Conscientious Objection, Coercion, the Affordable Care Act, and US States

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I. Introduction

NFIB v. Sebelius largely upheld the Affordable Care Act (ACA), except as to the proposed expansion of Medicaid. Seven of the nine US Supreme Court Justices (all except Justices Ginsburg and Sotomayor) endorsed a ‘coercion’ argument that essentially gave States a constitutional right to conscientiously object to expanding Medicaid as demanded by the federal government – without being directly penalized by a denial of federal funding.1 As I show in the present contribution, the Court reached this conclusion through a philosophically unsophisticated analysis of coercion. In my conclusion, I much more briefly note the way this decision continues an interesting intellectual approach of the Roberts Court, which I call ‘personification confusion’. In Citizens United, the Court declared that corporations were persons with full free speech rights typically associated with actual persons.2 In the ACA case, the Court makes a similar move as to States, treating them as subject to the same concerns regarding coercion as individual persons. Because what follows is aimed at a non-legal audience, I will try to keep legal jargon to a minimum, even if in some instances that means putting to one side the more legalistic aspects of the doctrines at issue. For longer explorations of these issues geared towards more legal audiences, see Blumstein (2012), Huberfeld, Weeks and Outterson (2012), and Berman (forthcoming).

II. NFIB v. Sebelius, Medicaid Expansion, and Coercion

Medicaid is a cooperative state and federal programme that provides funding to States to assist pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care.3 As a condition of funding, States must comply with federal rules “governing matters such as
who receives care and what services are provided at what cost.”⁴ By the early 1980s, every State chose to participate in Medicaid, and funds received now constitute more than ten percent of most States’ total revenue.

The ACA purported to expand the scope of Medicaid and increase the number of individuals the States must cover, most importantly by requiring States to provide Medicaid coverage to adults with incomes up to 133 percent of the federal poverty level. At the time the ACA was passed, most States covered adults with children only if their income was much lower, and did not cover childless adults.⁵ Under the ACA reforms, the federal government would have increased federal funding to cover the States’ costs for several years in the future, with States picking up only a small part of the tab.⁶ However, a State that did not comply with the new ACA coverage requirements could lose not only the federal funding for the expansion, but all of its Medicaid funding.

Congress is authorized to fund Medicaid by virtue of its Constitutional power under the ‘Spending Clause’, which grants Congress the power “to pay the Debts and provide for the […] general Welfare of the United States.”⁷ As interpreted by the US Supreme Court, Congress may “grant federal funds to the States, and may condition such a grant upon the States’ ‘taking certain actions that Congress could not require them to take’.”⁸ “Such measures ‘encourage a State to regulate in a particular way, [and] influenc[e] a State’s policy choices’.”⁹ Nevertheless, in prior cases the Court had hinted (though never held) that programmes authorized by the Spending Clause that required the State’s compliance were “so coercive as to pass the point at which ‘pressure turns into compulsion’”, and thus unconstitutional.¹⁰

In Sebelius, for the first time in its history, the Court found such unconstitutional ‘compulsion’ in the deal offered to States in order to expand Medicaid under the ACA.¹¹ In finding the Medicaid expansion unconstitutional, the Court contrasted the ACA case with the facts of the Dole case, wherein Congress “had threatened to withhold five percent of a State’s federal highway funds if the State did not raise its drinking age to 21.”¹² In
discussing *Dole*, the *Sebelius* Court determined that “that the inducement was not impermissibly coercive, because Congress was offering only ‘relatively mild encouragement to the States’,” and the Court noted that it was “less than half of one percent of South Dakota’s budget at the time” such that “[w]hether to accept the drinking age change ‘remain[ed] the prerogative of the States not merely in theory but in fact’.”

By contrast, when evaluating the Medicare expansion under the ACA, the *Sebelius* Court held that the

financial “inducement” Congress has chosen is much more than “relatively mild encouragement” – it is a gun to the head […] A State that opts out of the Affordable Care Act’s expansion in health care coverage thus stands to lose not merely “a relatively small percentage” of its existing Medicaid funding, but all of it. Medicaid spending accounts for over 20 percent of the average State’s total budget, with federal funds covering 50 to 83 percent of those costs […] The threatened loss of over 10 percent of a State’s overall budget, in contrast [to *Dole*], is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.

In *Sebelius*, the government argued that the Medicaid expansion merely involved a modification of Medicaid’s terms, which had been done on several earlier occasions without constitutional controversy. As the government pointed out, the “Social Security Act, which includes the original Medicaid provisions, contains a clause expressly reserving ‘[t]he right to alter, amend, or repeal any provision’ of that statute.” Therefore, the government contended that a “State confronted with statutory language reserving the right to ‘alter’ or ‘amend’ the pertinent provisions of the Social Security Act might reasonably assume that Congress was entitled to make adjustments to the Medicaid program as it developed.”

