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Big Tobacco, Medicaid-Covered Smokers, and the Substance of the Master Settlement Agreement

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[W]e will not sacrifice substance to form.

- William Blackstone¹

I. INTRODUCTION

In 1994, executives from “Big Tobacco”—industry leaders Philip Morris, R.J. Reynolds, Brown and Williamson Tobacco, and Lorillard²—appeared before Congress and denied that nicotine is addictive despite internal documents disclosing a long history of industry-wide awareness about the addictive nature of the drug.³ One executive even denied that smoking causes death despite the well-established scientific consensus to the contrary.⁴

Worse still, tobacco companies had consciously targeted children as young as fourteen-years-old in their advertising schemes. In an internal R.J. Reynolds memorandum to Vice President of Marketing C.A. Tucker, J.F. Hind wrote: “To ensure increased and longer-term growth for CAMEL FILTER, the brand must increase its share penetration among the 14-24 age group which have a new set of more liberal values and which represent tomorrow’s cigarette business.”⁵ The popular cartoon character “Joe Camel” was born soon thereafter. Philip Morris shared the same marketing strategy; in an internal research report, a research executive for Philip Morris wrote that “[t]oday’s teenager is tomorrow’s potential regular customer.”⁶

1. 1 WILLIAM BLACKSTONE, COMMENTARIES *122, *127.

2. On July 30, 2004, R.J. Reynolds acquired Brown & Williamson Tobacco in a horizontal divestiture for \$3.2 billion. *Brown & Williamson Tobacco Corp.*, MERGERSTAT, M&A DATABASE, June 28, 2005, Deal No. 230844, <https://www.mergerstat.com/newsite/>. Liggett Group, the “runt of the litter,” could also be included in “Big Tobacco,” although Liggett’s market share is significantly smaller than the others. MICHAEL OREY, ASSUMING THE RISK: THE MAVERICKS, THE LAWYERS, AND THE WHISTLE-BLOWERS WHO BEAT BIG TOBACCO 315 (1999). At the end of 1996, the companies’ respective market shares were: Philip Morris, 47.8 percent; R.J. Reynolds, 24.6 percent; Brown & Williamson, 17.2 percent; Lorillard, 8.4 percent; other companies, 2 percent. W. KIP VISCUSI, SMOKE-FILLED ROOMS: A POST-MORTEM ON THE TOBACCO DEAL 39 (2002).

3. Philip J. Hiltz, *Tobacco Company Was Silent on Hazards*, N.Y. TIMES, May 7, 1994, at 1 (discussing internal tobacco-industry documents disclosing the addictive nature of nicotine and tobacco executives’ statements to Congress denying its addictive nature).

4. Marlene Cimon, *Cigarette Chiefs Steadfastly Deny Smoking Kills*, L.A. TIMES, Apr. 15, 1994, at A1.

5. Memorandum from J.F. Hind to C.A. Tucker, Vice President of Marketing, R.J. Reynolds (Jan. 23, 1975), available at http://tobaccodocuments.org/ftc_rjr/CX000052.html.

6. RESEARCH CTR., PHILIP MORRIS, YOUNG SMOKERS: PREVALENCE, TRENDS, IMPLICATIONS, AND RELATED DEMOGRAPHIC TRENDS 1 (1981) [hereinafter YOUNG SMOKERS], available at

The misdeeds of Big Tobacco have been reported extensively by the media in an understandably negative light.⁷ The label “merchants of death” has been etched into popular culture as a particularly appropriate appellation for not only Big Tobacco executives, but also lobbyists who assist the industry.⁸ This characterization contrasts starkly with descriptions of those who challenge the tobacco industry, who are often presented as heroes, lionized by both the media and legal scholars as David-types battling the great Goliath.⁹

The most important legal challenge to Big Tobacco came from Michael Moore, a lawyer who decided to “make a difference.”¹⁰ As attorney general of Mississippi, Moore was selected as the “Lawyer of the Year” and graced the cover of the *National Law Journal* in 1997.¹¹ Underneath a caricature of Moore, the caption on the cover read, “Mississippi Attorney General Michael C. Moore took on Big Tobacco and came out smokin.’”¹² Moore, described as “[a]mbitious and charismatic,” was praised by the *National Law Journal* for his

http://tobaccodocuments.org/usc_tim/108.html. For background on the tobacco industry’s advertising to children, see generally CLETE SNELL, PEDDLING POISON: THE TOBACCO INDUSTRY AND KIDS 19–36 (2005).

7. See, e.g., Myron Levin, *New Tobacco Records: Did Industry Know Risks Early?*, L.A. TIMES, Apr. 21, 1988, at 1 (discussing internal Philip Morris documents disclosing use of insecticides in cigarette production); John Mintz & Saundra Torry, *Internal R.J. Reynolds Documents Detail Cigarette Marketing Aimed at Children*, WASH. POST, Jan. 15, 1998, at A01 (discussing the Tucker Memo and other internal R.J. Reynolds documents about advertising aimed at children); John Schwartz, *Pesticides in Older Cigarettes, Papers Say*, WASH. POST, Apr. 11, 1997, at A04 (discussing internal documents disclosing use of pesticides and other hazardous chemicals in cigarette production); Henry Weinstein, *R.J. Reynolds Targeted Kids, Records Show*, L.A. TIMES, Jan. 15, 1998, at A1 (reporting on the Tucker Memo).

8. See, e.g., Joan Beck, *Ruining the ‘Merchants of Death’*, CHI. TRIBUNE, Apr. 12, 1998, at C15 (referring to Steven F. Goldstone, then-CEO of RJR Nabisco, as “an evil man . . . the merchant of death and illness who heads RJR Nabsico”); Editorial, *Influential Mercenaries Join Big Tobacco’s Army*, SAN ANTONIO EXPRESS, Sept. 7, 1997, at J2 (referring to tobacco lobbyists who take “blood money” as “merchants of death”); Mike Littwin, *The Tobacco Cartel Lights a Fire Under a Sorry Network*, BALT. SUN, Aug. 23, 1995, at 1D (referring to “Philip Morris, Reynolds Tobacco and the other merchants of death”); Paul Vitello, *The True Face of Philip Morris*, NEWSDAY, July 22, 2001, at A08 (referring to Philip Morris as “dropp[ing] its mask of philanthropy, revealing beneath something else. Call it what you like. An unabashed merchant of death is one possibility.”).

9. See, e.g., Frank J. Vandall, *The Legal Theory and the Visionaries that Led to the Proposed \$368.5 Billion Tobacco Settlement*, 27 SW. U. L. REV. 473, 478 (1998) (referring to Mike Lewis, who brought the idea of Medicaid recoupment suits to Michael Moore, as “[o]ne of the heroes of the tobacco war”).

10. OREY, *supra* note 2, at 239.

11. *The Year in Review, Lawyer of the Year: Michael C. Moore*, NAT’L L.J., Dec. 29, 1997, at B7 [hereinafter *The Year in Review*]. Moore became Attorney General of Mississippi in 1988. Peter J. Boyer, *The Yuppies of Mississippi: How They Took Over the Statehouse*, N.Y. TIMES, Feb. 28, 1988, at 24.

