/2018/dec/evaluations-medicaid-1115-restrict-eligibility [https://perma.cc/QJ27-DLYK] (highlighting the lack of meaningful evaluation regarding an Arkansas experiment). *See generally* Anthony Albanese, Essay, *The Past, Present, and Future of Section 1115: Learning from History to Improve the Medicaid-Waiver Regime Today*, 128 YALE L.J.F. 827 (2019) (tracing the history and lack of follow-through on experiments). Recently courts have rejected HHS's determinations that certain controversial regulatory waivers were "likely to assist in promoting the objectives" of Medicaid. *See* Gresham v. Azar, 950 F.3d 93, 99-102 (D.C. Cir. 2020) (quoting 42 U.S.C. § 1315), *cert. granted*, 2020 WL 7086046 (Dec. 4, 2020) (No. 20-38); Stewart v. Azar, 313 F. Supp. 3d 237, 260 (D.D.C. 2018).

expenditure that HHS thought would contribute to the health of (or perhaps improve health coverage for) program beneficiaries.[47] 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.[48] HHS has not opted to exercise the authority in so expansive a manner, however.

Beginning with the Reagan administration, and as reportedly insisted on by the Office of Management and Budget (OMB) in the Executive Office of the President, HHS has voluntarily, as a matter of administrative discretion, converted section 1115(a)(2) from an almost unbounded agency power to increase state funding into a shared federal savings mechanism akin to that in the ACA.[49] In a perfect illustration of the influence of the "tyranny of the budget" over the development of health policy,[50] HHS (through its Centers for Medicare & Medicaid Services (CMS)) 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).[51] But the agency will only do so if the state makes changes, cuts, or investments that HHS calculates (often using fuzzy math[52]) will save the federal

47. *See* Griffin Schoenbaum, Comment, *Predetermined? The Prospect of Social Determinant-Based Section 1115 Waivers After* Stewart v. Azar, 124 DICK. L. REV. 533, 543-44 (2020).

48. *Id.* at 543-47.

49. Frank J. Thompson & Courtney Burke, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. HEALTH POL. 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. 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); Allen Dobson, Donald Moran & Gary Young, *The Role of Federal Waivers in the Health Policy Process*, 11 HEALTH AFFS. 72, 85-86 (1992).

50. *See infra* Part III.B.1 (discussing "tyranny of the budget").

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

52. U.S. GOV'T ACCOUNTABILITY OFF., 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

government amounts equivalent to the amount of the new federal expenditures.[53]

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.[54] 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.[55] Indeed, the Massachusetts

---

MOST VULNERABLE CITIZENS (2016).

53. Letter from Timothy B. Hill, Acting Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs., Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects (Aug. 22, 2018) [hereinafter CMS Budget Neutrality Policy], https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf [https://perma.cc/U9FA-BJQE] ("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 [hereinafter *Section 1115 Research and Demonstration Waivers*], https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/ [https://perma.cc/TL4N-V52N] ("Over time, CMS has allowed states to calculate budget neutrality in multiple ways.... Section 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.").

54. Alissa Halperin, Patricia Nemore & Vicki Gottlich, *What's So Special About Medicare Advantage Special Needs Plans? Assessing Medicare Special Needs Plans for "Dual Eligibles"*, 8 MARQ. ELDER'S ADVISOR 215, 245 (2007) ("Federal law allows states to seek a waiver ... while remaining budget neutral."); Lisa Dubay, Christina Moylan & Thomas R. Oliver, *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, Comment, *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.").

55. *See* John Holahan & Len Nichols, *State Health Policy in the 1990s*, *in* HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES 39, 48-54 (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).

expansion that inspired the ACA was made possible by shared federal savings awarded through the fiscal authority.[56] 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.[57] By 2015, 33 percent of federal Medicaid expenditures were spent through this fiscal waiver authority, accounting for $109 billion in forty states.[58]

II. AGENCY USE OF FISCAL WAIVERS TO INFLUENCE STATE POLICY MAKING

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 Section isolates from the messy, real world experience of health reform a distinct way that fiscal waiver authorities influence state policy making—inspiring states (Section A) and inducing states (Section B). 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 Section also develops implications of the function it describes from three normative perspectives: federalism, which focuses on the role of states;[59] substantive policy, which focuses on

56. *See* Nicole Huberfeld, *Federalism in Health Care Reform*, *in* HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 197, 198 (Ezra 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).

57. 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 108, 111 (Wolf 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 111-12.

58. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 52.

59. This Article focuses on the core federalism value of experimentation. *See* Schapiro, *supra* note 1, at 1532-38 (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).

real world outcomes in a given domain such as health,[60] including compliance with statutory goals;[61] and administrative law, which focuses on agency discretion and the separation of powers.[62] My goal in developing such implications is descriptive. I highlight effects of fiscal waiver authorities that are particularly salient from the standpoint of key 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

---

60. *See* 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." (footnote omitted)).

61. Courts and some readers may prefer to evaluate the policy impacts of fiscal waivers from a statutory perspective rather than a theoretical one. Both the Medicaid statute and the ACA have providing access to health insurance coverage as a broad purpose. *See* Gresham v. Azar, 950 F.3d 93, 99 (D.C. Cir. 2020) ("[T]he principal objective of Medicaid is providing health care coverage."), *cert. granted*, 2020 WL 7086046 (Dec. 4, 2020) (No. 20-38); 42 U.S.C. § 1396-1 (describing purpose of Medicaid statute as "to furnish ... medical assistance on behalf of families"); King v. Burwell, 576 U.S. 473, 498 (2015) ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them."); 42 U.S.C. § 18091 (describing the goal of ACA as to "add millions of new consumers to the health insurance market ... and ... increase the number and share of Americans who are insured"). Most of the normative concerns raised in this Article surround this core objective and so are the same regardless of 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.

62. This Article's normative approach to administrative law relies on two core values implicated when agencies rather than Congress make decisions, namely accountability and avoiding arbitrariness. *See* Lisa Schultz Bressman, *Beyond Accountability: Arbitrariness and Legitimacy in the Administrative State*, 78 N.Y.U. L. REV. 461, 464 (2003) ("[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, Liberty, and the Constitution*, 98 COLUM. L. REV. 531 (1998) (describing accountability value); Richard B. Stewart, *The Reformation of American Administrative Law*, 88 HARV. L. REV. 1667 (1975) (describing the roles of accountability and legitimacy questions in development of administrative law).

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.[63] 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),[64] as explained in Subsection 2.

1. Theory

a. Intersovereign 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 intersovereign spillover that predictably depresses state innovation and dilutes political accountability.[65] Interstate spillovers are well known in federalism theory, which predicts that when the state does not bear the costs or benefits of state activity (whether law,

63. *See* Steward Machine Co. v. Davis, 301 U.S. 548, 589-91 (1937) (discussing how federal spending could interfere with state innovation by directing or even coercing state action); Andrew B. Coan, *Commandeering, Coercion, and the Deep Structure of American Federalism*, 95 B.U. L. REV. 1, 28 (2015) ("[C]onditional 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* CONG. BUDGET OFF., FEDERAL GRANTS TO STATE AND LOCAL GOVERNMENTS 12 (2013) (including the promotion of experimentation as a function of federal grants, but describing this function as leaving states regulatory "flexibility" to vary their reforms within a federal superstructure, 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).

64. For a discussion on the nature of entitlements, see TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 23-51 (2003) ("disentitlement" means limiting the availability and generosity of an entitlement program by impeding eligibility or access).

65. The above discussion treats states and localities as an "it," but in fact policy making 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).

investment, or otherwise), that state has insufficient reason to reduce such costs or maximize such benefits.[66] Such spillovers include not only costs and benefits from concrete activities with cross-border impacts, such as environmental pollution, but also costs and benefits from more abstract activities that also have cross-border impacts, such as law reform and experimentation.[67]

Intersovereign spillovers—in which the federal government bears the costs or benefits associated with a state reform—have been noted in prior scholarship as a potential problem whenever the federal government takes on significant responsibility for costs incurred by (or benefits produced by) states or their residents, including sovereign bankruptcy,[68] welfare,[69] and health care.[70]

---

66. Economists assume that jurisdictions compete with each other for residents who will contribute to their tax base, a theory credited to Charles M. Tiebout, *A Pure Theory of Local Expenditures*, 64 J. POL. ECON. 416, 422 (1956). *See* Bruce H. Kobayashi & Larry E. Ribstein, *Introduction* to 1 ECONOMICS OF FEDERALISM (Bruce H. Kobayashi & Larry E. Ribstein eds., 2007); *cf.* Davidson, *supra* note 65, at 628 (explaining the incentive of states and towns to avoid the exit of their residents and attract an influx of new residents). On this assumption, interstate spillovers are a major problem because they leave states with insufficient incentives to invest in public goods. *See, e.g.*, Richard L. Revesz, *The Race to the Bottom and Federal Environmental Regulation: A Response to Critics*, 82 MINN. L. REV. 535, 546 (1997) (examining this concept in terms of environmental regulation).

67. Susan Rose-Ackerman, *Risk Taking and Reelection: Does Federalism Promote Innovation?*, 9 J. LEGAL STUD. 593, 594, 603-04 (1980) (identifying the interstate spillover problem as one barrier to state experimentation and 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, 208-10 (2002) (discussing the free-rider problem); Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 925 (1994) ("[I]ndividual 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. 1484, 1498 & n.58 (1987) (describing the argument that "[a] consolidated national government ... stifles choice and lacks the goad of competition" and that in a 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's thesis and finding insufficient state investment in experimentation).

68. Clayton P. Gillette, *Fiscal Federalism, Political Will, and Strategic Use of Municipal Bankruptcy*, 79 U. CHI. L. REV. 281, 287 (2012) (noting the 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] fiscal distress[] and the need for centralized intervention").

69. DAVID A. SUPER, PUBLIC WELFARE LAW 781 (2017) ("[M]oral hazard is ... an extremely

Similar to interstate spillovers, such spillovers tend to depress state innovation and investment, because reforms that are worthwhile overall may not be worthwhile—or affordable—to the state with the cost or benefit that spills over to the federal government subtracted.

b. Fiscal Waiver Authorities as a Pigouvian Subsidy and Innovation Incentive

Economic thinking offers a simple theoretical solution to the intersovereign 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).[71] A Pigouvian subsidy could be used to cure intersovereign spillovers by sharing with a state the benefit to the federal government of state investments that create savings for the federal government due to the federal government's fiscal responsibility for state residents' education, health care, employment, and so on.[72]

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 intersovereign spillover associated with federal responsibility for state residents' health care costs.

---

important policy issue in public welfare law.").

70. Abigail R. Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844 (2009) [hereinafter Moncrieff, *Federalization Snowballs*]; Abigail R. 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 when present, intersovereign spillovers force total federalization because sharing federal savings is practically impossible. *Id.*

71. *See* WALLACE E. OATES, FISCAL FEDERALISM 66-67 (William J. Baumol ed., 1972) (describing A.C. Pigou's proposed subsidy to counteract positive externalities); Wallace E. Oates, *An Essay on Fiscal Federalism*, 37 J. ECON. LITERATURE 1120, 1127 (1999) (describing the theoretical potential of Pigouvian subsidies to correct interstate spillovers).

72. *See* OATES, *supra* note 71, 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.").