However, the Court found that the ACA’s Medicaid expansion “accomplishes a shift in kind, not merely degree”, noting how the original program “was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy
families with dependent children.” While prior amendments expanded the boundaries of these categories, Justice Roberts’ opinion concluded that the ACA transformed Medicaid “into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level […] It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance.”

In responding to an argument by the dissent, the Court echoed a point I made in the New England Journal of Medicine in an article with Jim Blumstein (2011) before the case was heard: under the logic of the coercion argument, in theory States can have no objection to the Medicaid expansion, because “Congress could have repealed Medicaid [and,] [t]hereafter, […] could have enacted Medicaid II, a new program combining the pre-2010 coverage with the expanded coverage required by the ACA.” Chief Justice Roberts responded, with a point we made in our article, that while true in theory, “it would certainly not be that easy. Practical constraints would plainly inhibit, if not preclude, the Federal Government from repealing the existing program and putting every feature of Medicaid on the table for political reconsideration. Such a massive undertaking would hardly be ritualistic.”

The end result of the Court’s decision was not to end the matching funds offered as part of the Medicaid Expansion – the ‘carrot’ offered by the federal government – but instead to eliminate the ‘stick’. As the Court put it “[n]othing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.” In the aftermath of the decision, a number of governors have suggested they will turn down the matching funds from the government condition on the expansion, and retain their current Medicaid plans that cover fewer people.
In dissent, Justice Ginsburg (joined by Justice Breyer) stressed that this case was no different than *Dole*, and suggested the Court had invented an unmanageable standard for coercion/compulsion:

When future Spending Clause challenges arrive, as they likely will in the wake of today’s decision, how will litigants and judges assess whether “a State has a legitimate choice whether to accept the federal conditions in exchange for federal funds”? Are courts to measure the number of dollars the Federal Government might withhold for non-compliance? The portion of the State’s budget at stake? And which State’s – or States’ – budget is determinative: the lead plaintiff, all challenging States (26 in this case, many with quite different fiscal situations), or some national median? Does it matter that [...] the coercion state officials in fact fear is punishment at the ballot box for turning down a politically popular federal grant? The coercion inquiry, therefore, appears to involve political judgments that defy judicial calculation.22

Of course, there are many moving parts in the *Sebelius* decision, relating to the Commerce Clause of the US Constitution, the Taxing Power (Mello and Cohen 2012), and the like. Even in the portion of the opinion focused on Medicaid, the court somewhat blends the coercion analysis with an ‘anti-commandeering’ analysis (Blumstein 2012), focused on how using spending to induce state compliance ‘commandeers’ the states and where “Congress compels the states to do its bidding” it and thus problematically “blurs the lines of political accountability.”23 As Berman (forthcoming) has argued, it is hard to read this passage “with a straight face”, in that the “Court was, after all, deliberating over the face of a law universally known as ‘Obamacare’” and this “inconvenient datum might be taken to cast doubt on the suggestion that the Constitution must be interpreted to proscribe federal spending programs that exert too much pressure on the states lest federal officials escape accountability for an unpopular law.” In any event, in this short space I cannot examine all of this, and will focus only on the Supreme Court’s conclusion that the
states would have been coerced under the ACA’s Medicaid funding rule. I will make two main claims here. First, that the coercion analysis offered by the Supreme Court, and the grant to them of a constitutional right to ‘conscientious objection’, founders on the shoals of a more serious philosophical examination of coercion. Second, and more speculatively, I want to press on what I term the Court’s ‘personification confusion’, and the underlying idea that a theory of coercion and conscientious objection can be articulated in a domain-general way that applies to all kinds of entities. That is, even if we conclude that an individual would be coerced or have a right to conscientiously object in a given instance, it does not follow that a state or other kind of entity (a hospital, a university) would be coerced or have such a right. Once this is understood, I suggest that the Court’s analysis seems even more deficient.

III. CONSCIENTIOUS OBJECTION, COERCION, AND THE STATE EXAMINED

Seven Justices on the Supreme Court gave individual States a right of ‘conscientious objection’ grounded in the Constitution’s Spending Clause, wherein States could refuse to expand the population they cover in a programme funded by the federal government without facing a potential loss of federal funding. Two Justices in dissent focused on the lack of judicial administrability of such a standard, and suggested it would open up a Pandora’s box of future constitutional challenges without any clear rules. I see a more fundamental question: by what theory is the Medicaid expansion coercive, and even if coercive, by what theory is it coercive in a problematic way that justifies constitutional redress?