12. *The Year in Review, supra* note 11.

political and personal courage; “Moore Did Good Like an Attorney General Should,” read the secondary headline.¹³

What did Moore do to deserve such lavish praise? In 1994, Mississippi, with Moore at the helm, was the first state to bring a Medicaid-recoupment suit against Big Tobacco.¹⁴

Established in 1965 as Title XIX of the Social Security Act (“the Act”), Medicaid is a joint federal-state program that provides medical assistance to needy families.¹⁵ Today, all fifty states and the District of Columbia have Medicaid programs.¹⁶ Mississippi’s suit sought reimbursement from Big Tobacco for the costs of treating tobacco-related disease through its Medicaid program. “It is only fair,” Moore

13. *Id.*

14. *Id.*

15. Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C.A. § 1396 (West 2010)). When a state decides to participate in the Medicaid program, it must provide medical assistance to (1) all individuals who receive other assistance from the State, such as old-age assistance, benefits for the blind and permanently and totally disabled, or AFDC benefits; (2) all individuals who receive Supplemental Security Income benefits; (3) all individuals who are “severely impaired” under § 1396d(q) of the Act; certain “qualified” pregnant women or children, defined in § 1396d(n); (4) all pregnant women with infants under a year old whose family income does not exceed 133 percent of the Federal Poverty Level; (5) all “qualified” family members, defined in § 1396d(m)(1); (6) all children between the ages of one and six whose family income does not exceed 133 percent of the Federal Poverty Level; and (7) all children born after September 30, 1983, between the ages of six and nineteen, whose family income does not exceed 133 percent of the Federal Poverty Level. 42 U.S.C.A. § 1396(a)(10)(A)(i)(I)–(VII). The specific number of categories could be more or less than the seven listed here, depending on the level of generality used to formulate the categories. Some commentators group the above categories into only three: “(1) single-parent families who are eligible for Aid to Families with Dependent Children (“AFDC”) and low-income elderly, blind, and disabled individuals who qualify for Supplemental Security Income (“SSI”); (2) low-income pregnant women and children who cannot receive cash assistance and low-income pregnant women and children who do not qualify for welfare but have large medical or long-term care expenses; and (3) low-income Medicare beneficiaries who are unable to afford deductibles or premiums of Medicare Part B, or the cost of medical care not covered by Medicare.” Andrew R. Gardella, Note, *The Equal Access Illusion: A Growing Majority of Federal Courts Erroneously Foreclose Private Enforcement of § 1396a(a)(30) of the Medicaid Act Using 42 U.S.C. § 1983*, 38 U. MEM. L. REV. 697, 710 (2008). For the political climate surrounding the passage of Title XIX, see JONATHAN ENGEL, POOR PEOPLE’S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965, at 48–51 (2006).

The Act further specifies the type of “medical assistance” a state must provide. At a minimum, the state must provide (1) inpatient hospital services, (2) outpatient hospital services, (3) laboratory and X-ray services, (4) nursing facility services, (5) physician services, (6) services furnished by a nurse-midwife, and (7) services furnished by a pediatric nurse-practitioner. 42 U.S.C.A. §§ 1396d(a)(1)–(5), (17), (21); *see also id.* § 1396(a)(10)(A) (explaining that these subsections of § 1396(d) constitute the required medical assistance that states must provide).

16. While no state is required to have a Medicaid program, the Act encourages states to enact such programs “as far as practicable.” ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 57 (1974).

said, “for the industry that primarily caused the damage to pay for it.”¹⁷

And Big Tobacco paid mightily: the industry settled the Mississippi suit for \$3.6 billion.¹⁸ Other states, using the Mississippi complaint as a model, soon filed their own lawsuits. Big Tobacco settled individually with three other states, and in 1998 the companies and the remaining forty-six states, the District of Columbia, and five U.S. territories executed the Master Settlement Agreement (“MSA”), settling the rest of their claims.¹⁹ The reported value of the settlement for the first twenty-five years is \$206 billion, although the tobacco companies must continue to make annual payments of \$9 billion a year into perpetuity even after the initial \$206 billion.²⁰ Moore’s work thus led to a truly “landmark outcome”: an industry that had been virtually untouched throughout almost fifty years of litigation agreed to pay amounts that make even the largest tort-liability judgments seem trivial.²¹ While not quite a knockout, Moore’s legal punch landed Big Tobacco on the mat for a standing eight count.²²

The only problem with Moore’s triumph is that it violated—and continues to violate—federal law. By structuring the MSA so that tobacco companies can pass on most of their costs to their consumers (i.e., smokers), the settlement effectively causes Medicaid-covered smokers to pay for their own benefits, a condition unequivocally barred by the Social Security Act.

This Note examines the relationship between the MSA, Medicaid-covered smokers, and the Social Security Act and shows how the MSA violates the Act by forcing Medicaid-covered smokers to pay de facto premiums for their Medicaid coverage. After a brief description of the history of tobacco litigation, Part II examines the economic and regulatory terms of the MSA. Part III presents a new

17. Mike Moore, *The States Are Just Trying to Take Care of Sick Citizens and Protect Children*, A.B.A. J., Jan. 1997, at 53.

18. Memorandum of Understanding, *In re Moore ex rel. State Tobacco Litig.*, No. 94-1429 (Miss. Ch. Ct. Jackson County July 2, 1997), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/ms_settlement.pdf; see also VISCUSI, *supra* note 2, at 37 (discussing the \$3.6 billion settlement).

19. Master Settlement Agreement (Nov. 1998), available at http://www.naag.org/backpages/naag/tobacco/msa/msa-pdf/MSA%20with%20Sig%20Pages%20and%20Exhibits.pdf/file_view.

20. *Id.* at 44–66.

21. W. Kip Viscusi, *A Postmortem on the Cigarette Settlement*, 29 CUMB. L. REV. 523, 523 (1999).

22. On Big Tobacco’s profit increases post-MSA, see, for example, Stuart J. Fowler & William F. Ford, *Has a Quarter-Trillion-Dollar Settlement Helped the Tobacco Industry?*, 28 J. ECON. & FIN. 430, 433 (2004).

characterization of the MSA as a violation of the Act's restrictions on premiums. Following the MSA, tobacco companies passed the costs of the MSA to smokers in the form of cigarette-price increases. Part III examines the transactions between Medicaid-covered smokers, Big Tobacco, and the states in light of the principle that substance prevails over form. Applying this principle, the payments made by Big Tobacco to the states can be characterized as payments made by smokers to the states. Medicaid-covered smokers make de facto payments, best construed as premiums, to the states for their own Medicaid coverage, which violates the Social Security Act. Part IV evaluates three options to address the problem created by the MSA. In the end, this Note concludes that Medicaid-covered smokers may be presented with a choice: either quit smoking or continue paying unlawful de facto premiums for their Medicaid coverage.

II. TOBACCO LITIGATION

A. *Early Lawsuits*

Prior to the 1950s, lawsuits against tobacco companies were based on contaminants within tobacco not intentionally placed there by the manufacturers, like a "decomposed human toe"²³ or "mutilated fragments of a dead mouse."²⁴ These plaintiffs were, with a few exceptions, successful.²⁵ But things changed during the first half of the twentieth century. Smoking rates increased drastically—from 2.5 billion cigarettes consumed in 1900 to 369.8 billion in 1950.²⁶ As more

23. *Pillars v. R.J. Reynolds Tobacco Co.*, 78 So. 365, 365 (Miss. 1918).

24. *Foley v. Liggett & Myers Tobacco Co.*, 241 N.Y.S. 233, 235 (N.Y. App. Term 1930).

25. See, e.g., *Liggett & Myers Tobacco Co. v. Rankin*, 54 S.W.2d 612, 612 (Ky. 1932) (holding manufacturer liable for injuries resulting from wooly worm in chewing tobacco); *Weiner v. D.A. Schulte, Inc.*, 176 N.E. 114, 116 (Mass. 1931) (holding manufacturer liable for injuries resulting from nail in chewing tobacco); *R.J. Reynolds Tobacco Co. v. Loftin*, 99 So. 13, 13 (Miss. 1924) (holding manufacturer liable for injuries resulting from partially decomposed snake in chewing tobacco); *Corum v. R.J. Reynolds Tobacco Co.*, 171 S.E. 78, 81 (N.C. 1933) (holding manufacturer liable for injuries resulting from fishhook in chewing tobacco); *Liggett & Myers Tobacco Co. v. Wallace*, 69 S.W.2d 857, 859 (Tex. Civ. App. 1934) (holding manufacturer liable for injuries resulting from metal particles in chewing tobacco). *But see* *Block v. Liggett & Myers Tobacco Co.*, 296 N.Y.S. 922, 923 (N.Y. App. Term 1937) (per curiam) (excluding cigarettes from the category of "dangerous articles" and not holding manufacturer liable for injuries resulting from piece of razor blade in tobacco); *Delk v. Liggett & Myers Tobacco Co.*, 186 S.E. 383, 386, 388 (S.C. 1936) (rejecting *res ipsa loquitur* and finding insufficient proof of negligence when chewing tobacco contained a tack); *Liggett & Myers Tobacco Co. v. Cannon*, 178 S.W. 1009, 1010–11 (Tenn. 1915) (excluding tobacco from the category of "foodstuffs" and not holding manufacturer liable for injuries resulting from insect in chewing tobacco).