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.[73] 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.[74]

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 that require expenditures upfront.[75] (This liquidity constraint also offers one

---

73. *See* Hannah J. Wiseman & 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, 55 (2011) ("In experimentalist regimes, central institutions.... monitor[ ] local performance, pool[ ] information in disciplined comparisons, and create[ ] pressures and opportunities for continuous improvement at all levels.").

74. Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267, 340, 345 (1998) ("The task of the legislature is to authorize ... deliberations and finance the ensuing experiments where local resources are insufficient to do so.... 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 (2008), Dorf and Sabel were imprecise about how the federal government would calculate its fiscal transfers or set guardrails for those transfers, concluding 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.

75. *See* Michael S. Sparer & Lawrence D. Brown, *States and the Health Care Crisis: The Limits and Lessons of Laboratory Federalism*, *in* HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES, *supra* note 55, at 181, 185 (arguing that a first barrier to state-based health investment is "money" because "finding dollars for reform is difficult"); Super, *supra* note 1, at 2629 (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).

reason to doubt the simple economic prediction that federal spending depresses state innovation—because federal spending may free up state resources that can be directed toward innovation elsewhere.) 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.[76] 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 nonstarter, and so have not explored the possibility or its broader implications.[77]

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

76. *Compare* Anthony T. Lo Sasso, Erik Byro, Leonard A. Jason, Joseph R. Ferrari & Bradley Olson, *Benefits and Costs Associated with Mutual-Help Community-Based Recovery Homes: The Oxford House Model*, 35 EVALUATION & PROGRAM PLAN. 47 (2012) (estimating significant per person savings from a particular recovery home model as compared to standard treatment), *with infra* Table 1 (explaining the federal government's share in medical costs).

77. *See* Matthew C. Stephenson, *Information Acquisition and Institutional Design*, 124 HARV. L. REV. 1422, 1431 n.20 (2011) (addressing the possibility of rewarding states in the specific context of state incentives to develop, test, and report on innovative policies, but finding a reward system "would seem to face formidable practical difficulties"); Moncrieff, *Federalization Snowballs*, *supra* note 70, at 879, 886 (raising and rejecting possibility of a grant-based solution in medical malpractice, noting, "there is a prohibitive practical problem with block grants: [t]he real dollar level of the grant would be nearly impossible to determine").

possible despite the challenge of accurate prediction is that 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.[78] As long as the subsidy aligns with the state's predictions about the cost or 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.[79]

ACA waivers also illustrate that an important obstacle noted by Professor Stephenson—that of precommitment[80]—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.[81] 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.[82]

Fiscal waivers' inspiration function is a positive from the standpoint of federalism values, as experimentation is a core such value.[83] Fiscal waivers therefore represent an additional means by which

---

78. *See, e.g.*, Marshall Allen, *Why Health Insurers Track When You Buy Plus-Size Clothes or Binge-Watch TV,* PBS NEWSHOUR (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 [https://perma.cc/FBC3-YRBZ] (explaining that insurers collect information on insureds to make "predictions about how much your health care could cost them"); OFF. OF MGMT. & BUDGET, EXEC. OFF. OF THE PRESIDENT, CIRCULAR NO. A-11, PREPARATION, SUBMISSION, AND EXECUTION OF THE BUDGET (2006), https://georgewbush-whitehouse.archives.gov/omb/circulars/a11/current_year/a_11_2006.pdf [https://perma.cc/6XB9-XBGP] (describing predictions in scoring legislation and developing baselines).

79. *See* CMS Budget Neutrality Policy, *supra* note 53, at 3-4 (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.

80. *See* Stephenson, *supra* note 77, at 1432-33.

81. *See* Patient Protection and Affordable Care Act § 1401(d)(1), 31 U.S.C. § 1324.

82. *See generally* Matthew B. Lawrence, *The Social Consequences Problem in Health Insurance and How to Solve It*, 13 HARV. L. & POL'Y REV. 593 (2019).

83. *See supra* note 59 (describing federalism values).

the federal government can spur state innovation.[84] However, 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.[85] 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,[86] 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.[87] 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,[88] and the Trump administration took steps that were inconsistent with the law's approach to health reform,[89] Alaska proposed and the Trump administration approved the reinsurance waiver. Alaska's approach has now proven successful, furthering the access and cost goals of health policy while inspiring fifteen additional states to adopt analogous reforms.[90]

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.[91] That approach

84. *Cf.* Madison, *supra* note 7.

85. *See* Gluck & Huberfeld, *supra* note 7, at 1802 ("The ACA's architecture challenges whether any ... goals and values are unique to federalism .... It illustrates how federalism is a proxy for many ideas and challenges us to ask what we are really fighting over.").

86. *See supra* notes 60-61 (describing health justice approach to health policy as well as statutory goals of Medicaid statute and ACA).

87. *See* DOONAN, *supra* note 56, at 99-114.

88. Gluck & Huberfeld, *supra* note 7, at 1759-66.

89. *See, e.g.*, Texas v. United States, 945 F.3d 355, 373 (5th Cir. 2019) (highlighting the DOJ's decision not to defend the constitutionality of the ACA).

90. *See* Wright et al., *supra* note 36; Katie Keith, *CMS Announces 2019 Pass-Through Funding for State Waivers*, HEALTH AFFS. BLOG (Dec. 10, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181210.621103/full/ [https://perma.cc/FX4W-4N6V] (describing waivers); *supra* Part I.A (describing states that have followed Alaska's waiver).

91. CMS Budget Neutrality Policy, *supra* note 53.

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)[92] but not for saving the federal government by investing in their residents' health or their health care systems.[93] 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, such as the Temporary Assistance for Needy Families program, which ultimately facilitated massive disentitlement in many states.[94]

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.[95] 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.[96] Second, the agency limits its calculation of savings to a

---

92. JOST, *supra* note 64 (discussing the nature of entitlements).

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

94. *E.g.*, Hammond, *supra* note 12 (describing the erosion of the Temporary Assistance for Needy Families block grant program); *see also* Michael S. Greve, Essay, *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 Sheryll D. Cashin, *Federalism, Welfare Reform, and the Minority Poor: Accounting for the Tyranny of State Majorities*, 99 COLUM. L. REV. 552 (1999); Super, *supra* note 74.

95. ACA waiver pass through is limited by the statute to ACA subsidy amounts. *See* 42 U.S.C. § 18052(a)(3). Medicaid savings are not so limited by statute, *see id.* § 1315(a)(2), but the agency's guidance and concepts choose to impose such a limitation. *See* Letter from Calder Lynch, Dir., Ctr. for Medicare & Medicaid Servs. to State Medical Dirs. 18 (Jan. 30. 2020) [hereinafter Letter to State Medicaid Dirs.], https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf [https://perma.cc/8EVP-RB23] (limiting to "savings [from] spending less on Medicaid expenditures"); CMS Budget Neutrality Policy, *supra* note 53, at 3-5 (explaining the 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 KAISER FAM. FOUND., THE ROLE OF SECTION 1115 WAIVERS IN MEDICAID AND CHIP: LOOKING BACK AND LOOKING FORWARD (2009), https://www.kff.org/wp-content/uploads/2013/01/7874.pdf [https://perma.cc/8DM8-3FXH].

96. *See* State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575, 53,580 (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.").

five-year window, refusing to consider federal savings that accrue over the long term.[97] Third, the incentive mechanism shares savings annually only as they accrue, which leaves cash-strapped states unable to adopt reforms that require front-loaded investments.[98] Fourth, states are liable if the federal government's costs unexpectedly go up rather than down as a result of the state investment,[99] discouraging states from making risky but worthwhile bets—unless they rely on a private contractor to administer the investment.[100]

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 up-front 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.[101] The savings associated with such cuts are immediate and derived entirely within the program.

---

97. CMS Budget Neutrality Policy, *supra* note 53, at 8; *cf.* Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 127, 147 n.94 (2011) ("OMB has used longer term windows in the past in approving Medicaid section 1115 demonstrations.").

98. Letter to State Medicaid Dirs., *supra* note 95, at 20 (agency anticipates approving reward payments "during the state's the next demonstration year"); CMS Budget Neutrality Policy, *supra* note 53, at 1-4 (shared savings through enhanced expenditure authorities awarded only in a year for which savings are expected to accrue).

99. CMS Budget Neutrality Policy, *supra* note 53, at 3 ("[T]he state is at risk ... for increases to the [per member per month] cost growth.").

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

101. *See, e.g.*, Andy Schneider, *Weaponizing Medicaid Paperwork*, GEORGETOWN UNIV. HEALTH POL'Y INST. (Jan. 23, 2018), https://ccf.georgetown.edu/2018/01/23/weaponizing-medicaid-paperwork/ [https://perma.cc/DW76-K7V9].

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.[102] So too with sustained investments in the social determinants of health, such as workforce or housing development.[103]

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 savings because the benefits of spending on preventive care for a sixty- to sixty-four-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 sixty-five but is ignored in the administration's savings calculations.[104] 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.[105]

---

102. *See* Rebecca Masters, Elspeth Anwar, Brendan Collins, Richard Cookson & Simon Capewell, *Return on Investment of Public Health Interventions: A Systematic Review*, 71 J. EPIDEMIOLOGY & CMTY. 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).

103. *E.g.*, Wiley, *supra* note 7, at 879 (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).

104. Such reforms with cross-program benefits are not difficult to identify. *E.g.*, Kenneth E. Thorpe, *Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles* 2 (2011), https://www.kff.org/wp-content/uploads/sites/2/2011/09/dual-eligible-study-september-2011.pdf [https://perma.cc/A2MN-RJ3Q] ("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.").

105. *See* Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL'Y L. & ETHICS 147, 170 (2016) (describing gaps left "in home- and community-based long-

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 primarily impact which policies that differ from the legislative default states *may* nonetheless adopt, fiscal waiver authorities primarily influence which actions from the broad range of permissible state actions states *choose* to pursue, by changing the monetary calculus. When 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 when 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.[106]

The potential for federal spending to steer state policy making 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.[107] And, of course, a long-standing body of legislative coercion doctrine limits the ability of Congress to influence state action by imposing conditions on spending.[108]

---

term care" programs in order to satisfy budget neutrality).

106. John Kincaid, *The Constitutional Frameworks of State and Local Government Finance*, *in* THE OXFORD HANDBOOK OF STATE AND LOCAL GOVERNMENT FINANCE 45, 64-68, 74-77 (Robert D. Ebel & John E. Petersen eds., 2012) (describing financial constraints on states).

107. Super, *supra* note 1, at 2577-79 (describing the role of federal funding in leading states); Eloise Pasachoff, *Agency Enforcement of Spending Clause Statutes: A Defense of the Funding Cut-Off*, 124 YALE L.J. 248, 270-71 (2014).

108. *See infra* note 213 and accompanying text.

2. Practice

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.[109] Indeed, even the requirement that waivers be budget neutral to the federal government is an agency-created condition on approval.[110] 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.[111]

Fiscal waiver authorities' steering function was an emphasis of the Trump administration's health care agenda. In traditional grant programs, the question of 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 to ensure that grants are used to encourage adoption of the reforms that Congress decided to favor.[112] That is not the case for the fiscal waiver authorities discussed here, which leave the

---

109. Thompson & Burke, *supra* note 49, at 977, 987 ("The [George W.] Bush administration held strong views on how to improve Medicaid .... The administration invited states to submit waivers targeted toward these ends" and "articulated 1115 waiver themes that it would welcome," such as providing health insurance for the uninsured and covering pharmaceuticals.); Bagenstos, *supra* note 7, at 228-30 (describing historical use of waivers); *see also* John Dinan, *Implementing Health Reform: Intergovernmental Bargaining and the Affordable Care Act*, 44 PUBLIUS 399, 418 (2014) (describing the influence of federal regulators over states in health care); Frohnen, *supra* note 7 (expressing rule of law concern about power agency officials exert over states through health care waivers).