The Court’s failure to address this issue stems, in part, from confusion over what it means for an offer to be coercive. In some sense, Justice Kagan seemed to recognize this issue in a question to Paul Clement, the lawyer for the challengers to the ACA, at oral argument: “Why is a big gift from the federal government a matter of coercion?” Kagan asked. “It’s just a boatload of federal money for you to take and spend on poor
people’s health care,” Kagan added. “It doesn’t sound coercive to me, I have to tell you.” The exchange is all the more curious because, despite her scepticism, Kagan signed on to the Court’s holding that the Medicaid expansion was coercive.

I will examine this issue by first discussing whether Medicaid itself and the ACA’s expansion are coercive (as stand-alone offers). I will then examine whether the offer to change from the existing Medicaid programme to the ACA’s Medicaid expansion was problematic. I will analyze these questions under the assumption that the Court is not committing a category error by treating States as the kinds of entities subject to this kind of coercion inquiry. In my conclusion, however, I briefly consider whether that assumption is warranted.

Is Medicaid or the Medicaid Expansion Problematically Coercive?

What does it mean for an offer to be ‘coercive’? In what is probably the leading philosophical account of the idea, Alan Wertheimer suggests that only threats (as opposed to offers) can be coercive, but not all threats are coercive (1987, 204). To use a stylized framing, imagine that A proposes to B:

(i) If you do X, I will bring about, or allow to happen, S.
(ii) If you do not do X, I will bring about, or allow to happen, another state of affairs, T.

This maps on perfectly to what the federal government proposed to do in the ACA:

(i) If you expand Medicaid coverage, I will give you matching funds to facilitate that expansion.
(ii) If you do not expand Medicaid coverage, I will deny you all Medicaid funding.
Has A coerced B? Wertheimer provides a two-pronged test for whether a proposal constitutes a coercive threat. The first part, which Wertheimer names the “choice prong”, determines whether “A’s proposal creates a choice situation for B such that B has no reasonable alternative but to do X” (1987, 172). Importantly, this prong does not ask whether B has some alternative to doing X, but rather whether the alternatives available to B are acceptable ones (Wertheimer 1987, 267-274). Indeed, even in “your money or your life”, the prototypical coercive encounter, the victim has some choice; he or she can choose to surrender the money instead, the problem is instead that surrendering one’s life is not an acceptable alternative to turning over one’s money; it is too costly an alternative to complying with A’s demand (Wertheimer 1987, 267-274). Rather than calling for an empirical determination that B has ‘no choice’ but to do what A proposes, the choice prong requires a judgment as to whether the costs to B of not doing what A proposes are too high (Wertheimer 1987, 267-274). What is an acceptable choice is an inherently normative determination (Wertheimer 1987, 267-274; Fried 1981, 104).25

The dispute between the majority and the dissent in Sebelius centred on this prong of the coercion analysis. The majority thought that the coercion test was satisfied by the size/value of the threat in this case, in contrast to the threat to reduce highway funding in Dole. The dissent thought the matter was far from clear, and in any event, that courts were not the appropriate body to make this determination; instead, the matter is one that should be left to voters. While I have my doubts on this issue, and others have more directly attacked the majority on this score (Huberfeld, Weeks and Outerson 2012) in an attempt to be as charitable as possible to the Court, let us imagine arguendo that the majority has the better of the argument. Does it follow that the ACA Medicaid expansion was inappropriately coercive?

No. Why? Finding that the person receiving the proposal has no acceptable choice is a necessary but not sufficient condition for finding coercion. Wertheimer gives the example of a surgeon who refuses to amputate
a patient’s leg for a fair price: while the patient had no acceptable choice, we do not think the act morally problematic, nor would we allow him to renge on the contractual obligation (Wertheimer 2008, 71; Wertheimer 1987, 192-201). This example points us to the need for a second prong to determine whether there is a problematic form of coercion at work, what Wertheimer calls the “proposal prong”, which asks whether the proposal is one that A has a right to make (1987, 172). To illustrate, Wertheimer offers the following paired cases (1987, 208):

*The Private Physician Case.* B asks A, a private physician, to treat his illness. A says that he will treat B’s illness if and only if B gives him $100 (a fair price).

*The Public Physician Case.* B asks A, a physician, to treat his illness. A is employed by the National Health Plan, and is legally required to treat all patients without cost. A says that he will treat B’s illness if and only if B gives him $100.

While in both cases B has no acceptable alternative but to pursue treatment from the surgeon, the first case (unlike the second) seems unproblematic; the reason is that only in the second case does A make a proposal he does not have the right to make. Therefore, only the second case is coercive under Wertheimer’s framework.