26. EPIDEMIOLOGY AND STATISTICS UNIT, AM. LUNG ASS'N, TRENDS IN TOBACCO USE 16 tbl.2 (2008), http://www.notontobacco.com/media/files/TREND_TOBACCO_JULY_08-1.pdf

and more Americans smoked, more and more Americans developed lung cancer.²⁷ Between 1938 and 1948, for example, lung-cancer rates grew five times faster than any other form of cancer.²⁸ Influential medical journals, including the *Journal of the American Medical Association* and the *British Medical Journal*, published epidemiological studies concluding that the increased smoking rates had caused the increased lung-cancer rates.²⁹ Popular periodicals like *Reader's Digest* disseminated the findings to the public through stories with frightening titles, such as "Cancer by the Carton."³⁰

America's "age of innocence" with tobacco had ended, and the first wave of litigation against Big Tobacco for the adverse health effects of its product was about to begin.³¹

1. The First Wave

The first wave lasted from the mid-1950s until the late 1960s.³² The most successful plaintiff during this time was the surviving spouse of a thirty-year smoker who died from lung cancer. In *Green v. American Tobacco Company*, the plaintiff-widow alleged that the messages communicated in cigarette advertisements breached express

[hereinafter TRENDS IN TOBACCO USE] (estimating total consumption of cigarettes in 2007 as 360 billion). During the 1940s, for example, Americans smoked "with growing abandon" and whatever health issues were associated with smoking were viewed as trifling. RICHARD KLUGER, *ASHES TO ASHES: AMERICA'S HUNDRED-YEAR CIGARETTE WAR, THE PUBLIC HEALTH, AND THE UNABASHED TRIUMPH OF PHILIP MORRIS* 132 (1997); see also *id.* (noting that, in 1949, surveys indicated that more than half of all men and one-third of all women in the United States smoked); Robert L. Rabin, *A Sociolegal History of the Tobacco Tort Litigation*, 44 STAN. L. REV. 853, 855 (1992) (remarking that, during the 1950s, "[i]t seems no exaggeration to say that Americans loved the cigarette almost as much as the automobile").

27. See Colin Talley, Howard I. Kushner & Claire E. Sterk, *Lung Cancer, Chronic Disease Epidemiology, and Medicine, 1948-1964*, 59 J. HIST. MED. & ALLIED SCI. 329, 335 (2004) (noting that, in the 1930s, reports about "alarming increases in lung cancer rates" began to emerge).

28. KLUGER, *supra* note 26, at 133.

29. Richard Doll & A. Bradford Hill, *Smoking and Carcinoma of the Lung*, 2 BRIT. MED. J. 739 (1950); E. Cuyler Hammond & Daniel Horn, *The Relationship Between Human Smoking Habits and Death Rates: A Follow-Up Study of 187,766 Men*, 155 J. AM. MED. ASS'N 1316 (1954); Morton L. Levin, Hyman Goldstein & Paul R. Gerhardt, *Cancer and Tobacco Smoking: A Preliminary Report*, 143 J. AM. MED. ASS'N 336 (1950); Ernest L. Wynder & Everts A. Graham, *Tobacco Smoking as a Possible Etiologic Factor in Bronchiogenic Cancer: A Study of Six Hundred and Eighty-Four Proved Cases*, 143 J. AM. MED. ASS'N 329 (1950).

30. Roy Norr, *Cancer by the Carton*, READER'S DIG., Dec. 1952, at 7. Thus began the "cancer scare" of the 1950s, a fearful time in American history, in general. MARTHA A. DERTHICK, *UP IN SMOKE: FROM LEGISLATION TO LITIGATION IN TOBACCO POLITICS* 27 (2002); see also EUGENIA KALEDIN, *DAILY LIFE IN THE UNITED STATES, 1940-1959: SHIFTING WORLDS* 76 (2000) (describing the late forties and early fifties—the McCarthy Era—as "a period of turmoil and fear as great as any in American history").

31. KLUGER, *supra* note 26, at 133.

32. DERTHICK, *supra* note 30, at 27.

and implied warranties—a legal theory that proved popular, but ultimately unsuccessful, during the first wave.³³ The jury returned a verdict for the manufacturer,³⁴ which the appeals court upheld, finding that the proper benchmark for measuring the wholesomeness of cigarettes was the standard set by other cigarettes.³⁵ The decedent had consumed cigarettes that were “exactly like all others of the particular brand and virtually the same as all other brands on the market.”³⁶ The *Restatement (Second) of Torts* provided further support: “Good tobacco is not unreasonably dangerous merely because the effects of smoking may be harmful.”³⁷

Green was only one of between 100 and 150 lawsuits filed against tobacco companies during the first wave.³⁸ The relative “success” of the *Green* plaintiff was making it to trial.³⁹ By that benchmark, the plaintiff in *Pritchard v. Liggett & Myers Tobacco Company* was also successful.⁴⁰ Yet, in *Pritchard*, the tobacco company

33. 304 F.2d 70, 71 (5th Cir. 1962), *question certified on rehearing*, 154 So.2d 169 (Fla. 1963), *rev'd and remanded*, 325 F.2d 673 (5th Cir. 1963), *rev'd and remanded on rehearing*, 391 F.2d 97 (5th Cir. 1968), *rev'd per curiam*, 409 F.2d 1166 (5th Cir. 1969) (en banc), *cert. denied*, 397 U.S. 911 (1970). In both express and implied warranty claims, the plaintiff alleged that the manufacturer provided a warranty that its cigarettes would not cause cancer or otherwise be harmful to health. *Id.* at 73. In express warranty claims, the plaintiffs often relied on cigarette advertisements touting the health benefits of smoking. For example, an advertisement for Chesterfield brand cigarettes featured celebrity Arthur Godfrey, who seemed to be relaying scientific news: “Nose, throat, and accessory organs not adversely affected by smoking Chesterfield. This is the first such report ever published about any cigarette. A responsible consulting organization has reported the results of a continuing study by a competent medical specialist and his staff on the effects of smoking Chesterfield cigarettes.” *Pritchard v. Liggett & Myers Tobacco Co.*, 295 F.2d 292, 297 (3d Cir. 1961). Later in the same advertisement, Godfrey says: “That they mean what they say—that specialist[s] said it, Liggett and Myers have substantiated it. Remember that when you’re wondering about cigarettes. Smoke Chesterfields—they’re good. Thank you.” *Id.* On the role of cigarette advertisements in the 1950s, see JOHN C. BURNHAM, *BAD HABITS: DRINKING, SMOKING, TAKING DRUGS, GAMBLING, SEXUAL MISBEHAVIOR, AND SWEARING IN AMERICAN HISTORY* 102–06 (1993).

34. *Green*, 391 F.2d at 99.

35. *Green*, 409 F.2d at 1166 (en banc rehearing adopting the reasoning of Judge Simpson’s dissent in the previous hearing).

36. *Green*, 391 F.2d at 110 (Simpson, J., dissenting).