110. *See supra* notes 49-53 and accompanying text.

111. *See* Plaintiffs-Petitioners' Memorandum of Law in Support of Motion for Preliminary Injunction or, in the Alternative, Petition for a Writ of Mandamus at 1, 11-12, Scott v. U.S. Dep't of Health & Hum. Servs., No. 3:15-cv-00193-RS-CJK (N.D. Fla. May 7, 2015), ECF No. 15-1 [hereinafter Pls.' Memo, Scott v. HHS]; Declaration of Justin M. Senior, *Scott*, No. 3:15-cv-00193-RS-CJK (May 7, 2015), ECF Nos. 15-2, 15-3 [hereinafter Senior Decl., Scott v. HHS]; *see also* Defendants' Memorandum in Opposition to Plaintiffs' Motion for Preliminary Injunction, *Scott*, No. 3:15-cv-00193-RS-CJK (June 1, 2015), ECF Nos. 30 to 30-11 [hereinafter Defs.' Memo, Scott v. HHS].

112. Such programs certainly present opportunities for agency discretion, especially surrounding whether and how to sanction states that fail to comply with grant requirements. Pasachoff, *supra* note 107.

agency apparently broad discretion to choose which reforms to favor with an award of federal dollars.[113]

The Trump administration 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.[114] These reforms include recalibrated subsidies based on age rather than income,[115] relaxed insurance protections that allow greater discrimination against those with preexisting conditions,[116] and increased cost sharing coupled with health savings accounts.[117] Similarly, in Medicaid, HHS has taken the same approach, announcing in a 2018 "Dear Medicaid Director" letter a new "policy" to favor "community engagement" (also known as work requirements) in state waivers.[118] More recently, the agency in January 2020 invited states to adopt "aggregate caps," which cap the potential federal expenditure, creating an incentive structure

113. *See* Social Security Act § 1115(a)(2), 42 U.S.C. § 1315(a)(2); Patient Protection and Affordable Care Act § 1332(a)(3), 42 U.S.C. § 18052(a)(3). For a discussion of the precise bounds of this discretion, see *infra* Part IV.

114. *See* State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575 (Oct. 24, 2018); CTRS. FOR MEDICARE & MEDICAID SERVS., SECTION 1332 STATE RELIEF AND EMPOWERMENT WAIVER CONCEPTS (2018) [hereinafter CMS WAIVER CONCEPTS], https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF [https://perma.cc/Q67C-XLY8]; CTRS. FOR MEDICARE & MEDICAID SERVS., TAKING ACTION USING SECTION 1332 WAIVERS (2019), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Take-Action-Using-1332-Waivers.pdf [https://perma.cc/373Q-H89T] ("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 (pass-through funding)."); *see also* Press Release, Ctrs. for Medicare & Medicaid Servs., Fact Sheet: State Empowerment and Relief Waiver Concepts (Nov. 29, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf [https://perma.cc/7SXY-V4NM].

115. CMS WAIVER CONCEPTS, *supra* note 114, at 8.

116. *Id.* at 13 (noting that "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).

117. *Id.* at 20 ("[T]he consumer's overall cost for premiums and out of pocket [expenses] would increase.").

118. Letter from Brian Neale, Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. 1 (Jan. 11, 2018), https://perma.cc/FY5Z-YHU4 ("CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility.").

analogous to block grants,[119] as part of "Healthy Adult Opportunity" reforms, which states have begun to do.[120] 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.[121]

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.[122] Opponents of an expanded government role in health insurance have cited that lack of interest in advocating against state-based reforms that would if successful rely on a waiver,[123] and they are right that federal

---

119. Letter to State Medicaid Dirs., *supra* note 95, at 1-3.

120. The agency has trumpeted the Healthy Adult Opportunity initiative, which explicitly makes states "eligible to access shared savings," *id.* at 2, as "[t]ransformative," *Trump Administration Announces Transformative Medicaid Healthy Adult Opportunity*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 30, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-announces-transformative-medicaid-healthy-adult-opportunity [https://perma.cc/5TKP-9ASW]; *Section 1115 Research and Demonstration Waivers*, *supra* note 53; *see also* Edward Alan Miller, Nicole Huberfeld & David K. Jones, Pursuing Medicaid Block Grants with the Healthy Adult Opportunity Initiative: Dressing Up Old Ideas in New Clothes 16-17, J. HEALTH POL. POL'Y & L. (forthcoming 2021) (manuscript on file with author) (describing Oklahoma and Tennessee efforts to adopt healthy adult opportunity reforms).

121. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., CHECKLIST FOR SECTION 1332 STATE INNOVATION WAIVER APPLICATIONS (2019), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf [https://perma.cc/6TUT-2C3H]; CTRS. FOR MEDICARE AND MEDICAID SERVS., SECTION 1332 STATE RELIEF AND EMPOWERMENT WAIVER PASS THROUGH FUNDING FREQUENTLY ASKED QUESTIONS (FAQ) (2019), https://www.cms.gov/files/document/section1332-pass-through-funding-faq.pdf [https://perma.cc/9V28-GL8X] ("[T]he savings are paid from the federal government to the state.").

122. *See* Virgil Dickson, *Verma Will Reject Any Single-Payer State Waivers*, MODERN HEALTHCARE (July 25, 2018, 1:00 AM), https://www.modernhealthcare.com/article/20180725/NEWS/180729942/verma-will-reject-any-single-payer-state-waivers [https://perma.cc/359N-BL2W] (quoting CMS Administrator Verma as stating that "[i]t doesn't make sense to waste time on something that's not going to work" and indicating that "CMS would likely deny waivers to launch single payment systems"); Nathaniel Weixel, *Top Trump Health Official Slams 'Medicare for All,'* THE HILL (Jul. 25, 2018, 5:11 PM), https://thehill.com/policy/healthcare/398871-top-trump-health-official-slams-medicare-for-all [https://perma.cc/PQ4V-KJ4C].

123. *See* Press Release, New York Health Plan Association, Memorandum in Opposition (Feb. 27, 2019), https://realitiesofsinglepayer.com/wp-content/uploads/2019/02/HPA-MIO-

resistance effectively precludes state innovation along these lines.[124] Administrator Verma also spoke out against public option proposals.[125] And as another example, Massachusetts's recent effort to redesign its health care system to bring down drug prices was foreclosed by HHS's rejection of its waiver application.[126]

We can only speculate what health-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.[127] 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

---

A5248-NY-Health-Act.pdf [https://perma.cc/SD3M-Q8T8] (citing Verma's statement as reason New York should not attempt to pursue state-based single payer).

124. *See* Wiley, *supra* note 7, at 876 ("The starting point for single-payer financing at the state level is to repurpose ... federal funds already committed to covering the state's residents."). Wiley analyzed the potential for state-based single-payer financing and revealed repeatedly how the availability of federal funding through fiscal waiver authorities constrains such efforts.

125. *See* Paige Minemyer, *Verma: Public Option Like 'Sending Your Referees to Compete in the Game*,*'* FIERCE HEALTHCARE (Oct. 27, 2019, 11:36 PM), https://www.fiercehealthcare.com/payer/verma-bashes-public-option-says-it-s-like-sending-your-referees-to-compete-game [https://perma.cc/75DR-2MAQ].

126. Letter from Tim Hill, Acting Dir., Ctrs. for Medicare & Medicaid Servs., to Daniel Tsai, Assistant Sec'y, MassHealth (June 27, 2018), https://www.mass.gov/doc/1115-mass health-demonstration-amendment-approval-letter-6-27-18-0/download [https://perma.cc/7HTY-R7MR] (denying Massachusetts's effort to develop a drug formulary for its Medicaid program).

127. *See infra* note 192 (describing the line between inspiration and coercion).

with political alignment, thereby both exacerbating the fiscal inequity between states lamented by Schapiro,[128] and creating a tool for partisan weaponization.[129]

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 (such as its waiver concepts) while simultaneously stifling major state reforms designed to improve quality or resident health that would at least offer valuable lessons for future reform (such as 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.[130] 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 (other than the limited process surrounding the ultimate waivers denials that enforce these efforts, if they become necessary).[131]

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.[132] But by then, the really important policy decision—about which waivers to encourage by promising

---

128. Schapiro, *supra* note 1. On the problem of unequal fiscal treatment of states generally, see Paul Bernd Spahn, *Equity and Efficiency Aspects of Interagency Transfers in a Multigovernment Framework*, *in* INTERGOVERNMENTAL FISCAL TRANSFERS 75, 76-77 (Robin Boadway & Anwar Shah eds., 2007) (describing the equalization of transfers to regional governments in various countries and considerations underlying equalization).

129. *See* Greve, *supra* note 94, at 279-80, 287 (describing the risk of partisanship in agency exercises of authority over states); Michael A. Livermore, *The Perils of Experimentation*, 126 YALE L.J. 636 (2017) (noting the risk that local experiments will be tailored to support partisan narratives rather than discover genuinely better policies).

130. *See supra* note 62 (collecting sources regarding normative considerations in administrative law).

131. *See* Frohnen, *supra* note 7, at 61-64 (expressing rule-of-law concerns about the power agency officials exert over states through health care waivers).

132. *See* 42 U.S.C. § 1315(d) (requiring notice and comment for waiver approvals); 42 C.F.R. §§ 431.400-.428 (2019) (implementing statutory notice-and-comment requirements).

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 policy making 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*.[133] 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 spending.[134] Should you include a fiscal waiver authority empowering an agency to alter payments to states like that in the ACA or Medicaid?

Section A briefly canvases benefits and risks of waiver authorities developed in prior scholarship. The remainder of the Part then

---

133. *See* Pls.' Memo, Scott v. HHS, *supra* note 111; Defs.' Memo, Scott v. HHS, *supra* note 111.

134. In 2019 the federal government spent $4.45 trillion, an amount equal to about 21 percent 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/ [https://perma.cc/TDK4-CEU3] (to view data in terms of U.S. gross domestic product, click "Learn more about Federal Spending" and then click "U.S. Economy" on the resulting page). States and localities in the United States spent approximately $3.1 trillion combined in 2017. *State and Local Expenditures*, URBAN INST., https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/state-and-local-back grounders/state-and-local-expenditures [https://perma.cc/SXZ2-7HAA]. With the arguable exception of national security, which made up 11 percent of federal spending in 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 Your Guide to America's Finances*, *supra* (click "Learn more about Federal Spending" and then click the "Spending Categories" tab); *see also supra* notes 68-70 (collecting scholarship discussing intersovereign spillovers in municipal bankruptcy, welfare, and health care).

explains how fiscal waiver authorities add to the benefits of big waiver, but also add to the risks. Section B 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." Section C isolates and elaborates on a previously under-explored 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 values of policy substance, federalism, and administrative law 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—in other words, states will be inclined predominantly toward changes that cut benefits and eligibility.[135] Professors Jones, Miller, and Huberfeld offer specific evidence in support of that concern in the context of the "Healthy Adult Opportunity" waiver concept.[136] 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 would otherwise opt out of,[137] and Professors Gluck and Huberfeld see this playing out in the ACA's implementation.[138] Moreover, Professors Gluck and Huberfeld and Professor Bulman-Pozen each identify another substantive benefit of waivers, namely, that the complexity (and,

135. Stiglitz, *supra* note 7, at 152 ("The forces that operate at the level of state implementation tend to work towards cuts.").