Of course, what kind of proposals one does or does not have the right to make is itself an inherently normative inquiry. Wertheimer would incorporate a ‘moral’ test to distinguish the two types of proposals (1987, 207), while legal scholars have suggested the existing law could also define what one does or does not have the right to propose (Berman 2001, 16).

As applied to the ACA Medicaid expansion, it is difficult to argue that the federal government is making an offer it does not have the right to make. First, there is no normative or constitutional obligation for the federal government to create or fund a Medicaid programme *ab initio.* Even for those who think there is a moral obligation for the State to fund health care for the poor (Daniels 2008), there is no obligation on the
federal government to provide funding for that care via a cooperative programme with the States. Indeed, with the Medicare programme (which focuses on health care for the elderly), for example, Congress chose to make the programme largely federal.

Moreover, both the majority and dissent appear to agree that if we were at Time 0, and the federal government were initially offering the terms now present in the ACA Medicaid expansion, that would be unproblematic. Indeed, they both seem to take a step further and think it would not be coercive in the constitutional sense to end Medicaid as we know it at the end of this year, and offer States the new terms as a kind of ‘Medicaid 2.0’ – a point we made in our New England Journal of Medicine article (Cohen and Blumstein 2011, 103). As discussed above, even the majority recognizes that ending Medicaid would not be coercive, and instead merely claims that it is unlikely to happen for practical reasons.

Therefore, whether viewed on the internal logic of the majority and dissenting opinions or externally from a political theory vantage point, it is clear that a programme that offered the new terms set out in the Medicaid expansion would not satisfy the proposal prong and thus would not be coercive.

Is the Change In Terms Coercive?

The analysis above does not completely decide the matter, since it is possible that offer terms that are not coercive at the outset could become coercive if the offerer insisted upon changing them mid-way through the exchange. For example, consider the following hypothetical of my own devising:

Russia from My House — Stranded: Imagine that a ship captain offers to take Sarah Palin from Russia to her home in Alaska for free. Mid-way through he decides, though, to change the terms, and insists that he will leave her stranded on an iceberg in the Arctic Ocean if she does not agree to pay him $4,000 for the voyage.
Even if the original offer (free passage) and the new offer ($4,000 for passage) were not coercive – both were offers the ship captain has a right to make – the change in terms seems to be coercive, since Palin has no acceptable choice but to pay (she would be stranded on the iceberg otherwise), and because the proposal to change the terms is not one the captain has a right to make (having previously agreed to better terms and induced reliance thereon).

Thus, requiring an individual to change the terms can be problematically coercive even if neither set of terms would have been coercive on their own. Whether an offer to change terms will be problematically coercive, though, depends on the specifics of the circumstances. To try to understand the ACA ‘switch’ in Medicaid terms, it might be useful to work through some more hypotheticals of my own devising:

**Chocolate Treats – Delicious**: I am your secret admirer. Every day I leave a large G-shaped chocolate on your doorstep out of my affection for you. You love these chocolate treats – which end up being an excellent late afternoon snack. One day, a year later, my affections change, and I show up on your doorstep indicating to you that today and every day forward I will stop leaving these treats, but I will resume the service if you pay me $2 a day.

**Chocolate Treats – Delicious Addiction**: Same facts, but instead of being motivated by affection, I deliver the treats in the hope that you will get ‘addicted’ to the chocolateGs and pay me when I threaten to discontinue delivery.

**Chocolate Treats – Addiction, Diabetic Unknown**: Same facts, but it turns out that, unknown to me, you are a diabetic. You have, again unknown to me, relied on this chocolate delivery to help regulate your insulin levels. On the day I discontinue delivery without payment you are at significant risk of an adverse event if I don’t give you the chocolate.

**Chocolate Treats – Addiction, Diabetic Known**: Same facts, but I know you are a diabetic and I am hopeful that your condition will cause you to pay me on the day I threaten to discontinue chocolate delivery unless paid.
Similar to *Sebelius*, in each of these four cases I have conferred upon you something that you benefit from and enjoy – chocolate here, Medicaid funds in the ACA case. In each of these cases, as we saw with the ACA, you have no claim of entitlement to the benefit – there was no obligation to give you chocolate (or ACA funding) to begin with. But, after I started doing so, you began to enjoy it and even expected me to continue to do so. Should that course of conduct and your expectations make a difference in the coercion calculus?

I think it beyond cavil that I have not coerced you or otherwise acted improperly in the *Delicious* example. I have no obligation to continue to feed your sweet tooth just because I started to do so. I may deserve praise, or merely be thought of as a hopeless romantic, but I am certainly not acting in a morally problematic way.