37. *Id.* (quoting RESTATEMENT (SECOND) OF TORTS § 402A cmt. i (1965)); *cf. Pritchard*, 295 F.2d at 302 (Goodrich, J., concurring) (stating that one who damages his liver by drinking alcohol has no claim unless the alcohol is adulterated or the distributor gave assurances that the alcohol would not harm the consumer).

38. Rabin, *supra* note 26, at 857.

39. *Id.* at 859 (discussing the tobacco companies’ litigation strategies based on overpowering the plaintiffs and remarking that “[i]t should not be surprising, then, that only a handful of the first wave cases actually came to trial”).

40. 295 F.2d 292, 294 (3d Cir. 1961), 350 F.2d 479 (3d Cir. 1965), *cert. denied*, 382 U.S. 987 (1966), *amended*, 370 F.2d 95 (3d Cir. 1966), *cert. denied*, 386 U.S. 1009 (1967).

won at the trial level not once, but twice.⁴¹ After the second motion for a new trial, which would have been the plaintiff's third trial, the lawsuit was dropped.⁴²

Other claims were dismissed due to what appears to be the incompetence of counsel. In *Padovoni v. Liggett & Myers Tobacco Company*, for example, the plaintiff's lawyer refused to attend pretrial hearings, with excuses including being engaged in another trial and leaving the city for the holidays.⁴³ The plaintiff eventually stopped pursuing the claim.⁴⁴ Outside of their legal costs, Big Tobacco never paid a penny; they had no unfavorable jury verdicts or reported settlements throughout the entire first wave.⁴⁵

2. The Second Wave

After quiet on the litigation front during the 1970s, the second wave hit in the mid-1980s and continued through the early 1990s,⁴⁶ during which plaintiffs brought an estimated 175 to 200 cases against Big Tobacco.⁴⁷ By this point in American history, the antismoking movement was strong,⁴⁸ smoking was stigmatized,⁴⁹ more people

41. After the first jury verdict in favor of the plaintiff, the tobacco company successfully moved for a new trial. See *Pritchard*, 350 F.2d at 481 (describing the procedural posture of the case).

42. Donald W. Garner reports that the plaintiff did not pursue the claim because of the belief that "the problems of proof were 'insurmountable.'" *Cigarette Dependency and Civil Liability: A Modest Proposal*, 53 S. CAL. L. REV. 1423, 1427 (1980). This explanation is at odds with the actual rulings of the appeals court. On the first appeal, the Circuit Court found that "the plaintiff's evidence . . . definitely presents a jury question." *Pritchard*, 295 F.2d at 295. On the second appeal, the Circuit Court held that the plaintiff was not required to prove that he *actually* relied on the cigarette advertisements; rather, the plaintiff was required to prove only that the advertisements were "such as would naturally tend 'to induce the buyer to purchase the goods.'" *Pritchard*, 350 F.2d at 484. Moreover, the Circuit Court held that the defendant had failed to prove that the plaintiff, "a cabinetmaker with no scientific background," knew about the risks of smoking, thus eliminating the tobacco company's assumption-of-risk defense. *Id.* at 486.

43. 27 F.R.D. 37, 37-38 (E.D.N.Y. 1961).

44. Rabin, *supra* note 26, at 860. For another instance of apparent attorney incompetence, see *Albright v. R.J. Reynolds Co.*, 350 F. Supp. 341, 347 (W.D. Pa. 1972) (failing to reserve claim with tobacco company after settling suit against city).

45. DERTHICK, *supra* note 30, at 27.

46. *Id.*

47. Rabin, *supra* note 26, at 867 n.88 (basing the estimate on interviews with attorneys involved in the litigation).

48. In 1989, the Assistant Secretary for Health and the Director of the Centers for Disease Control could say: "The last 25 years have witnessed phenomenal changes in the way Americans think about tobacco use. More people now than ever before consider smoking to be outside the social norm." U.S. DEPT OF HEALTH & HUMAN SERVS., REDUCING THE HEALTH CONSEQUENCES OF SMOKING: 25 YEARS OF PROGRESS, A REPORT OF THE SURGEON GENERAL, DHHS PUB. NO. (CDC) 89-8411, at ii (1989) [hereinafter 25 YEARS OF PROGRESS], available at <http://profiles.nlm.nih.gov/NN/B/B/X/S/>.

believed that smoking caused cancer,⁵⁰ and concern over the health effects of smoking permeated all levels of the federal government.⁵¹ The number of deaths due directly to smoking was shocking: in 1985, for example, doctors attributed more than 314,000 U.S. deaths to smoking.⁵² If juries were sympathetic to smokers' claims against Big Tobacco, the industry's very existence would be in danger.⁵³

To Big Tobacco, the second wave of litigation amounted to a declaration of war, and the companies responded in kind.⁵⁴ They consistently employed the infamous "scorched-earth" defense:⁵⁵ they resisted discovery, obtained confidentiality orders on any discovery produced, took lengthy depositions, appealed every adverse decision, and acquired "every scrap of paper ever generated about a plaintiff, from cradle to grave."⁵⁶ Teams of lawyers from the nation's most prestigious law firms handed down orders to local-firm lawyers, providing a friendly face to small-town juries.⁵⁷ Representing the plaintiffs, by contrast, were "lone wolves" relying on contingent fees for survival.⁵⁸ Paraphrasing General Patton, an attorney for R.J.

49. See *id.* at iv (noting that, in 1989, smoking was "shunned"); see also Patrick W. Corrigan, *Marlboro Man and the Stigma of Smoking*, in *SMOKE: A GLOBAL HISTORY* 344, 347–48 (Sander L. Gilman & Xun Zhou eds., 2004) (applying four criteria of stigmatization to smoking and concluding that the activity, not the group who engages in the activity, are stigmatized); Marc Z. Edell, *Cigarette Litigation: The Second Wave*, 22 *TORT & INS. L.J.* 90, 92 (1986) ("Cigarette smoking is now considered by many people to border on asocial behavior."); Rabin, *supra* note 26, at 864 ("Smoking . . . was now regarded with disdain by many – as an unhealthy sign of weak character.").

50. See 25 YEARS OF PROGRESS, *supra* note 48, at 188 (noting that, in 1954, 41 percent of adults believed that smoking causes cancer, and in 1985, 1986, and 1987, between 87 and 95 percent of adults believed that smoking causes cancer).

51. See John K. Iglehart, *The Campaign Against Smoking Gains Momentum*, 314 *NEW ENG. J. MED.* 1059 (1986) (discussing the federal government's actions against smoking).

52. Centers for Disease Control and Prevention, *Current Trends State-Specific Estimates of Smoking-Attributable Mortality and Years of Potential Life Lost – United States, 1985*, 37 *MORTALITY MORBIDITY WKLY. REP.* 689, 689 (1988), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/00001302.htm>.

53. See Rabin, *supra* note 26, at 858 (pointing out that the tobacco companies were aware of the published statistics on the number of deaths per year attributable to smoking, and that "[t]he industry saw its very existence threatened and responded in an uncompromising fashion"). Big Tobacco saw a recent example in the asbestos industry that made the possibility of bankruptcy even less abstract: Johns-Manville Corp. declared bankruptcy in 1982. *Id.* at 868.

54. See Mark Hansen, *Capitol Offenses*, *A.B.A. J.*, Jan. 1997, at 50 (noting Big Tobacco's "hardball litigation tactics").

55. See Roger C. Cramton, *Lawyer Conduct in the "Tobacco Wars,"* 51 *DEPAUL L. REV.* 435, 435 (2001) ("Nor is there any doubt that the companies and their lawyers have pursued scorched-earth litigation tactics.").

56. William E. Townsley & Dale K. Hanks, *The Trial Court's Responsibility to Make Cigarette Disease Litigation Affordable and Fair*, 25 *CAL. W. L. REV.* 275, 277 (1989).