136. Miller et al., *supra* note 120.

137. Bagenstos, *supra* note 7, at 239-40.

138. Gluck & Huberfeld, *supra* note 7, at 1737-40 (describing this dynamic in promoting Medicaid expansion).

often, lack of transparency) surrounding waiver decision-making 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.[139]

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."[140] 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).[141] In a similar vein, Professor Bagenstos explains that waivers in health care are preferable to the alternative of agency nonenforcement; 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 to waive explicitly.[142]

As discussed above, this prior scholarship has focused on the regulatory components of "big waiver": agency power to waive a rule created by statute.[143] Focusing on the 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.[144] The remainder of this Part

---

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

140. Barron & Rakoff, *supra* note 7, at 310.

141. *See id.* at 310-11 ("[I]t 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. 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.").

142. Bagenstos, *supra* note 7, at 236-37 (arguing that even where agency lacks statutory waiver authority, a "regime of de facto waivers" may emerge from agency nonenforcement).

143. *See supra* note 7.

144. 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* 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'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 563-74 (2012) (plurality opinion) (holding that the Constitution

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

One clear difference between fiscal and regulatory waivers is that fiscal waivers present fiscal questions; that is, 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.[145] 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.[146] Thus, arguments in favor of "big waiver" that rely on ways that it is better

---

gives federal government power to tax Americans who fail to purchase health care), *with id.* at 548-58 (holding that the 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 eligibility. *See* John Brooks, Brian Galle & Brendan Maher, *Cross-Subsidies: Government's Hidden Pocketbook*, 106 GEO. L.J. 1229 (2018); Engstrom, *supra* note 13 (describing potential for overlap between regulatory mandates and spending provisions). The discussion in Sections B and C offer two ways in which, blurry though it may be, the distinction between fiscal and regulatory authorities is a useful one.

145. *Supra* note 140 and accompanying text.

146. 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 & Huberfeld, *supra* note 7, at 1729 n.197 (explaining the history of section 1115). The ACA'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 POL. POL'Y & L. 1099, 1102-06 (2014) (describing legislative history of ACA waiver).

than "big delegation" do not apply when it comes to fiscal waiver,[147] because the question is not whether fiscal waiver is better than "big delegation," but 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 Subsection 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 Subsection 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.[148] These include PAYGO requirements and discretionary caps that impede Congress's 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.[149]

It is difficult to overstate the significance of scorekeeping considerations in the contemporary federal legislative process.[150] Such

147. *See supra* note 7.

148. ALLEN SCHICK, THE FEDERAL BUDGET: POLITICS, POLICY, PROCESS 1-5 (3d ed. 2007); David Kamin, *Basing Budget Baselines*, 57 WM. & MARY L. REV. 143, 162-70 (2015) (explaining the influence of the federal budget process); *see* OFF. OF MGMT. & BUDGET, *supra* note 78, at app. A (describing scorekeeping practices).

149. SCHICK, *supra* note 148, at 167-68 (describing PAYGO).

150. *See 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, 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* Sage, Adding Principle to Pragmatism, *supra* note 2, at 2, 5-9; Steven D. Gold, *Health Care and the Fiscal Crisis of the States*, *in* HEALTH POLICY, FEDERALISM, AND THE AMERICAN

considerations impact policy choices across the board, including in infrastructure, education, emergency relief, and myriad other domains.[151]

Scorekeeping's distortions are a partial explanation for a larger underlying problem in health care, that of underinvestment.[152] Scholars have documented underinvestment in health-related accessible transportation,[153] housing,[154] nutrition,[155] preventing or overcoming antibiotic resistance,[156] hospital construction and workforce development (especially in rural areas),[157] environmental protection,[158] and education and investment regarding risks, such as communicable disease, tobacco, safe drug use, and fall prevention.[159] And scholars, especially legal scholars, have expressed concern about underinvestment in less tangible but no-less-impactful levers

---

STATES, *supra* note 55, at 97 (describing at granular level impact of fiscal crisis on state health policy).

151. *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.").

152. 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, 1244, 1270 (2014) (collecting sources).

153. *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 AFFS. 1223 (2018) (focusing on transportation as example of underinvestment and noting that "[t]here is growing awareness that funding for interventions related to social determinants of health has long been inadequate").

154. Lo Sasso et al., *supra* note 76; Leonard A. Jason, Margaret I. Davis & Joseph R. Ferrari, *The Need for Substance Abuse After-Care: Longitudinal Analysis of Oxford House*, 32 ADDICTIVE BEHAVS. 803 (2007).

155. *E.g.*, Diller, *supra* note 152, at 1243-48 (documenting adverse impacts of federal and state failure to invest in obesity and tobacco regulation).

156. *E.g.*, Kevin Outterson, *The Legal Ecology of Resistance: The Role of Antibiotic Resistance in Pharmaceutical Innovation*, 31 CARDOZO L. REV. 613, 645 (2010).

157. *See, 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).

158. *See, e.g.*, Elise Gould, *Childhood Lead Poisoning: Conservative Estimates of the Social and Economic Benefits of Lead Hazard Control*, 117 ENV'T HEALTH PERSPS. 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.").

159. Masters et al., *supra* note 102.

for promoting health, such as policy innovation, experimentation, and improvement.[160] (Of course, although health care is the substantive focus here, scholarly concern about underinvestment in public goods is hardly limited to health care.[161])

Professors Westmoreland and Sage document how some of this underinvestment 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.[162] 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.[163] And together, Westmoreland and Sage catalogue how scorekeeping considerations shaped the ACA, prompting design choices that ultimately made the Act vulnerable in litigation.[164]

A feature of American health care that exacerbates scorekeeping rules' impact on health programs is the fiscal fragmentation across

---

160. *See, e.g.*, Daniel E. Ho, *Does Peer Review Work? An Experiment of Experimentalism*, 69 STAN. L. REV. 1 (2017) (analyzing peer review as a governance mechanism for food safety inspections); Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1764 (2013) (describing a "dearth of state-led policy experimentation").

161. *See, e.g.*, Lisa Larrimore Ouellette, *Patent Experimentalism*, 101 VA. L. REV. 65 (2015) (describing the lack of investment in experimentation in innovation policy); Zachary J. Gubler, *Experimental Rules*, 55 B.C. L. REV. 129, 140, 156 (2014) (expressing concern about insufficient policy experimentation at the federal agency level and explaining the prediction of public choice theory that interest groups' incentive to ensure the entrenchment of the policies they achieve will tend to cause underinvestment in reversability and so experimentation); Stephenson, *supra* note 77, at 1427-37 (describing underinvestment in "research," broadly defined); Michael Abramowicz, *Tax Experimentation*, 71 FLA. L. REV. 65, 67 (2019) (describing the "empirical deficit" in the study of the effects of tax policies and calling for greater experimentation in tax policy as a way to address this deficit).

162. Tim Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 GEO. L.J. 1555, 1590-92 (2007).

163. Sage, *Ends and Means*, *supra* note 2; *see also* DAVID G. SMITH, ENTITLEMENT POLITICS: MEDICARE AND MEDICAID 1995-2001, at 177-184 (2002) (describing the importance of budgetary considerations in federal legislative process for health-care legislation).

164. Sage & Westmoreland, *supra* note 2.

health programs, within the federal budget and beyond.[165] At the federal level, costs are categorized into two major categories, "mandatory" expenditures (like Medicare and Medicaid) and "discretionary" expenditures (like COVID relief),[166] and then further categorized into programs ("Medicare Part A" or "Medicaid"), and so on. Table 1 illustrates this: while the federal government bears approximately 36 percent of Americans' medical costs,[167] that expenditure is spread out over numerous distinct programs, including Medicare,[168] Medicaid,[169] ACA,[170] and employer subsidies,[171] each of which is budgeted and accounted for separately.[172]

---

165. *See* Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American Style*, 48 J.L., MED. & ETHICS 411, 415 (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).

166. 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. *See* SCHICK, *supra* note 148, at 57-61.

167. Abigail Moncrieff originally highlighted this point. Moncrieff, *Federalization Snowballs*, *supra* note 70, at 848 ("[T]he federal government bears forty percent of the costs of U.S. healthcare spending.").

168. *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 more than sixty-one million Americans enrolled in Medicare. BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, 2020 ANNUAL REPORT 6 (2020), https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf [https://perma.cc/LKM2-L8AP] (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. *See infra* Table 1.

169. For a deeper discussion of Medicaid, see *supra* Part I.B.

170. For a description of ACA subsidies, see *supra* Part I.A.

171. *See* Brendan S. Maher, *Unlocking Exchanges*, 24 CONN. INS. L.J. 125, 142-43 (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, 1059-61 (2016) (discussing similarities between tax expenditures and other forms of government spending).

172. *Cf.* Elizabeth Weeks & Paula Sanford, *Financial Impact of the Opioid Crisis on Local Government: Quantifying Costs for Litigation and Policymaking*, 67 U. KAN. 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).

Table 1. Federal Share of Medical Costs Through Fragmented Programs[173]

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	$55 billion	1%-100%
Employer sponsored insurance (and other tax expenditures)	Full time employees of large- and mid-sized firms	Federal tax deduction	$175 billion	10%-40%

173. Data on federal expenditures collected from: TAX POL'Y CTR., BRIEFING BOOK, https://www.taxpolicycenter.org/briefing-book [https://perma.cc/7MU3-6A4P]; 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, EXEC OFF. OF THE PRESIDENT BUDGET OF THE U.S. GOVERNMENT, FISCAL YEAR 2020 (2019). These report nearly $1.1 trillion in direct spending in 2018 with an additional $225 billion in tax spending. TAX POL'Y CTR., *supra*. U.S. health-care spending was $3.6 trillion in 2018. *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet [https://perma.cc/7T9C-KR7U]; *see also* JOINT COMM. ON TAX'N, *supra* (acknowledging similar expenditures); Press Release, Ctrs. for Medicare & Medicaid Servs., 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 [https://perma.cc/2QR3-ZHTP] (projecting similar figures); Thomas M. Selden & Bradley M. Gray, *Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006*, 25 HEALTH AFFS. 1568, 1570-71 (2006) (estimating figures); Moncrieff, *Federalization Snowballs*, *supra* note 70, at 862-63 (discussing similar analysis); Huberfeld, *supra* note 93, at 474-76 (discussing similar analysis; collecting sources).

Other direct federal expenditures (Veterans, workers compensation, Indian Health Insurance)	Various	Various	$70 billion	Various
Indirect federal costs[174]	Various	Various	Unknown	Unknown
TOTAL/ Average	Varies	Varies	$1.28 trillion	35.5% (of $3.6 trillion annual)

Coupled with scorekeeping constraints, the fiscal fragmentation of costs into artificial categories prevents needed investment in public goods by pushing reforms to be cost-justified within a given narrow fiscal category. Put differently, this effectively impedes state and federal investments that incur costs within one fiscal category but create benefits within another category.[175]

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.[176] And while its Medicaid fiscal waiver authority includes no

174. 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*, TRUMP WHITE HOUSE ARCHIVES (Oct. 28, 2019), https://trumpwhitehouse.archives.gov/articles/full-cost-opioid-crisis-2-5-trillion-four-years/ [https://perma.cc/H253-9VUP] (explaining how the federal government bears indirect costs associated with medical care); David W. Brown, Amanda E. Kowalski & Ithai Z. Lurie, *Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood*, 87 REV. ECON. STUD. 792, 795 (2019) (finding increased earnings and lower use of social supports means "that the government recoups 58 cents of each dollar it spends on childhood Medicaid by age 28").