What about the other cases? One way of stating the States’ claim regarding Medicaid expansion is that they have become ‘addicted’ to the Medicaid money. While they might have done without this money to begin with and funded their own health care systems for the poor (or not provided such funding at all), after so many years of the programme’s existence their citizens now expect them to fund the programme as well as the attendant institutional. To be clear, this is not a case where someone is actually addicted in the physiological sense. If my chocolate were laced with cocaine, things might look different. Instead the addiction is more in the sense of ‘you have caused me to want what you are providing by giving it to me without conditions, and thus I suffer loss when you stop providing it to me unless I agree to those conditions’. Understood in these terms, it is hard to believe that anyone can think I have done something wrong in *Delicious Addiction*. This is, after all, what every supermarket does when they provide free samples to customers. If *Sebelius* and the ACA involve merely this kind of conduct, I do not think one could seriously consider the federal government’s actions as coercive or otherwise wrongful.

But perhaps the addiction is more real in the ACA case. I have used the diabetes cases to try and get closer to the notion of ‘need’, where the
good is needed to avoid serious adverse health consequences. Perhaps the States’ complaint in the ACA Medicaid expansion is more like this? Blumstein makes a claim along these lines when he says the Medicaid programme and other forms of federal funding “creates political dependence – a ‘political addiction,’ that locks in cooperative federalism programs and makes cutbacks painful” (2012, 103).

Even granting that the Medicaid funding in its current form is a ‘need’ not just a ‘want’, I think it is hard to argue that I have done something wrong in either of the diabetic cases. In Unknown Diabetic, it hardly seems fair to fault you for the fact that these sweets were more important to the recipient than you thought. Known Diabetic seems to be the most plausible case for a moral problem, but is it? For those who believe the law ought to put in place Good Samaritan or Rule of Rescue type obligations, perhaps the offerer faces some limited duties here: on the day I first plan on discontinuance, perhaps I have an obligation to provide the chocolate to avoid my recipient going into diabetic shock, but if I then explain my condition going forward it seems hard to think I have an obligation to provide chocolate on the next day, and the next day, in perpetuity. Similarly, the fact that the ACA Medicaid expansion had a phase-in period – rather than an immediate start date – is analogous to providing the chocolate on that day I propose to change the terms, but not in perpetuity. The fact that our hypothetical chocolate recipient may not be able to afford his or her chocolate if I did not provide it is of no moment. That need may give the recipient a claim for redistribution or state assistance, but not a claim from the person giving the chocolates. This conclusion echoes a point that I made above. Even if you thought there was a right to health care, it does not follow that there is a right to health care delivery in one particular manner, namely federal funding for cooperative Medicaid programmes with the terms that existed before the ACA was passed.

Nor does it seem to matter that the states may have made investments in their health care infrastructure keyed to an expectation that
Medicaid would remain largely unchanged, as Blumstein argues (2012, 103). After all, if in one of the chocolate hypotheticals you had bought large quantities of really expensive milk you only like to drink with the chocolate, that would not give me an obligation to provide the chocolate to you in perpetuity.

To be clear, it is it is important to distinguish a case of taking advantage of someone’s existing condition versus putting a person in a condition which you then exploit. Thus, we should distinguish Known Diabetic from the following hypothetical cases:

\textit{Induced Diabetic}: I deliver my chocolates as in the prior cases (above). However, this time my chocolate is laced with a chemical that induces you to become a diabetic and thus to need my chocolates.

Or consider the Sara Palin Stranded hypothetical with which I began this section. In such cases the party that provided the good has, in so doing, made the recipient worse off than she would have been without the good, if the good is discontinued. Stranded does seem morally problematic for this reason. Palin has been made worse off by the offer and partial performance, and at the very least the Russian captain owes it to her to return her to the shore; Induced Diabetic seems more likely to involve morally dubious actions, especially if I gave you the chocolate hoping it would have this effect on your diabetes, although on some views it might matter whether the benefits given to you of enjoying the chocolate outweighs the harm of the induced diabetes.

Is the ACA expansion offer anything like Stranded or Induced Diabetic? Only if one thought that having been offered Medicaid funding at its existing levels for all of these years made the States that received that money worse off. This seems highly implausible. Something can be worse off \textit{ex ante} or \textit{ex post} all things considered. I have elsewhere argued that usually the \textit{ex ante} view makes more sense as the evaluative perspective in these types of cases (Cohen 2013). But under either vantage point I do not think the States have a credible argument that they have been
made worse off by the initial Medicaid offer with the possibility of a switch in terms. From the *ex post* perspective, States have benefitted from receiving Medicaid money on the old terms up to this point – even if it means now having to accept the new (and, by hypothesis, less attractive) terms, or losing funding altogether. From the *ex ante* (pre-offer) perspective, the relevant question to ask a State is: ‘knowing that the federal government would alter Medicaid in the following way at some point down the road, would you like to receive Medicaid money for the time being under the existing plan, provided that you can always opt out of the programme entirely if you do not like the new terms?’ I do not think there is a credible argument that a State would have refused Medicaid funding. And even if we emphasized to States at this moment of decision that if they accept the funding they will likely make infrastructure investments related to Medicaid and that their constituents might become ‘politically addicted’ to this funding, things that I think would be fairly obvious to any politician but which we could make explicit if one prefers, it does not seem plausible to me they would have refused. That they would rather the existing terms continue indefinitely is understandable, but that does not coercion make.