57. *Id.* at 278.

58. Rabin, *supra* note 26, at 858.

Reynolds described the company's hard-hitting litigation strategy: "[T]he way we won these cases was not by spending all of Reynolds' money, but by making (the enemy) spend all [of] his."⁵⁹ The plaintiffs were simply outmatched.⁶⁰

One plaintiff came close to besting Big Tobacco, though, in *Cipollone v. Liggett Group, Inc.*⁶¹ The plaintiff in *Cipollone*, a widower whose spouse had died from lung cancer, claimed breach of express warranty and strict liability for failure to warn of the adverse health effects of smoking.⁶² On the failure-to-warn claim, the jury found that although the tobacco company had, in fact, failed to warn the decedent about the adverse health effects of smoking, the decedent had "voluntarily and unreasonably" assumed the risk by smoking, thereby precluding any recovery.⁶³ For the breach-of-warranty claim, the plaintiff had relied on a cigarette advertisement in *Life* magazine that asserted "no adverse effects."⁶⁴ The jury found that Liggett Group had breached this warranty when its cigarettes caused the decedent's lung cancer, and—for the first time in the history of litigation over the adverse health effects of tobacco—awarded the plaintiff damages of \$400,000.⁶⁵ But the plaintiff's success was short-lived. On appeal, the

59. Myron Levin, *Tobacco Industry Unharmful by Landmark Defeat in Smoker Death Case*, L.A. TIMES, Dec. 31, 1989, at A41.

60. See DERTHICK, *supra* note 30, at 27 (noting the tobacco industry's repeated successes in court); Rabin, *supra* note 26, at 860 (noting the success of tort litigation for tobacco companies). But see VISCUSI, *supra* note 2, at 3 (stating that, although "some plaintiffs attribute this success to 'scorched earth litigation tactics,' the basic fact is that when cases reached the jury, the jurors consistently concluded that the risks of cigarettes were well known and voluntarily incurred").

61. 693 F. Supp. 208 (D.N.J. 1988), *rev'd in part*, 893 F.2d 541 (3d Cir. 1990), *rev'd in part*, 505 U.S. 504 (1992).

62. *Cipollone*, 693 F. Supp. at 210.

63. *Id.* The Cigarette Labeling and Advertising Act became effective in 1966, which required tobacco companies to place warnings on packages of cigarettes. 15 U.S.C.A. §§ 1331–33 (West 2010). The jury's finding was, therefore, restricted to Liggett's failure to warn before 1966. *Cipollone*, 693 F. Supp. at 210. Further, in a pre-trial ruling, the Third Circuit held that the Labeling Act "preempts those state law damage actions relating to smoking and health that challenge either the adequacy of the warning on cigarette packages or the propriety of a party's actions with respect to the advertising and promotion of cigarettes." *Cipollone v. Liggett Group, Inc.*, 789 F.2d 181, 187 (3d Cir. 1986), *cert. denied*, 479 U.S. 1043 (1987). For a discussion of the Third Circuit's rationale behind finding preemption, see Rabin, *supra* note 26, at 869.

64. *Cipollone*, 693 F. Supp. at 214 n.8.

65. *Id.* at 210; see also Laurie P. Cohen & Alix M. Freedman, *Cracks Seen in Tobacco's Liability Dam*, WALL ST. J., June 15, 1988 (discussing the verdict and predicting more lawsuits as a result); Kurt Eichenwald, *Setback to Tobacco Industry Is Termed Slim by Analysts*, N.Y. TIMES, June 14, 1988, at B4 (discussing the implications of the verdict); Alix M. Freedman, Timothy K. Smith & John Helyar, *Liggett Ordered to Pay \$400,000 in Damages for Smoker's Death, Jury's Ruling on Liability is First Against Industry*, WALL ST. J., June 14, 1988 (discussing the implications of the verdict).

federal circuit court vacated the award on the basis of faulty jury instructions.⁶⁶

Assumption of risk was a constant refrain in the second wave, as demonstrated in *Horton v. American Tobacco Company*.⁶⁷ The original plaintiff in *Horton* had smoked cigarettes for over thirty years, developed emphysema and lung cancer, and died eight months after suing the American Tobacco Company for breach of warranty.⁶⁸ After an initial mistrial,⁶⁹ the jury found the tobacco company liable but awarded no damages.⁷⁰ When the plaintiff was initially deposed, he had admitted that “[h]e had been aware, over the years, of purported links between smoking and disease,” even the link between smoking and cancer.⁷¹ Indeed, he himself had referred to cigarettes as “cancer sticks.”⁷² One of the jurors on the case later reported: “I think that we probably all felt that [smoking] caused him to be sick, but he was an adult, he knew what he was doing, there was information at that time.”⁷³ Big Tobacco’s defenses—assumption of risk, in particular—seemed impenetrable.⁷⁴ But the litigation landscape would change once again for Big Tobacco.

B. The Third Wave: Medicaid Suits by the States

1. An Epiphany in Mississippi

Mississippi resident Jackie Thompson had smoked cigarettes for decades and was lying in a hospital bed suffering from heart

66. *Cipollone*, 893 F.2d at 569. Specifically, the jury should have been instructed that, to prevail on the breach of warranty claim, the plaintiff was required to prove that Cipollone “had read, seen, or heard the advertisements at issue.” *Id.*

67. 667 So. 2d 1289 (Miss. 1995).

68. OREY, *supra* note 2, at 30, 32, 63.

69. *Id.* at 131. For media coverage, see Patricia Bellew Gray, *Mistrial in American Brands Unit Suit Seen as Setback for Anti-Tobacco Forces*, WALL ST. J., Feb. 1, 1988.

70. *Horton v. Am. Tobacco Co.*, 667 So. 2d 1289, 1290 (Miss. 1995).

71. *Id.*

72. *Id.*

73. OREY, *supra* note 2, at 143. The jury was instructed on assumption of risk as follows: “[I]f [the jury] found that Horton appreciated the risk of using cigarettes and voluntarily used cigarettes in violation of that risk, then the jury should find for the defendant American Tobacco Company.” *Horton*, 667 So. 2d at 1292.

74. For other cases filed during the second wave, see, for example, *Marsee v. U.S. Tobacco Co.*, 639 F. Supp. 466 (W.D. Okla. 1986), *aff'd in part*, 866 F.2d 319, 321 (10th Cir. 1989) (upholding defense verdict in strict liability suit on behalf of 19-year-old who used smokeless tobacco and died from tongue cancer); *Roysdon v. R.J. Reynolds Tobacco Co.*, 623 F. Supp. 1189 (E.D. Tenn. 1985), *aff'd*, 849 F.2d 230, 236 (6th Cir. 1988) (upholding directed verdict for defense in strict liability suit brought by smoker, and holding that cigarettes are not unreasonably dangerous).

disease, awaiting a heart-lung transplant.⁷⁵ It was March 1993, and Mississippi attorney Mike Lewis was visiting Thompson at Baptist Memorial Hospital in Memphis.⁷⁶ Lewis reported the experience of seeing Thompson, ravaged by the toll that cigarette smoking had taken on her body: “The emotion that I was really feeling was a desire for revenge, for vindication . . . I wanted to destroy the tobacco industry, to put them out of business.”⁷⁷

While driving back to his home in Clarksdale, Mississippi, Lewis was struck by the possibility of a lawsuit against Big Tobacco based on the financial harm that its products caused state taxpayers; that is, a lawsuit against Big Tobacco filed not by an individual smoker, but by the state *qua* state.⁷⁸ The states, Lewis thought, were financially harmed by the tobacco industry’s products when they expended money on tobacco-related disease through Medicaid.⁷⁹ Lewis contacted his friend and former law-school classmate, Michael Moore, who also served as Mississippi’s attorney general.⁸⁰ Just two months later, on May 23, 1994, Mississippi became the first state to sue the tobacco industry on behalf of its citizens to recover funds expended through its Medicaid program on tobacco-related diseases.⁸¹ The complaint contained a host of equitable theories of recovery, including unjust enrichment, indemnity, public nuisance, and a request for injunctive relief.⁸²

a. Unjust Enrichment

In its complaint, the state asserted that Big Tobacco had a duty to cover the costs of treating tobacco-related disease—that is, to “stand financial[ly] responsible for the harm done by their cigarettes.”⁸³ Many of those harmed by cigarettes, the complaint noted, “are poor, undereducated, and unable to provide for their own medical care.”⁸⁴

75. OREY, *supra* note 2, at 223.

76. *Id.*

77. *Id.* at 224.