175. Fuse Brown et al., *supra* note 165.

176. Patient Protection and Affordable Care Act § 1332, 42 U.S.C. § 18052.

such requirement, HHS has self-imposed (albeit originally at OMB's insistence[177]) an analogous restriction on its use of that authority.[178]

At the same time, fiscal waivers offer a way to mitigate some of the distortions of the budget process on health policy. A requirement measured and enforced by Congress when legislation is considered is a very different mechanism from a requirement measured and enforced by an agency when a program is 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.[179] 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).[180] 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[181]). Fourth, an agency tasked with ensuring deficit neutrality across federal

177. *Supra* note 49.

178. *Supra* notes 49-53 and accompanying text.

179. 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. *See supra* notes 29-32 and accompanying text. Congressional budget law often does not score for such effects. *See* Scott Levy, *Spending Money to Make Money: CBO Scoring of Secondary Effects*, 127 YALE L.J. 936 (2018) (describing challenges to offsetting the "cost" of an expenditure expected to produce savings against its anticipated "benefits").

180. 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.

181. *Outlook for the Budget and the Economy*, CONG. BUDGET OFF., https://www.cbo.gov/taxonomy/term/26/recurring-reports [https://perma.cc/4DLK-2A2M] (referring to "the 10-year period used in the Congressional budget process").

programs may have greater flexibility to pool otherwise fragmented fiscal categories than scorekeepers bound by congressional budget rules that enforce sometimes rigid distinctions between mandatory and discretionary, and revenue 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 underinvestment 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,[182] 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 purposes. The potency of such budgetary arguments will only increase in the years to come.[183]

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 the Congressional Budget Office

182. *Supra* Part I.A.

183. 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. Sukhatme & M. Gregg Bloche, *Health Care Costs and the Arc of Innovation*, 104 MINN. L. REV. 955, 957 (2019) ("Medical spending is the fiscal analogue of global warming.").

appears to have done with ACA programs.[184] The growth of limitations in Medicare may be one example of delegated scorekeeping to compare and contrast with the fiscal waiver examples.[185]

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.[186] 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).[187] Shining a light on waiver approvals is appropriate and

---

184. For example, the ACA gave new experimental expenditure authorities to the Center for Medicare and Medicaid Innovation that are conditioned on the requirement that to be implemented 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 [CMS] certifies that [payments] would reduce (or would not result in any increase in) net program spending under applicable subchapters"). The Congressional Budget Office does not appear to have scored these new authorities as a cost of the ACA in developing its pivotal report predicting the law's fiscal consequences. *See* Letter from Douglas W. Elmendorf, Dir., Cong. Budget Off., to Nancy Pelosi, Speaker, U.S. House of Representatives, at 4 tbl.5 (Mar. 20, 2010), https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf [https://perma.cc/AZ8A-LVRQ] (showing net reduction in spending as result of creation of Center for Medicare and Medicaid Innovation).

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

186. *Id.* § 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 327-30 (discussing "explanatory duties of an agency that makes a change in regulatory policy by waiving a congressional requirement" (emphasis omitted)); Sidney D. Watson, *Medicaid, Work, and the Courts: Reigning in HHS Overreach*, 46 J.L., MED. & ETHICS 887 (2018); 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," also known as 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, Comment, *Working 9 to 5? Equal Protection and States' Efforts to Impose Work Requirements for Medicaid Eligibility*, 69 AM. U. L. REV. 703 (2019) (same); Thompson & Burke, *supra* note 49 (focusing on process for approvals); Gresham v. Azar, 950 F.3d 93, 103-04 (D.C. Cir. 2020) (invalidating Arkansas Medicaid waiver and holding arbitrary and capricious agency's finding that waiver would further objectives of the Medicaid statute), *cert. granted*, 2020 WL 7086046 (Dec. 4, 2020) (No. 20-38).

187. One exception is the discussion in prior literature of explicit conditions on waivers—which are a form of threatened denial—built upon below in Part IV. For other exceptions, see

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.[188] 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.[189]

The fungibility of money and the variability of terms on which money can be made available through partial denials make fiscal waiver denials a more 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.[190] But that threat is useless 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

---

Gillian E. Metzger, *Administrative Law as the New Federalism*, 57 DUKE L.J. 2023, 2107 & n.295 (2008) (noting federalism implication of agency decisions denying state waiver applications); Nicholas Bagley & Rachel E. Sachs, *Limiting State Flexibility in Drug Pricing*, 379 NEW ENGL. J. MED. 1002, 1002 (2018) (describing lack of transparency surrounding waiver denials).

188. *Supra* notes 122-26 and accompanying text (describing importance of denials, and threat of denials, in shaping state incentives).

189. According to one empirical study, the agency much more often lets waiver application languish until the state withdraws it or it lapses. Thompson & Burke, *supra* note 49, at 978. The agency may also punt by asking the state to elaborate upon detailed, seriatim questions. *Id.* at 996 (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 delays in processing waiver applications).

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

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.[191] The point at which inspiration becomes inducement may be difficult to identify with precision,[192] but it depends on how 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

---

191. 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.

192. Like the associated constitutional line between 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* Wiseman & Owen, *supra* note 73, at 1137-45; Madison, *supra* note 7. 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 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'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012) (plurality opinion) ("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." (quoting Steward Machine Co. v. Davis, 301 U.S. 548, 591 (1937))). *See generally* Gerken, *supra* note 12. 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 by 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).

denials and partial denials that HHS has constrained fiscal waiver calculations to exclude long-term and cross-program savings, tending to bias states toward cutting benefits rather than investing in health or quality.[193] Through threatened denials federal officials have discouraged more sweeping state-based reforms, such as single payer.[194] And through denials federal officials have the power to punish states, whether for partisan reasons, any reason, or no reason.[195]

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 pioneer pathway proposal discussed in 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.[196] But not so denials, as Bagley and Sachs point out and is elaborated upon below.[197] 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 to an entitlement) would, by contrast, not raise these administrative law concerns (even if it still presented substantive and federalism concerns).[198]

---

193. *See supra* Parts II.A.2, II.B.2 (describing these limitations).

194. *See supra* Part II.B.2.

195. *Supra* note 129 and accompanying text (discussing risk of weaponization).

196. 42 U.S.C. § 1315(d) (requiring notice and comment for waiver approvals); 42 C.F.R. §§ 431.400-.428 (implementing statutory notice-and-comment requirements); Gresham v. Azar, 950 F.3d 93, 99-104 (D.C. Cir. 2020) (describing decision granting Kentucky waiver), *cert. granted*, 2020 WL 7086046 (Dec. 4, 2020) (No. 20-38).

197. *See* Bagley & Sachs, *supra* note 187, at 1002 (decrying the lack of explanation accompanying denial of Massachusetts's drug-pricing Medicaid waiver application); *infra* Part IV.A.1, *infra* note 222 and accompanying text (describing HHS's assertion of authority to deny waivers without explanation).

198. *See* Jerry L. Mashaw & Dylan S. Calsyn, *Block Grants, Entitlements, and Federalism:*

IV. EXECUTIVE CONDITIONS

Giving HHS discretion to change the fiscal relationship between states and the federal government can make sense, and, anyway, the ACA and Medicaid currently do so. That leaves the question of the scope of the agency's discretion.

Any waiver provision, fiscal or otherwise, will have statutory minima—legislative conditions that a state request must meet in order for it to be lawfully granted. But what about agency authority to impose additional terms or requirements beyond those created by Congress, executive conditions that even statutorily eligible agency requests must meet before the agency will grant them?

This Part integrates the foregoing analysis with prior "big waiver" scholarship to address the question of executive conditions—that is, conditions on when and how HHS should deny statutorily eligible waivers. Section A begins with underlying legal issues, explaining that the "black box" of modern fiscal waiver practice is susceptible to previously unrecognized legal pitfalls surrounding executive conditions. Section B turns to normative questions, explaining how the goals of preventing disentitlement, facilitating inducement, and promoting innovation counsel contradictory approaches to executive conditions—the "black box" is good for inducement but predictably facilitates disentitlement and discourages innovation. The next Part turns to prescriptions.

A. An Executive Conditions Doctrine?

Agency-imposed terms and conditions on the award of state fiscal waivers play such a pivotal role today that they can easily be overlooked, taken as a given. Budget neutrality in Medicaid and its associated (and sometimes problematic) formulae is an exemplar of this—the statute does not require budget neutrality, but the agency does. So, too, executive conditions are what makes HHS's waiver concepts work, and the agency's ability to discourage innovative reforms such as single payer reflects a condition on awards as

---

A Conceptual Map of Contested Terrain, 14 YALE L. & POL'Y REV. 297, 319-20 (1996).

well—an unwritten, nonbinding, suggestive condition that a request not include single payer if it hopes to be granted.

Executive conditions in health care 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.[199] The state alleged that HHS had conditioned renewal of the waiver on the state's agreement to expand Medicaid.[200] After failing to obtain emergency relief, the state ultimately sought dismissal of its case as moot, so it was never litigated,[201] 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?

1. Practical Differences Between Legislative and Executive Conditions

The topic of legislative conditions on payments to states—of federal statutes providing states money *if* they comply with statutory criteria—is explored in a significant body of case law and scholarship.[202] The topic of executive conditions has not been explored to the same degree. Yet it raises difficult questions. 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

199. Pls.' Memo, Scott v. HHS, *supra* note 111, at 1.

200. *Id.*

201. *See* Order, Scott v. U.S. Dep't of Health & Human Servs., No. 3:15-cv-00193-RS-CJK (N.D. Fla. June 17, 2015), ECF No. 41 (stating that Florida withdrew its Motion for Preliminary Injunction after "the Florida Legislature ha[d] agreed on a budget that appropriates sufficient state funds to compensate Florida healthcare providers in the coming month, which mitigates the threat of *immediate* harm"); Plaintiffs-Petitioners' Notice of Voluntary Dismissal, *Scott*, 3:15-cv-00193-RS-CJK (N.D. Fla. June 25, 2015), ECF No. 44.

202. *E.g.*, Samuel R. Bagenstos, *The Anti-leveraging Principle and the Spending Clause After* NFIB, 101 GEO. L.J. 861 (2013) (describing this issue).

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.[203] To oversimplify, 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.[204]

This Article's study of fiscal waivers in health care highlights a key practical difference between legislative conditions and executive conditions that could support a distinctive executive conditions doctrine. Whereas legislative conditions are by definition memorialized publicly in statute, executive conditions may be unwritten or undisclosed. Sidney Watson has aptly described agency/state negotiation and deliberation about fiscal waivers as a "black box."[205] 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 in Medicaid is to deny waivers for any reason or no reason, often without even explaining its reasons (or lack of reasons).[206] As for ACA waivers, the agency is required by statute to notify Congress of denials with an explanation of reasons, but the agency can circumvent this requirement by letting an application languish for months, and reasons given may be cursory.[207] The nonpartisan Government Accountability Office has repeatedly lamented the arbitrariness and secrecy of the waiver consideration and related process.[208] While HHS has recently published guidance

---

203. *See* Jindal v. U.S. Dep't of Educ., No. 14-CV-534, 2015 WL 854132 (M.D. La. Feb. 26, 2015) (challenge to condition on waiver of No Child Left Behind Act requirements on federal funding).