One possible disanalogy between the chocolate and the ACA case is that in the ACA case the loss of funding inures not only to the party receiving the ‘gift’, the State, but to its beneficiaries – the individuals currently on Medicaid who may lose that funding due to the decision of the State to refuse to comply with the ACA. Below, I suggest that far from rendering my argument problematic, this actually problematizes the personification of States as entities capable of coercion and thus the conceptual foundation of the Supreme Court’s argument. But for present purposes, it is enough to show that adding the idea of ‘third party beneficiaries’ does not alter our conclusion. If we alter the chocolate examples, such that the recipient does not even like (or is allergic to) chocolate but relies on the deliveries to feed the sweet tooth (or diabetic needs) of his or her children, I do not see how the conclusion changes.
A reviewer helpfully raised the question of whether the examples are disanalogous because the chocolate recipient may have access to many shops at which he or she can buy chocolate other than the individual who was gifting it. I am not sure that is different from the ACA case. The ‘gift’ is funding for healthcare for patients, and the States have the ability to get that at other ‘shops’, for example by increasing tax rates or shifting money from other social programmes and fund the programme. So the analogy seems to hold. Moreover, even if we thought the ‘gift’ was something that was unique, that should not change the analysis. If it was a very special kind of chocolate that was unavailable elsewhere (or particularly beautiful set of paintings made by the giver himself and unforgeable), I do not see how that would lead us to think the gift-giver thereby had an obligation to give it away for free in perpetuity.

Does Contract Make A Difference?

But perhaps I have been unfair to Chief Justice Roberts’ opinion in one crucial respect. He analogizes the Medicaid programme to a contract at one point, noting: “We have repeatedly characterized […] Spending Clause legislation as ‘much in the nature of a contract’. The legitimacy of Congress’s exercise of the spending power ‘thus rests on whether the State voluntarily and knowingly accepts the terms of the contract’.”29 At another point, Roberts’ opinion emphasized the idea of the ACA as a major modification in Medicaid that “accomplishes a shift in kind, not merely degree.”30 Jim Blumstein has pressed this point very explicitly in defending the ACA decision, arguing that “[t]he law of contract draws a critical distinction between contract formation and contract modification” (Blumstein 2012, 74).

This raises the question of whether the possibility of a more formal contractual element should change the analysis? Consider these three variations on our earlier hypotheticals:
**Diabetic Contract Expires:** I own a chocolate delivery service. We sign a contract under which I will deliver a G-shaped chocolate on your doorstep for $1 for the next ten years. I know you are a diabetic and rely on my chocolate to get your blood sugar levels properly set. Six months before the end of the ten year period, I tell you that once our contract period ends I will be offering you new terms. I will now deliver you not only G-shaped chocolates but also pineapple wedges in the shape of the letter I. I will now charge you $5 for the service, and you cannot opt for only the chocolate, but must take chocolate and pineapple or nothing. You can, however, refuse to renew our contract altogether.

**Diabetic Contract Modification:** The facts are the same as the prior example, but instead of waiting until the end of our contractual period to change to the new chocolate plus fruit bundling, I instead tell you one year into our ten year contract that I will be changing my terms in the next six months. You can ‘take it or leave it’, accept the bundled chocolate and fruit arrangement or terminate our contract altogether.

**Diabetic Illusory Promise:** The same facts above, but our ‘contract’ has the following additional language, known as an alteration clause: ‘I reserve the right to alter, amend, or repeal any provision’ of this contract (similar to the language of the Medicaid statute itself, as discussed above).

As most students learn in the first semester of law school, these are three very different cases.

There is no plausible argument that the chocolate delivery service has done anything wrong in *Contract Expires*. Merely because you offer particular contract terms for a specific period of time does not obligate you to continue offering the same terms, or offering any terms at all, to the other party after the contract expires. This is true even if the recipient hopes the existing terms will continue and relies on that hope. There may be reliance, but it is not *reasonable* reliance, to use the language of the law. I think there is a plausible argument that the Medicaid programme is most like the *Contract Expires* case. The federal government offered certain funding and terms for the programme on a yearly basis and sometimes
made changes from year to year. The States were free to take or leave it, and up until this point in history they always decided to ‘re-up’ and stay in the programme.