78. *Id.*

79. *Id.*

80. *Id.*

81. Moore *ex rel.* State v. Am. Tobacco Co., No. 94-1429 (Miss. Ch. Jackson County May 23, 1994), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/ms_complaint.pdf.

82. *Am. Tobacco Co.*, No. 94-1429, ¶¶ 78–83, 84–88, 89–91, 92–98; see also Michael C. Moore & Charles J. Mikhail, *A New Attack on Smoking Using an Old-Time Remedy*, 111 PUB. HEALTH REP. 192, 198 (1996) (claiming that the State is entitled to restitution/unjust enrichment, indemnity, public nuisance relief, and injunctive relief).

83. *Am. Tobacco Co.*, No. 94-1429, ¶ 82.

84. *Id.* ¶ 79.

For these smokers, the state stepped in and fulfilled Big Tobacco's obligation through its Medicaid program, which is partially funded by the state's taxpayers.⁸⁵ Taxpayers had "thus unofficially expended hundreds of millions of dollars in caring for their fellow citizens who have" tobacco-related diseases, while "the tobacco cartel continues to reap billions of dollars in profits."⁸⁶ Therefore, the tobacco industry was unjustly enriched by the amount the companies should have paid to cover the harm caused by cigarettes—namely, the same amount that the state had paid to cover the healthcare costs of tobacco-related diseases for Medicaid-covered smokers. In addition, the State sought damages "for the sums of money to be paid by the State *in the future* on account of the defendants' wrongful conduct."⁸⁷

b. Indemnity

Similarly, the state's indemnity theory asserted that the tobacco industry had a duty to cover the healthcare costs of tobacco-related disease.⁸⁸ The state, however, "was legally obligated to pay" these costs under its Medicaid program.⁸⁹ Moore, writing separately from the original complaint, said that the state "is an innocent third party to the dealing between the indigent sick smoker and the industry" and therefore "should be indemnified for its losses by shifting those costs to the industry."⁹⁰ For relief, the State sought damages, prejudgment interest, attorneys' fees, expert fees, and punitive damages "in such amount as will sufficiently punish the defendants for their conduct."⁹¹

c. Public Nuisance

Mississippi's complaint also contained several allegations about Big Tobacco's wrongful conduct. The state alleged that, acting through

85. States receive reimbursement from the United States Department of Health and Human Services for the costs of administering their Medicaid programs. Each state's respective per capita income determines the level of reimbursement. Generally, reimbursement ranges from 55 percent for states with average to above average per capita incomes, to 83 percent for states with the lowest per capita incomes. 42 U.S.C.A. § 1396b (West 2010).

86. *Am. Tobacco Co.*, No. 94-1429, ¶¶ 79–80. Moreover, the State contended that the *reason* the tobacco industry was so profitable was because the industry had "spent billions in slick, sophisticated marketing tactics designed to make smoking appear more glamorous to our youngsters." *Id.* ¶ 81.

87. *Id.* ¶ 83(b) (emphasis added).

88. *Id.* ¶¶ 84–88.

89. *Id.* ¶ 86.

90. Moore & Mikhail, *supra* note 82, at 198.

91. *Am. Tobacco Co.*, No. 94-1429, ¶ 88.

the Council for Tobacco Research, the industry had intentionally deceived the citizens of Mississippi about the health risks of smoking by questioning the scientific evidence linking smoking and lung cancer.⁹² The goal of this “promotional, public relations, and lobbying blitz,” the state argued, was to increase the number of people addicted to nicotine and to decrease the number of people who would quit smoking.⁹³ By engaging in such wrongful conduct, the manufacturers of tobacco became a public nuisance that caused the state to spend “millions of dollars in support of the public health and welfare” through its Medicaid program.⁹⁴

d. Injunctive Relief

The state’s request for injunctive relief centered on Big Tobacco’s marketing aimed at children.⁹⁵ Marketing cigarettes to children created “successive generations of addictive customers” who ultimately would develop tobacco-related diseases.⁹⁶ To stop the recruitment of minors into the ranks of addicted smokers, the state sought to enjoin the industry not only from promoting cigarettes to children, but also from assisting—“aiding, abetting or encouraging,” in the words of the complaint—in the distribution of cigarettes to children.⁹⁷ Failing to impose such an injunction, the state asserted, would lead to irreparable harm to minors, who would be doomed to a life of addiction and the attendant consequences for their health.⁹⁸

2. The Master Settlement Agreement

Soon after filing the Mississippi complaint, Moore recruited other states to join the effort. Moore spoke at antitobacco conferences and, with the help of his friend Richard “Dickie” Scruggs, the hugely successful plaintiffs’ class-action attorney, “flew around the country in Scruggs’s Lear jet, touching down in state capitals to plead their cause.”⁹⁹ Using the Mississippi complaint as a model, Minnesota and West Virginia filed suits in 1994; Florida and Massachusetts followed

92. *Id.* ¶¶ 42–43.

93. *Id.* ¶ 59.

94. *Id.* ¶ 90.

95. *Id.* ¶¶ 93–95.

96. *Id.* ¶ 93. A Philip Morris executive stated that “[t]oday’s teenager is tomorrow’s potential regular smoker.” *YOUNG SMOKERS*, *supra* note 6, at 6.

97. *Am. Tobacco Co.*, No. 94-1429, ¶ 95.

98. *Id.* ¶ 96.

99. *DERTHICK*, *supra* note 30, at 79; *see also* Vandall, *supra* note 9, at 480 (noting that Michael Moore spoke at antitobacco conferences).

in 1995.¹⁰⁰ Thirteen more states filed in 1996,¹⁰¹ twenty-two in 1997, and two more in 1998.¹⁰² Moore had attained one of his original goals: to “build an army the size the tobacco industry had.”¹⁰³

Moore’s army had considerable resources. Each of the forty-two attorneys general had substantial legal departments devoted solely to the Medicaid suits.¹⁰⁴ Additionally, the states hired around one hundred private law firms to assist with the effort.¹⁰⁵ And unlike individual plaintiffs’ lawyers, the states had “moral authority”¹⁰⁶—the imprimatur of the government gave the lawsuits a new form of legitimacy. Big Tobacco now faced a unique foe, and traditional defenses developed in response to individual smokers’ claims were unavailable. Assumption of risk, for example, would be at least “one step removed” from the role it played in individual actions, if not entirely unavailable: the states did not assume the risks of smoking, unlike individual smokers, who did so either knowingly or

100. *Minnesota v. Philip Morris, Inc.*, No. C1-94-8565 (D. Minn. Aug. 17, 1994), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/mn_complaint.pdf; *State v. Am. Tobacco Co.*, No. 95-1466AO (Fla. Cir. Ct. Palm Beach County Feb. 21, 1995), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/1florida.pdf; *Massachusetts v. Philip Morris, Inc.*, No. 95-7378 (Mass. Super. Ct. Middlesex County Dec. 19, 1995), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/8macomplaint.pdf; *McGraw ex rel. State v. Am. Tobacco Co.*, No. 94-1707 (W.V. Cir. Ct. Kanawha County Sept. 20, 1994), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/wvcomplaint.pdf.