204. Zachary S. Price, *Seeking Baselines for Negative Authority: Constitutional and Rule-of-Law Arguments over Nonenforcement and Waiver*, 8 J. LEGAL ANALYSIS 235, 265-71 (2016); Barron & Rakoff, *supra* note 7, at 312-18. *But see* Black, *supra* note 190 (expressing legal concerns about executive conditions).

205. 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 POL'Y L. & ETHICS 213 (2015) (explaining current "black box" in which agency waiver decisions are made).

206. *See, e.g.*, Bagley & Sachs, *supra* note 187, at 1002.

207. Patient Protection and Affordable Care Act § 1332(d), 42 U.S.C. § 18052(d).

208. *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 52, at 25; U.S. GOV'T ACCOUNTABILITY OFF., GAO-13-384, MEDICAID DEMONSTRATION WAIVERS: APPROVAL PROCESS RAISES COST CONCERNS AND LACKS TRANSPARENCY 32-33 (2013); U.S. GOV'T ACCOUNTABILITY OFF.,

explaining aspects of its approach to deciding whether to grant fiscal waivers and how much to award, for years these fundamental criteria were unwritten.[209]

The opacity surrounding denials facilitates a waiver decision-making process that 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 approval.[210] 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.[211] Former CMS Administrator Seema Verma was a leading consultant in this field before being tapped for a government role.[212]

2. Legal Vulnerability Associated with Identification of Executive Conditions

The current lack of transparency surrounding the agency's decisions of which waivers to deny impedes enforcement of any legal or constitutional restrictions on the agency's authority to impose

---

GAO-14-689R, MEDICAID DEMONSTRATIONS: HHS'S APPROVAL PROCESS FOR ARKANSAS'S MEDICAID EXPANSION WAIVER RAISES COST CONCERNS 13 (2014); U.S. GOV'T ACCOUNTABILITY OFF., GAO-08-87, MEDICAID DEMONSTRATION WAIVERS: RECENT HHS APPROVALS CONTINUE TO RAISE COST AND OVERSIGHT CONCERNS 7 (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 the calculation of the Medicaid waiver payment for the Arkansas waiver and noting the tension between the budget neutrality requirement and encouraging state innovation); Watson, *supra* note 205, at 217 ("The U.S. Government Accountability Office ... has already called CMS to task for failing to ensure budget neutrality in the Arkansas waiver approval.").

209. *See supra* Part II.

210. *See* Pls.' Memo, Scott v. HHS, *supra* note 111 (describing waiver negotiations); Gluck & Huberfeld, *supra* note 7, at 1778-80 (describing "picket fence" relationships "between state insurance experts and their federal counterparts").

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

212. Tony Cook, *Seema Verma, Powerful State Health-Care Consultant, Serves Two Bosses*, INDYSTAR (Nov. 29, 2016, 12:54 PM), https://www.indystar.com/story/news/politics/2014/08/25/powerful-state-healthcare-consultant-serves-two-bosses/14468683/ [https://perma.cc/LS65-XDR7].

conditions on waiver approvals. Take for example the constitutional limits on Congress's 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."[213] In the case of a nonpublic, 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 President Biden's son.[214] 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 nonpublic, 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 conditioned renewal of the state's fiscal waiver on the state's agreement to expand Medicaid, which the state

---

213. South Dakota v. Dole, 483 U.S. 203, 207-08, 210 (1987) (first quoting Helvering v. Davis, 301 U.S. 619, 640-41 (1937); then citing United States v. Butler, 297 U.S. 1, 65 (1936); then quoting Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17 (1981); and then quoting Massachusetts v. United States, 435 U.S. 444, 461 (1978) (plurality opinion)); *see also* Bagenstos, *supra* note 202 (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, 584-87 (2013) (describing *Dole* test).

214. *See* U.S. GOV'T ACCOUNTABILITY OFF., B-331564, DECISION, OFFICE OF MANAGEMENT AND BUDGET—WITHHOLDING OF UKRAINE SECURITY ASSISTANCE 8 (Jan. 16, 2020) ("OMB violated the [Impoundment Control Act] when it withheld ... funds from obligation for policy reasons.").

alleged was unconstitutional.[215] 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.[216] Florida eventually dismissed the case after failing to obtain emergency relief.[217] 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.[218]

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 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.

The potential informality and lack of clarity—from the perspective of both states and courts—surrounding executive conditions could give rise to legal challenges either to approved or to denied waivers. Such challenges might press on four arguable legal vulnerabilities. The first comes from 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

215. *See* Senior Decl., Scott v. HHS, *supra* note 111.

216. *See* Defs.' Memo, Scott v. HHS, *supra* note 111 (exhibits including declarations from federal officials disputing state's reading of agency letter).

217. *See supra* note 201 and accompanying text.

218. *See* Defs.' Memo, Scott v. HHS, *supra* note 111 (offering these considerations as reasons to deny Florida's motion for relief).

doctrinal "move" in administrative law.[219] 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—or permitting discovery and cross-examination of officials involved in negotiations in order to confirm or deny alleged conditions—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.[220] Courts may be concerned that insofar as constitutional guarantees are a blend of the underlying standard and the likelihood of enforcement and remediation,[221] subjecting executive conditions to the same standard as legislative conditions would produce a very different constitutional rule.

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.[222] 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

219. *See* Citizens to Pres. Overton Park, Inc. v. Volpe, 401 U.S. 402, 420 (1971) (holding that effective judicial review may require agency officials to testify regarding their reasons for decision where contemporaneous administrative record is inadequate), *overruled on other grounds by* Califano v. Sanders, 430 U.S. 99 (1977).

220. 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. Galle, *supra* note 63; *see also* Brian Galle, *Does Federal Spending "Coerce" States? Evidence from State Budgets*, 108 NW. U. L. REV. 989 (2014) (assessing "the danger that federal taxes will 'crowd-out' state revenues"). Courts that accept this argument might particularly scrutinize fiscal waivers when used to induce but not when used to inspire.

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

222. Price, *supra* note 204; Barron & Rakoff, *supra* note 7, at 325-27.

undeveloped condition expressed in the course of state-agency negotiation.

A third source of legal vulnerability is the nondelegation doctrine. This doctrine limits Congress's ability to empower agencies to make policy, though the standard courts use to judge nondelegation claims is notoriously vague and currently up for grabs.[223] Professor Black has argued that executive conditions can violate the nondelegation doctrine because they permit an agency to shape policy without guidance from Congress.[224] 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 (that is, conditions on approval) to influence which policy changes states seek to make.[225] Because both approvals and denials thus shape the course of national health policy, both entail policy discretion, the nondelegation 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 (APA). 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, which may permit

---

223. Under the nondelegation doctrine, Congress may not delegate authority to an agency without providing an "intelligible principle" to guide the agency's exercise of discretion. J.W. Hampton, Jr., & Co. v. United States, 276 U.S. 394, 409 (1928) (holding 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 should closely scrutinize delegations giving agencies authority to make judgments that are inherently policy based. *See* Gundy v. United States, 139 S. Ct. 2116, 2131 (2019) (Gorsuch, J., dissenting) (stating, in dissent joined by Justices Roberts and Thomas, that he would have held the statute to be an unconstitutional delegation, reviving doctrine); *id.* at 2131 (Alito, J., concurring) (stating "I would support" an effort to reconsider the nondelegation doctrine); Paul v. United States, 140 S. Ct. 342 (2019) (Kavanaugh, J., respecting denial of certiorari) ("Justice Gorsuch's scholarly analysis of the Constitution's nondelegation doctrine in his *Gundy* dissent may warrant further consideration in future cases."). *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 nondelegation doctrine in the near future.

224. Black, *supra* note 190. *But see* Price, *supra* note 204, at 269 (doubting this concern).

225. *See supra* notes 122-26 and accompanying text.

judicial review. Waiver approvals are subject to ordinary arbitrary and capricious review, and denials likely would be too.[226] The DOJ has argued that denials are committed to agency discretion by law,[227] and the courts have remained agnostic on that argument even while asserting authority to review waiver approvals.[228] 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.[229] The viability of such an

226. *See* Metzger, *supra* note 187, at 2107 (suggesting that more stringent judicial review of waiver denials may be warranted because of the federalism implication of denials).

227. *See* Final Brief for the Federal Appellants 19-22, Gresham v. Azar, 950 F.3d 93 (D.C. Cir. 2020) (No. 19-5096) ("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) .... 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."), *cert. granted*, 2020 WL 7086046 (Dec. 4, 2020) (No. 20-38); *see also* 5 U.S.C. § 701(a)(2).

228. *See Gresham*, 950 F.3d at 98-99 ("The Medicaid statute provides the legal standard we apply here: The Secretary may only approve 'experimental, pilot, or demonstration project[s],' and only insofar as they are 'likely to assist in promoting the objectives' of Medicaid, 42 U.S.C. § 1315(a). Section 1315 approvals are not among the rare 'categories of administrative decisions that courts have traditionally regarded as committed to agency discretion.'" (quoting Dep't of Com. v. New York, 139 S. Ct. 2551, 2568 (2019))). The court's carefully worded language avoids opining on whether denials are also outside the category of decisions committed to agency discretion.

229. 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 Lab'ys. v. Gardner, 387 U.S. 136, 140 (1967); 3 RICHARD J. PIERCE, JR., ADMINISTRATIVE LAW TREATISE § 17.6, at 1591-95 (5th ed. 2010) (describing the presumption of reviewability); *id.* § 17.8, at 1648-53 (describing the "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 the flow of federal funding to states, these authorities can be read to provide "no law to apply" on the question of whether the agency must grant a waiver whenever it has the authority to do so. Final Brief for the Federal Appellants, *supra* note 227, at 21-22. 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. This reading would therefore require 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, 139 S. Ct. 2116, 2123 (2019) (plurality opinion) (reading statutory purpose as constraint on decision-making in order to save it from a nondelegation doctrine challenge);

argument would depend critically on the challenging party's ability to articulate a legally relevant distinction between waiver denials and typical agency nonenforcement decisions.[230]

An important feature of APA review is the agency's obligation 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.[231] 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.[232] 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 decision-making process featured

---

Gresham, 950 F.3d at 100-01 (finding required considerations in authorization of appropriations). The same is true of the ACA. *See* 42 U.S.C. § 18091 (describing the purposes of ACA); King v. Burwell, 576 U.S. 473, 498 (2015) (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 to consider factors consistent with the statute in wielding its discretion and provide a contemporaneous written explanation of its decision susceptible to judicial review. Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983) (holding 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'ns, 531 U.S. 457, 465 (2001) (concluding an agency action was arbitrary and capricious because the agency considered cost in setting an air quality standard, but cost was not a permissible consideration under the statute).

230. One promising such distinction is the simple fact that waiver denials are not nonenforcement decisions; they are denials of state applications. Courts routinely review agency decisions denying applications for issues big and small. *See, e.g.*, Boniface v. U.S. Dep't of Homeland Sec., 613 F.3d 282 (D.C. Cir. 2010) (ordering judicial review of agency denial of particular driver's application for hazardous materials endorsement on license). It is not apparent why state waiver applications should be any different. Another promising distinction draws from the fact that waivers are requested by states, raising federalism concerns that may counsel in favor of a greater judicial role. *Cf.* Metzger, *supra* note 187, at 2105 ("Agencies should face a greater burden of persuasion and explanation when their decisions substantially restrict state experimentation and traditional state functions.").