Unlike my example there was no explicit end point for the ‘Medicaid contract’, but it seems to me to be unhelpfully elevating form over substance to harp on that point. All nine Justices accept the fact that the federal government could terminate Medicaid funding altogether without constitutional problem. Unlike stranded and similar cases, the allegedly coercive party is not threatening to breach the contract unless terms are renegotiated but instead failing to renew it on its existing terms. Indeed the nine Justices seem to go so far as to accept that the federal government could end Medicaid altogether at the end of the year and offer a new ‘Medicaid 2.0’ with the new terms without engaging in unconstitutional coercion. It seems problematically formalistic to think that accomplishing the same thing via two steps (ending one contract, starting a new one) is permissive, while doing it in one step (contract modification) is problematically coercive.

In any event, suppose you disagree with my characterization of the Medicaid programme. Is the case then more like Contract Modification or Illusory Promise? If it is like Contract Modification, then the deliverer will have breached the contract unless he or she can argue that there was an ambiguous term or gap in the contract (that could be read to permit him or her to move to the fruit + chocolate scheme). By contrast, the second hypothetical is probably not a contract at all. It is instead what we would call in the law, an ‘illusory promise’. As the Restatement (Second) of Contracts notes: “Words of promise which by their terms make performance entirely optional with the ‘promisor’ do not constitute a promise”, and thus cannot form the basis of a contract. The words I chose are more or less the exact words of the “Social Security Act, which includes the original Medicaid provisions, [that] contains a clause expressly reserving ‘[t]he right to alter, amend, or repeal any provision’ of that statute.”
Even if the contract in this case was understood not to be an illusory promise, the performance (chocolate + fruit) appears to fall within what is contemplated by the alteration clause. The majority opinion, as discussed above, contends that expanding the eligibility criteria for certain existing categories within Medicaid (as Congress has done many times before) meaningfully differs from adding new categories. I think this distinction is quite dubious, and Huberfeld, Weeks and Outterson (2012) have attacked it in much greater depth, but even taking it at face value, the alteration language seems broad enough to capture both. In my hypothetical, fruit has been added to chocolate; in the world according to Justice Roberts, the poor-but-not-so-poor have been added to pregnant women, children, needy families, the blind, the elderly, and the disabled in terms of coverage. Either seems as though it falls within the terms of the alteration language. While one could imagine alterations to the Medicaid programme that would be so radical as to exceed even this generous alteration language – for example, requiring all states that want to participate in Medicaid to provide free firearms to their citizens on the theory that it would help to prevent future injury – the alterations contemplated by the ACA seem to fall comfortable within the plain language of the clause.

Therefore, even if we treat the original terms of Medicaid as a contract, the coercion argument still fails.

IV. THE QUESTION OF STATE PERSONIFICATION

All of my coercion analysis has been done under a generous assumption to the Court’s argument: that personification of States is appropriate, rather than it being a category error. It is not clear that assumption is warranted. To be fair, this personification is not an assumption newly made in *Sebelius*, but one that harkens back through this entire line of spending clause jurisprudence, which suggests the theoretical possibility of constitutional coercion by the federal government of the States through offers of funding.

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Still, while long standing, it is unclear to me whether this is a sensible construct. When we say the ‘federal government’s offer to the States in the ACA is coercive’, that is perfectly sensible in ordinary language, but may actually bury some conceptual difficulties.

What does it mean for a State to be coerced? Many individuals in the State, especially those who would benefit from the Medicaid expansion, presumably would welcome it and not feel coerced at all. Who is feeling the coercive pressure, then? In the ACA case, it is Republican governors, and perhaps other state officials. They may feel the pressure to appear ‘fiscally conservative’ or responsibly manage their budgets by not expanding their Medicaid rolls (albeit with very generous federal matching funds), while keeping the existing Medicaid funding. Understood as such, do we really think politicians have an entitlement claim not to be put in this difficult choice situation? Is making such hard choices not part of being a government official? They are quite far from the destitute organ seller that is more commonly the focus of coercion concerns (Cohen 2013). Also, what of the fact that the officials who are facing the offer of new terms were not the ones who accepted the original Medicaid terms, and will not be the chief future beneficiaries? Does it make sense to think of them as coerced? One answer is that the State of Texas, for example, has had a continual existence from the time Medicaid was started to now and into the foreseeable future, even if its Governor changes. But that answer seems to shift us, possibly confusedly, into seeing the State as the target of coercion and not its officials.