101. The thirteen states that filed in 1996 were Utah, Texas, Arizona, Connecticut, Illinois, Iowa, Kansas, Louisiana, Maryland, Michigan, New Jersey, Oklahoma, and Washington. For both a chart summarizing the dates for all fifty states, and the complaints as filed, see Tobacco Control Archives, UCSF Library, State Lawsuits, available at <http://www.library.ucsf.edu/tobacco/litigation/states>.

102. The twenty-two states that filed in 1997 were Alaska, Arkansas, California, Colorado, Georgia, Hawaii, Idaho, Indiana, Maine, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Vermont, and Wisconsin. The two that filed in 1998 were Nebraska and South Dakota. For the actual complaints, see Tobacco Control Archives, UCSF Library, State Lawsuits, available at <http://www.library.ucsf.edu/tobacco/litigation/states> (select name of state and follow complaint hyperlink).

103. *The Year in Review*, *supra* note 11, at B7.

104. Eight states never filed lawsuits against Big Tobacco, although they were signatories to the MSA: Alabama, Delaware, North Carolina, North Dakota, Tennessee, Wyoming, Kentucky, and Virginia.

105. DERTHICK, *supra* note 30, at 183. The decision to contract with private tort lawyers was, at least in Mississippi, political as well: “When [Moore] filed his lawsuit, a key state legislative chairman told Mr. Moore he would get ‘not one penny’ of taxpayer money to sue the tobacco industry. So he pursued the case using well-financed tort lawyers . . .” *The Year in Review*, *supra* note 11, at B7.

106. Richard L. Cupp, Jr., *State Medical Reimbursement Lawsuits after Tobacco: Is the Domino Effect for Lead Paint Manufacturers and Others Fair Game?*, 27 PEPP. L. REV. 685, 689 (2000).

otherwise.¹⁰⁷ Finally, given the size, resources, and collective determination of the attorneys general, Big Tobacco's scorched-earth litigation strategy was effectively nullified.¹⁰⁸

The states' legal theory was unique, although not original to Mike Lewis. In 1977, Donald Garner published *Cigarettes and Welfare Reform*, where he argued:

[A] substantial and growing part of the economic costs wrought by smoking are borne by nonsmokers. . . . [W]hen an indigent smoker develops a cigarette-related illness, his medical bills are often paid by the public through tax-supported hospitals and social health care programs. The nonsmoking taxpayer is sick much less frequently; consequently . . . the nonsmoker is contributing proportionately more to the various health funds than he will receive in return. . . . Thus, the nonsmoking public indirectly subsidizes and promotes the consumption of tobacco products.¹⁰⁹

This "irrationality," as Garner called it, could be remedied by terminating the subsidies provided by taxpayers.¹¹⁰ The healthcare costs of smoking could be transferred from the taxpayers to the tobacco companies. Beyond remedying this irrationality, transferring the costs to manufacturers would provide incentives to produce safer cigarettes.¹¹¹ One mechanism for this transfer of costs would be "civil adjudication," which Garner described as "a system of civil liability that would make the manufacturer whose cigarettes caused an illness liable to repay the appropriate government agency."¹¹² Seventeen

107. *Id.* Cupp bases this one-step-removed point on the notion that the states were suing on behalf of smokers, *id.* at 696, which is false. The states were suing on behalf of taxpayers who bore the financial burden of Medicaid-covered smokers' health care. As part of the unjust enrichment count, the Mississippi complaint refers to the burden on "Mississippi taxpayers" who have "expended hundreds of millions of dollars in caring for their fellow citizens." Moore *ex rel.* State v. Am. Tobacco Co., No. 94-1429, ¶ 79 (Miss. Ch. Ct. Jackson County May 23, 1994), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/ms_complaint.pdf. Moreover, the complaint explicitly contended that Big Tobacco was "unjustly enriched to the extent that Mississippi's taxpayers have had to pay these costs." *Id.* ¶ 82.

108. See Cupp, *supra* note 106, at 689 (stating that "[o]ne of the keys to the states' success was combining their efforts," and that even a single state has "greater litigation resources and moral authority than is typically present in mass tort actions initiated by private attorneys"); see also Howard M. Erichson, *The End of the Defendant Advantage in Tobacco Litigation*, 26 WM. & MARY ENVTL. & POL'Y REV. 123, 134 (2001) ("[T]he state governments were not outsized by the tobacco defendants in terms of resources or power, especially when those state attorneys general joined forces and pursued their claims collectively.").

109. 26 EMORY L.J. 269, 272 (1977) (footnotes omitted).

110. *Id.* at 275.

111. *Id.*

112. *Id.* at 277. Big Tobacco had also considered a similar argument one year after the publication of Garner's article. In 1978, Philip Morris explicitly discussed the argument that "cigarettes cause disease; disease requires treatment; major health costs are borne by the government; taxpayers pay in the end." Memorandum from R.B. Seligman, Vice President of Research & Dev., Philip Morris, to J.C. Bowling, Senior Vice President, Philip Morris (Nov. 20, 1978), available at <http://tobaccodocuments.org/pm/2015015777.html>.

years after writing his article, Garner's idea came to fruition in the states' recoupment suits.

At first, it seemed as if Big Tobacco would not back down. "We don't intend to lose," R.J. Reynolds's general counsel remarked in January 1997.¹¹³ "[W]e're not in the business of settling cases that have no merit in law or fact."¹¹⁴

Six months later, as the Mississippi case was set for trial,¹¹⁵ the industry settled with the state for \$3.6 billion.¹¹⁶ One month later, it settled with Florida for \$11.3 billion,¹¹⁷ and during the first half of 1998, Big Tobacco settled with Texas for \$15.3 billion¹¹⁸ and Minnesota for \$6.6 billion.¹¹⁹ On November 16, 1998, the tobacco industry and the remaining forty-six states, the District of Columbia, and five U.S. territories executed the Master Settlement Agreement.¹²⁰ The original signatories on the industry side were Philip Morris, R.J. Reynolds, Brown & Williamson Tobacco, Lorillard, and Liggett Group.¹²¹

113. Hansen, *supra* note 54, at 53 (quoting Daniel W. Donahue, deputy general counsel for R.J. Reynolds Co.).

114. *Id.* This is inconsistent with R.B. Seligman's assessment, made in 1978, of a similar argument as a "potent weapon[.]" Memorandum from R.B. Seligman, Vice President of Research & Dev., Philip Morris, to J.C. Bowling, Philip Morris (Nov. 20, 1978), available at <http://tobaccodocuments.org/pm/2015015777.html>.

115. See VISCUSI, *supra* note 2, at 37 (noting that the Mississippi settlement was the first after "the June 1997 Proposed Resolution effort began to dim").

116. *Id.*; Memorandum of Understanding, *In re Moore ex rel. State Tobacco Litig.*, No. 94-1429 (Miss. Ch. Ct. Jackson County July 2, 1997), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/ms_settlement.pdf; see also John Schwartz & Sandra Torry, *Tobacco Firms, Mississippi Settle*, WASH. POST, July 4, 1997, at A1 (reporting that the settlement was for \$3.4 billion).

117. VISCUSI, *supra* note 2, at 37; Settlement Agreement, *State v. Am. Tobacco Co.*, No. 95-1466 (Fla. Cir. Ct. Palm Beach County Aug. 25, 1997), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/flsettle.pdf; John Schwartz, *Cigarette Makers Settle Florida Suit for \$11.3 Billion*, WASH. POST, Aug. 26, 1997, at A1.

118. VISCUSI, *supra* note 2, at 37; Comprehensive Settlement Agreement and Release, *Texas v. Am. Tobacco Co.*, No. 5-96CV-91 (E.D. Tex. Jan. 16, 1998), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/tx_settlement.pdf; Sandra Torry & Ceci Connolly, *Tobacco Firms Set to Pay Texas \$14.5 Billion*, WASH. POST, Jan. 16, 1998, at A1.