231. *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43; *see* 2 PIERCE, *supra* note 229, § 11.4, at 1018-34 (describing arbitrary and capricious test).

232. *E.g.*, *Dep't of Com.*, 139 S. Ct. at 2551 (holding agency's stated reasons for decision were pretextual based in part on evidence obtained through discovery to supplement administrative record filed by agency).

agency conditions that were not memorialized in the administrative record.

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.[233]

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.[234] At this writing, it seems possible if not likely that President Biden will rely heavily on health care waivers to pursue his health reform agenda and that this use will become subject to political polarization that draws public interest litigation.[235] Furthermore, given the increasing reliance on

233. 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 also 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. *See infra* note 240 and accompanying text. 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.

234. Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L.J. 1471 (2020).

235. Press Release, Biden-Sanders Unity Task Force Recommendations 93 (July 8, 2020), https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf [https://perma.cc/P8TQ-KXEL] ("Democrats will 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.").

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.

B. Processes that Facilitate Steering May Undermine Innovation

Putting the legal risks surrounding executive conditions and their manner of imposition to one side, how *should* fiscal waivers be administered? The desirability of fiscal waiver authorities in health care is itself a subtle question, as discussed in Part III. The question of whether and how the agency should deny statutorily eligible waivers for failure to satisfy agency-created conditions is more subtle still. It depends in large part on which of the functions differentiated in Part II fiscal waivers are intended to serve: inducement or innovation.

Executive conditions appear to be more effective tools of inducement if, as they are today, they are implicit, unwritten, and, from a state's perspective, unpredictable.[236] From this inducement perspective, scholars have identified several potential benefits to informal waiver negotiations 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; that is, if the agency could not threaten to deny waivers absent the state's agreement to modify their application or comply with some other agency-created condition.[237] 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.[238] And another is the possibility that the obscurity

---

236. *But cf.* 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, 875-76 (1998) (describing downsides of letting states "hold out" for more generous terms, although ultimately concluding such concerns are "overstated").

237. Bagenstos, *supra* note 7.

238. Bulman-Pozen, *supra* note 7, at 955-56 (suggesting "lack of transparency" in negotiation between state and federal officials about waivers "may be an asset"); *id.* at 1002-03

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,[239] 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.[240]

At the same time, more clarity and constraint surrounding executive conditions would presumably make fiscal waivers a more effective tool for inspiring state innovation. A state's willingness to invest in developing a promising proposal predictably depends in part on the expected payoff of doing so. That payoff, in turn, depends on whether the state can accurately predict whether a proposal, once developed, would entitle it to a fiscal waiver award or not (and if so, on what timeframe). Informality, delay, and negotiation surrounding waivers all undermine such predictability.

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 exercise any executive condition power it had to foreclose true state experiments,

---

(arguing that the fact that negotiation occurs "in greater secrecy than legislative deliberation" is an "advantage" of waiver negotiation in that it may help overcome political polarization).

239. *See* Gluck & Huberfeld, *supra* note 7, at 1700-01 ("[H]ybrids ... gave red-state officials cover to entrench the ACA but arguably came at a steep price when it comes to accountability. One official 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.").

240. *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).

reserving approvals only for state adoption of federally desired reforms. The result would be less experimentation and less policy learning overall.

To be sure, process skeptics ordinarily worry that additional formality undermines rather than facilitates innovation.[241] Any such concern would be misplaced when it comes to formality 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[242]—apply only to judicial review of federal agency waiver approvals. Formality surrounding denials poses little risk of disrupting approved projects; indeed, in this context even judicial review would merely create a possibility that reforms stifled by the federal government might be revived, increasing the predicted payoffs to a state in terms of time and resources devoted to developing a proposal.[243]

Furthermore, clarity would also make it more difficult for HHS to create conditions that steer agencies toward taking actions that undermine statutory goals. The analysis in Part II of the formulae by which HHS calculates budget neutrality in Medicaid is possible today only because the agency has, after decades of pushing from the Government Accountability Office, published a summary of those formulae.[244] With that clarity, advocates could more readily

---

241. *See* Dorf & Sabel, *supra* note 74, at 356-57, 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) ("[A]n 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).

242. *See* 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. PROBS. 61, 92 (2015) (critiquing traditional administrative law doctrine as out of touch with performance-based regulation).

243. 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.

244. *Supra* notes 206-09 and accompanying text.

challenge even approved waivers that they believed gave their state an incentive to cut benefits or eligibility; opacity around the funding flows and conditions of a waiver makes identification of such problematic incentives difficult. Furthermore, it stands to reason that the ability to make conditions nonpublic 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.

Thus, the question of the processes that should govern administration of fiscal waivers—and especially conditions on waiver denials—is in large part a question of goals.[245] If the goal is inducing states to adopt policies favored by HHS (and, perhaps, the Congress creating the fiscal waiver authority), then a flexible, informal administrative process that conceptualizes waiver decisions as inherently political may make sense. If the goal, on the other hand, is inspiring states to develop promising innovations—or limiting a hostile administration's ability to undermine statutory goals—then clarity and predictability may be warranted.

V. THE FUTURE OF FISCAL WAIVERS IN HEALTH REFORM

Political appointees in agencies and members of Congress will inevitably decide for themselves whether to prioritize influence or inspiration in designing or administering waivers. This Part turns to prescriptions, taking the reality of HHS's current inducement-focused approach as a starting point. Section A acknowledges that under current law HHS will prioritize its own inducement power but recommends that the agency formalize its use of executive conditions in order to avoid the legal pitfalls this Article identifies. Section B suggests that Congress or HHS develop a distinctive waiver pathway for pioneering and substantively promising state reforms that features more clarity, predictability, and state flexibility than the default waiver process.

245. These implications are tentative and depend on questions further scholarship might usefully develop, including the determinants of state innovation.

A. HHS Should Formalize Waiver Negotiations

Under current law and given past practice, it is reasonable to assume that HHS will continue to make inducing states adopt federally desired reforms a focus of its regulatory and fiscal waiver practice. If so, HHS should endeavor to reduce the legal vulnerability of its process for administering waivers by bringing greater formality—if not transparency—to that process. Doing so would promote the agency's power by insulating its waiver decisions (whether to approve, deny, or revoke) from legal challenge, minimizing the risk of legal challenge that would create controversy, potential discovery, and less predictable standards than the agency would adopt for itself.[246]

How should HHS improve the formality of waiver deliberation? It should for the first time issue guidance describing protocols for waiver negotiation between federal officials and states. That guidance should provide that all substantive requirements will be communicated to states in official correspondence, and that any informal communication by email, telephone, or other format should serve only to discuss questions or logistics. Moreover, in any such communications, the agency should endeavor to connect the factors it considers to statutory authority.

This approach would have three main benefits. First, it 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.

Second, having a stated system for tracking official communications as they happen would protect the agency against invasive discovery in any litigation that might arise—the agency could argue that officials need not be deposed or informal communications reported because written correspondence captured all substantive conditions.[247] Absent such materials or practices in *Scott v. HHS* the

246. *See supra* notes 219-35 and accompanying text (describing possibility of litigation).

247. *Cf.* Sierra Club v. Costle, 657 F.2d 298, 396-410 (D.C. Cir. 1981) (addressing situations in which agency should include ex parte communications relevant to its ultimate decision in the administrative record).

agency was forced to hastily put together declarations by agency officials recounting (and sometimes disputing the state's version of) informal and formal communications between agency staff and states.[248] Third, this approach would guard against arbitrary and capricious challenges (by providing reasoning) and nondelegation claims (by connecting the agency's judgment to statutory criteria).[249]

As an additional step, the agency might consider putting its guidance documents articulating its waiver priorities and practice through notice-and-comment rulemaking.[250] This would help ensure the agency's interpretations of its statutory authorities receive *Chevron* deference[251] 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.[252]

B. The Case for a Pioneer Pathway

In addition to greater formality in waiver negotiations, Congress or HHS should create a pioneer pathway focused on stimulating novel state reforms—on maximizing fiscal waivers' innovation function. 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 explains the Article's proposed pioneer pathway.

---

248. *See* Defs.' Memo, Scott v. HHS, *supra* note 111 (declarations included in exhibits, along with emails and letters exchanged between state and agency officials).

249. *Cf.* Citizens to Pres. Overton Park, Inc. v. Volpe, 401 U.S. 402, 420 (1971) (to permit judicial review, agency officials must either testify to their reasons or prepare contemporaneous written explanation).

250. Miller, Huberfeld, and Jones suggest that agency invitations for waiver applications fitting specific agency-defined criteria are "substantive rules" for purposes of the APA, and so the agency does not have the legal authority to avoid notice and comment rulemaking in issuing such guidance. Miller et al., *supra* note 120, at 16. This is a challenging argument because such invitations are styled as nonbinding guidance, and guidance is not ordinarily subject to notice and comment requirements. 5 U.S.C. § 553.

251. United States v. Mead Corp., 533 U.S. 218, 226-27 (2001).

252. Gresham v. Azar, 950 F.3d 93 (D.C. Cir. 2020), *cert. granted*, 2020 WL 7086046 (Dec. 4, 2020) (No. 20-38); Stewart v. Azar, 313 F. Supp. 3d 237, 260 (D.D.C. 2018).

1. Expansion of Federal Role Would Not Alleviate Tyranny of the Budget

The ACA did not include any kind of waiver (whether fiscal or regulatory) until the last minute, when Senator Ron Wyden pushed for one.[253] Moreover, prominent current health reform proposals, such as Medicare for All, do not include waiver authorities.[254] One might assume that because a greater federal role in health care would reduce states' fiscal role, a fiscal waiver would be unnecessary in future legislation significantly expanding the federal role in health care.[255] This would be incorrect, however.

Although in some ways greater federalization would reduce fiscal fragmentation concerns, in other ways it would 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 interrelated determinants. The medical care

---

253. *See* McDonough, *supra* note 146, at 1102-04 (describing legislative history of ACA waiver).

254. Nicole Huberfeld, *Is Medicare for All the Answer? Assessing the Health Reform Gestalt as the ACA Turns 10*, 20 HOUS. J. HEALTH L. & POL'Y 69, 87 (2021) ("The Sanders bill does not address whether HHS would retain demonstration waiver authority."); *see also* 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); Sage, Adding Principles to Pragmatism, *supra* note 2, at 5-11 (surveying various proposals for expanded or universal federal health care coverage). 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 C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389 (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* Fuse Brown & McCuskey, *supra*, at 446 n.296 (treating as a separate question beyond the article's scope implications of "federal tax preference given to employer-sponsored health insurance").

255. As Professor Moncrieff understood it, significant intersovereign spillovers leave the federal government with "a decision between federalizing ... and devolving healthcare spending." *See* Moncrieff, *Federalization Snowballs*, *supra* note 70, at 877-78.

actually provided by one's doctor when she is sick is of course the most visible such determinant.[256] 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 professionals might have at their disposal and what they cost.[257] 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.[258] And health insurance itself influences at what stage of illness patients seek medical help, as well as the treatments and services their providers recommend when they do.[259]

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 are important determinants of health outcomes in the United States, health outcomes have

256. *See, e.g.*, Michelle M. Mello, David M. Studdert & Troyen A. Brennan, *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED. 2281, 2281-82 (2003).