Is it possible to adjust our theories of coercion to make it sensible to say that a State has been coerced in an offer of funding of this sort? Perhaps. For now, all I mean to say is that the personification of States for the purpose of coercion analysis that the US Supreme Court has implicitly endorsed seems to be fairly undertheorized, insofar as it treats States as being just like individuals for conceptual purposes.
V. CONCLUSION

Seven of the nine US Supreme Court Justices granted States a kind of right of conscientious objection in the ACA. They could refuse to expand Medicaid. While most conscientious objection is valorised because it forces on individuals hard choices, the Supreme Court softened the blow considerably by holding it unconstitutional to require States to expand Medicaid as a condition of future funding in the programme. It arrived at that conclusion because it believed that the Medicaid expansion was coercive. As I have shown, it could only have reached this conclusion through an unsophisticated understanding of coercion. If the new terms offered by the Medicaid expansion were not coercive, the old terms were not coercive, and the change in terms was not coercive, I find it hard to understand how seven Supreme Court Justices could have concluded that coercion was afoot; the only plausible explanation is that these seven Justices in Sebelius fundamentally misunderstood coercion. This misunderstanding becomes only more manifest when we ask exactly ‘who’ has been coerced, and see the way in which personifying the States as answer obfuscates rather than clarifies matters.\(^\text{35}\)

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**NOTES**

7. U.S. CONST. art. I, §8, cl. 1.
9. *Id.* (quoting New York v. United States, 505 U.S. 144, 166 (1992)).
11. Similar but not identical coercion arguments were offered in two separate opinions making up 7 out of the 9 votes on the Supreme Court. I focus on Chief Justice Roberts’ version of the argument for the sake of brevity, though I do not think the specific version matters very much for our purposes. For a thorough discussion of the differences between the two, see Huberfeld, Leonard, Outterson (2012).
13. Id. (quoting Dole, 483 U.S. at 211–12).
14. Id. (internal citations omitted).
15. Id. at 2605 (citing 42 U.S.C. §1304).
16. Id.
17. Id. at 2605–06 (citing 42 U.S.C. §1396a[a][10]).
18. Id. at 2606.
19. Id. at 2606 n.14 (quoting id. at 2636 [Ginsberg, J., dissenting in part]).
20. Id. at 2604 n.14.
21. Id. at 2607.
22. Id. at 2640 (Ginsburg, J., dissenting in part).
23. Id. at 2660.
24. See, for example, Mitchell N. Berman, The Normative Functions of Coercion Claims, 8 Leg.
Theory 45, 56 (2002); Joel Feinberg, Harm to Self 222 (1986).
25. It is also possible that our understanding of the ‘choice prong’ should be altered slightly
for constitutional analysis applicable to states. In particular, Baker and Berman have suggested
that the Court should “reconceptualize [this] prong as providing that a spending condition is
impermissibly coercive if it presents a state with either no rational choice or no fair choice but to
accept, even if it leaves the state with a practical choice not to” (Baker and Berman 2003, 521). Since
I am essentially assuming arguendo that the choice prong is met, I do not think these particular
distinctions matter for the purposes of my argument.
26. Wertheimer offers a similar distinction between causing and taking advantage, and notes that
the case law for contracts usually treats only the first – and not the second – as duress (1987, 39-41).
27. In somewhat different contexts, Seana Shiffrin (1999, 117) and I (Cohen 2012, 1244-
1264) have argued about whether providing a benefit can outweigh doing harm without consent
– and under what circumstances.
28. Blumstein argues explicitly that the ACA contract analogous to something like the
stranded case and constitutes a form of ‘predatory leveraging’ using a classic 1902 contract case
as his example:
A fishing vessel goes out to sea. Once the ship is in fishing waters, the crew demands a
substantial wage increase as a condition of performing its work. That is predatory leveraging as
part of contract modification and unenforceable. In contrast, it is entirely permissible for the crew
to demand higher wages before the ship sets sail – i.e. at the contract formation stage – when the
vessel owner has more options available and is less vulnerable. (Blumstein 2012, 74-77 quoting
Alaska Packers Ass’n v. Domenico, 117 F. 99 [9th Cir. 1902]).
30. Id. at 2605.
31. And Blumstein (Cohen and Blumstein 2012)
32. Restatement (Second) of Contracts §77 cmt. a (1981).
34. To be clear the assumption is ‘generous’ as to the pure coercion argument I have made
in that it treats States as the kinds of things that can be coerced. However, it may be the per-
sonification is less helpful to the Court to the extent it is making non-coercion claims relating to
federalism and political accountability, mentioned above but not dealt with in any great depth here. That is, it may be that for those arguments it is more helpful to foes of the Medicaid expansion to stress the ways in which States are not like real persons.

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