257. Rachel E. Sachs, *Prizing Insurance: Prescription Drug Insurance as Innovation Incentive*, 30 HARV. J.L. & TECH. 153, 157 (2016).

258. *See* Allison K. Hoffman, *What Health Reform Reveals About Health Law, in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 2, at 49, 61 ("[H]ealthcare regulation can have paralyzing effects on innovation, especially in healthcare delivery."); William M. Sage, *Fracking Health Care: How to Safely De-Medicalize America and Recover Trapped Value for Its People*, 11 N.Y.U. J.L. & LIBERTY 635, 647 (2017) ("[A]n astonishing amount of health care spending is plausibly unnecessary."); *see also* Gabriel Scheffler, *The Dynamism of Health Law: Expanded Insurance Coverage as the Engine of Regulatory Reform*, 10 U.C. IRVINE L. REV. 729, 768 (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*, *in* THE LAW AND POLICY OF HEALTHCARE FINANCING 17, 34-36 (Wolf Sauter et al. eds., 2019) (calling for a 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.* COMM. ON THE LEARNING HEALTH CARE SYS. IN AM., INST. OF MED., BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA 102 (Mark Smith et al. eds., 2013) (estimating $750 billion annual waste in U.S. health care system).

259. Lawrence, *supra* note 82 (describing the impacts of health insurance on health-care quality and access).

numerous other important, upstream determinants.[260] Vulnerability theory has developed an analogous but more general insight about the importance of state-influenced structures in promoting resilience.[261] Social, environmental, and behavioral factors—such as 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.[262]

In fact, these social determinants of health are collectively more influential than medical care in determining health care costs and outcomes.[263] Relatedly, many health policy scholars 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 Taylor call the "American Health Care Paradox"[264]—is that the United States spends too little on social services to prevent illness and too much on health care to cure the illnesses it failed to prevent.[265]

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.[266] Therefore, even if

---

260. *See* 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).

261. *E.g.*, Martha Albertson Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1, 13 (2008) ("[S]tate facilitated institutions .... provide individuals with resilience in the face of vulnerability." (internal quotation marks omitted)).

262. Yearby & Mohapatra, *supra* note 10, at 1-4; Elizabeth Y. McCuskey, *The Body Politic: Federalism as Feminism in Health Reform*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 303, 308-10 (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).

263. ELIZABETH H. BRADLEY & LAUREN A. TAYLOR, THE AMERICAN HEALTH CARE PARADOX: WHY SPENDING MORE IS GETTING US LESS 13-14 (2013).

264. *Id.* at 2-3.

265. *Id.* at 15, 71-72 (showing the United States spends much less on health-related social services *other* than medical care—such as employment counseling, housing, and paid parental leave—than comparable countries and noting the same correlation between spending on social services and health care costs repeats at the state level); *id.* at 173 (noting need for "shared accountability" for health costs in order to overcome the "American health care paradox").

266. It is conceivable that a single-payer or other plan for increasing federal responsibility for health care costs would also entail the federal takeover of responsibility for housing costs, transportation costs, infrastructure costs, education costs, and the regulation of medical practice. *See* Wiley, *supra* note 7, at 891 ("Federal single-payer health care could prompt further federalization."). No current plans propose this, and constitutional, historical, and

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. The federal government would now bear total responsibility for Americans' medical costs, while the states would continue to hold 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 and 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.

2. A Pathway for Pioneering Reforms Should Include More Predictability and Fiscal Flexibility for States

Fiscal waivers have a role to play in the future of health reform for their inspiration function, not just their inducement function—so long as fiscal waivers' capacity to inspire can be tapped without risking abuse. This Article's study of fiscal waivers in the ACA and Medicaid offers guidance for how a pioneer pathway might be structured for development by HHS or inclusion in future health reform legislation to serve as a necessary stepping stone to greater innovation in health reform while avoiding the risk of abuse and

---

practical considerations make it likely that states will continue to have significant influence over their residents' health. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 533-36 (2012) (describing the constitutional limitation of the federal role to enumerated powers); Jacobson v. Massachusetts, 197 U.S. 11, 24-25 (1905) ("State[s] did not surrender [the police power] when becoming ... member[s] of the Union."); Huberfeld, *supra* note 56, at 200-05 (describing the increasing, but still limited, federal role in health regulation over time from the Founding Era to present day). *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (describing the history of the regulation of medicine in states).

mitigating administrative law and federalism concerns.[267] This pathway could be structured as follows.

a. 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 sought to do,[268] undesirably encourages states to cut benefits and eligibility despite adverse health and equality impacts of such cuts.[269] On the other hand, rewarding investments in health-related public goods or equality, 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 sharing is analogous to other cutting-edge health care financing tools. Health Maintenance Organizations (HMOs), which came to the fore in the 1990s, 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,[270] 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 led them to reduce costs by avoiding

---

267. Public health scholars have recently noted the need for some entity to coordinate community investment in social determinants of health. Len M. Nichols & Lauren A. Taylor, *Social Determinants as Public Goods: A New Approach to Financing Key Investments in Healthy Communities*, 37 HEALTH AFFS. 1223 (2018). A pioneer pathway would empower states to play this role.

268. *See supra* notes 112-21 and accompanying text. 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 60-61 (explaining normative perspectives and statutory purposes on which disentitlement is undesirable).

269. *See* David A. Super, *The Political Economy of Entitlement*, 104 COLUM. L. REV. 633, 640-59 (2004) (offering taxonomy of senses in which word "entitlement" is used).

270. *See* Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 4-5 (1999) (describing the genesis of HMOs).

necessary treatment rather than merely by avoiding unnecessary treatment or promoting patient health.[271]

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.[272] 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 care they seek), while setting quality criteria that an entity must continue to satisfy in order to receive payment.

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.[273] 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.[274] 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

---

271. *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 the backlash).

272. *See* Donald M. Berwick, *Launching Accountable Care Organizations—The Proposed Rule for the Medicare Shared Savings Program*, 364 NEW ENG. J. MED., no. 16, 2011, at 1-2 (describing how shared savings in ACO program mitigates risks of abuse).

273. Some ACOs also take on the risk of increases in Medicare costs. *See* DAVID NEWMAN, CONG. RSCH. SERV., R41474, ACCOUNTABLE CARE ORGANIZATIONS AND THE MEDICARE SHARED SAVINGS PROGRAM (2011).

274. *Id.*; *see also* Berwick, *supra* note 272 (explaining that by sharing savings between "physicians, hospitals, public or private payers, or employers," ACO programs overcome the "[f]ragmentation" that "leads to waste and duplication"); NEWMAN, *supra* note 273 (collecting sources on shared savings between hospitals and other payers); Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L.J. 55, 63-64 (2016) (describing shared savings in Medicare between providers and payers); Bagley, *supra* note 168, at 574-77 (discussing shared savings in ACA).

shared carefully, with a focus on ensuring ACOs are not rewarded for preventing patients from obtaining care.[275]

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—such as 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 ensure that states are not rewarded for decreased utilization. First, any proposed 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 interpreted them in ways that risked harm to many state residents.[276] Future legislation should instead include explicit criteria that align with the Obama administration's (since rescinded) interpretive guidance.[277] Second, this 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 Medicaid waivers avoid encouraging disentitlement.[278] Third, as is a common step in mitigating adverse incentives, the statute should require any federal savings shared

275. NEWMAN, *supra* note 273, at 5-6.

276. *See* State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575 (Oct. 24, 2018); Katie Keith, *Feds Dramatically Relax Section 1332 Waiver Guardrails*, HEALTH AFFS. BLOG (Oct. 23, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181023.512033/full/ [https://perma.cc/Q463-G69G] ("[T]he new guidance .... significantly relaxes the standards outlined in the [Obama administration's] guidance.").

277. Waivers for State Innovation, 80 Fed. Reg. 78,131 (Dec. 16, 2015).

278. *See* Miller et al., *supra* note 120, at 10-11 (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).

with states be calculated on a per capita basis rather than on an overall population basis.

b. Guarantee Awards and Waive Budget Neutrality for Potentially Transformative State Requests

Two particular issues hold back fiscal waivers' capacity to inspire state reforms today. First, current consideration and formulae do not reward the first state to develop or demonstrate the effectiveness of a reform for doing so. 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.[279]

To solve this problem and increase the extent to which fiscal waivers serve an inspiration function rather than merely directing state reforms, a pioneer pathway (analogous to the NIH's "pioneer award" for innovative research) should reward early adopters.[280] Rewards might include lessened budget neutrality requirements or public praise. The value of additional fiscal support in facilitating startup costs is obvious. As for praise, 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.

A second problem today is that HHS is fickle. It reserves the right to deny waiver requests that satisfy statutory eligibility requirements, and often does so, or delays in responding to state requests altogether. This means that from a state's perspective, there is no

279. Sparer & Brown, *supra* note 75, at 192 ("States do look at and learn from other states."); *supra* note 67.

280. *See NIH Director's Pioneer Award Frequently Asked Questions*, NAT'L INSTS. OF HEALTH, https://commonfund.nih.gov/pioneer/faq [https://perma.cc/69J2-25NY] (offering pioneer award for creative and innovative biomedical researchers to fund cutting-edge research).

good way to tell whether time and effort put into developing a waiver proposal would be well spent—predictably reducing the payoff from such investment and, so, stifling innovation. Imagine working on an invention if the Patent Office retained the authority to reject a patent for any reason or no reason, and there were no legal recourse to challenge such rejections.

To solve this problem, a pioneer pathway, whether created by law or regulation,[281] should require that HHS grant any state request that satisfies pathway-specific eligibility criteria (above and beyond statutory minima for waiver eligibility), and further provide that such requests would automatically be granted if not denied within a set period of time—say a few months after submission. To ensure that this requirement would not overwhelm the agency's resources, the eligibility criteria might include a limitation on state applications; for example, states might be limited to submitting one "pioneer" waiver application every two years. As for the criteria, they should limit eligibility to novel reforms carrying the potential, if successful, to spur adoption at the federal level or in other states. Of course, the greater the specification in the statute or regulation creating the pathway about how these concepts of novelty and potential would be assessed, the more predictability the pathway would provide to states and, so, the greater its potential to stimulate innovation.

Finally, relaxed budget neutrality requirements might be coupled with the mandatory grant of eligible waivers. Waivers with the potential to bring savings nationwide or in other states if successful long term could be approved even if resource-intensive in the short term. 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.[282] This authority requires budget neutrality to be used nationwide in the long term, but not for an initial test to demonstrate proof of concept in the short term.[283] A similar approach could be used to

281. The goal of predictability described here would not necessarily require judicially enforceable constraints on the agency; internal controls could suffice as well. *See generally* Gillian E. Metzger & Kevin M. Stack, *Internal Administrative Law*, 115 MICH. L. REV. 1239 (2017) (describing internal checks on agency behavior).

282. *See supra* note 184.

283. 42 U.S.C. § 1315a(b)(3).

reward promising state reforms, recognizing that a state innovation is ordinarily costliest in the first state to adopt it.

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 greater formality in its use of its fiscal waiver authorities, and future health reform legislation including fiscal waiver authorities could make such formality mandatory as part of a pioneer pathway.

Finally, this Article underscores the need for greater understanding of the interaction between fiscal federalism and state innovation and develops 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.