119. Settlement Agreement and Stipulation for Entry of Consent Judgment, *State v. Philip Morris Inc.*, No. C1-94-8565 (Minn. D. Ct. May 8, 1998), available at http://www.library.ucsf.edu/sites/all/files/ucsf_assets/mnsettlement.pdf.

120. Master Settlement Agreement, *supra* note 19; John Schwartz, *Tobacco Settles Minnesota Suit*, WASH. POST, May 9, 1998, at A1. For a summary of the MSA, see *Up in Smoke: Coming to Terms with the Legacy of Tobacco*, 2 J. HEALTH CARE L. & POL'Y 167 app. III (1998).

121. The negotiations between the attorneys general and the states were secret, so any explanation of *why* Big Tobacco settled is, to some degree, speculative. On the negotiations, see Arthur B. LaFrance, *Tobacco Litigation: Smoke, Mirrors and Public Policy*, 26 AM. J.L. & MED. 187, 195 (2000); Panel Discussion, *The Tobacco Settlement: Practical Implications and the Future of the Tort Law*, 67 MISS. L.J. 847 (1998).

a. Economic Terms

Most reports value the settlement at \$206 billion through 2023,¹²² although the actual value through 2023 is slightly more than \$211 billion.¹²³ Table I summarizes the annual payments:

TABLE I. ANNUAL PAYMENTS UNDER MSA¹²⁴

Year	Total Payment (\$ billions)
1999	2.400
2000	6.972
2001	7.546
2002	9.123
2003	9.201
2004	8.000
2005	8.000
2006	8.000
2007	8.000
2008–perpetuity	9.000

The amount for which a particular company is responsible in a given year depends on that company's market share in the preceding year, measured by the number of cigarettes sold.¹²⁵ For example, if a company's market share in 2007 was 50 percent, then that company will be responsible for \$4.5 billion in 2008.

The MSA also included payment provisions earmarked for enforcement of the settlement.¹²⁶ The tobacco companies were

122. VISCUSI, *supra* note 2, at 41.

123. *See id.* at 44 (“These amounts are \$12.7 billion for the initial payments, \$190 billion for the annual payments, and \$9 billion for the additional payments, for a total amount of \$211 billion.”). Commenting elsewhere on the MSA, Viscusi says: “The settlement of the Attorney Generals’ suits against the cigarette industry for \$206 billion was a landmark outcome. By any standard, the financial stakes were enormous, dwarfing even the largest tort liability judgments and punitive damages awards. Moreover, what was especially noteworthy was that the party paying for the costs was the cigarette industry, which to date had been almost unscathed after decades of litigation involving the hazards of smoking.” Viscusi, *supra* note 21, at 523. It is important to note that the \$206 billion in the MSA is in addition to the \$36.8 billion to be paid to Mississippi, Florida, Texas, and Minnesota, which settled independently. *See* VISCUSI, *supra* note 2, at 38 (“The \$36.8 billion in settlements for the four separate state settlements are not included in the overall announced price tag of \$206 billion Thus, the total settlement value with all fifty states is \$243 billion.”).

124. VISCUSI, *supra* note 2, at 43 tbl.1.

125. Master Settlement Agreement, *supra* note 19, at 9 (defining “Market Share”), 45; VISCUSI, *supra* note 2, at 41.

126. Master Settlement Agreement, *supra* note 19, at Exhibit J; VISCUSI, *supra* note 2, at 42.

required to pay an initial amount of \$50 million in 1999 and thereafter \$150,000 annually over 10 years, or \$1.5 million.¹²⁷

In addition to the nonearmarked annual payments in Table I and the funding for enforcing the settlement, Big Tobacco must make special payments to establish a foundation.¹²⁸ The dual purposes of the foundation are to reduce youth smoking and support educational programs designed to prevent tobacco-related diseases.¹²⁹ The "Base Foundation Payments" are \$25 million annually from 1999 until 2008, for a total of \$250 million.¹³⁰ In addition to the base payments, the tobacco companies paid \$250 million in 1999 and \$300 million annually from 2000 until 2003, for a total of \$1.45 billion.¹³¹ All told, the payments—specifically designated to educate the public about tobacco-related disease and prevent youth-smoking—constitute less than 1 percent of the total settlement value.¹³²

b. Regulatory Terms

The MSA contains regulatory measures aimed at cigarette advertising. Big Tobacco cannot "target Youth within any Settling State in the advertising, promotion, or marketing of Tobacco Products, or take any action the primary purpose of which is to initiate, maintain or increase the incidence of Youth smoking within any Settling State."¹³³ Cartoons used in advertising, packaging, or labeling are banned,¹³⁴ although R.J. Reynolds voluntarily withdrew "Joe Camel" from the market in 1997.¹³⁵ Big Tobacco cannot advertise on outdoor billboards; cannot advertise on signs and placards in arenas, in shopping malls and arcades, or on transit systems; and cannot institute any new outdoor advertising of any kind.¹³⁶ The only exception is for adult-only facilities.¹³⁷ The MSA also prohibits product placements and limits Big Tobacco's lobbying activities. The companies cannot sponsor sporting events, concerts, or any event

127. Master Settlement Agreement, *supra* note 19, at 54; VISCUSI, *supra* note 2, at 42.

128. Master Settlement Agreement, *supra* note 19, at 41.

129. *Id.*

130. *Id.* at 42.

131. *Id.*

132. VISCUSI, *supra* note 2, at 42; *see also id.* (noting that "[t]hese [educational] measures are not the main point of the settlement, which is simply to transfer money to the states").

133. Master Settlement Agreement, *supra* note 19, at 18–19. The MSA defines "Youth" as "any person or persons under 18 years of age." *Id.* at 18.

134. *Id.* at 19.

135. VISCUSI, *supra* note 2, at 38.

136. Master Settlement Agreement, *supra* note 19, at 22.

137. *Id.*

where a significant number of children will be present. Finally, the MSA dissolved the Center for Tobacco Research and the Tobacco Institute.¹³⁸

III. THE SUBSTANCE OF THE MSA

On its face, the MSA appears to be a fair deal. An industry with a history of deception that produces a product that kills hundreds of thousands of Americans each year must pay for the economic harm it inflicts on taxpayers who, through Medicaid, foot the bill that the industry should be paying. But the law is concerned with the substance of a matter, not how it appears.¹³⁹ An examination of the MSA's detailed provisions in light of the "time honored precept"¹⁴⁰ that substance should prevail over form reveals a violation of the Social Security Act. Title XIX of the Act, which established the Medicaid program, also governs the conditions under which a state may charge a Medicaid recipient a premium or other fee for Medicaid coverage.

138. *Id.* at 32.

139. Courts have applied the substance-over-form doctrine in various legal contexts. *See, e.g.*, *Boulware v. United States*, 552 U.S. 421, 430 (2008) ("There is no reason to doubt that the economic substance remains the right touchstone for characterizing funds received when a shareholder diverts them before they can be recorded on the corporation's books."); *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 773 n.21 (1984) (referring to the "broader principle that substance, not form, should determine whether a separately incorporated entity is capable of conspiring under § 1" of the Sherman Act); *Diedrich v. C.I.R.*, 457 U.S. 191, 195 (1982) (remarking that, when determining whether taxable income was received, "the substance, not the form, of the agreed transaction controls"); *Frank Lyon Co. v. United States*, 435 U.S. 561, 573 (1978) (referring to the "doctrine of substance over form" and noting that, in applying this doctrine, "the Court has looked to the objective economic realities of a transaction rather than to the particular form the parties employed"); *United States v. R.F. Ball Const. Co.*, 355 U.S. 587, 593 (1958) ("Substance, not form or labels, controls the nature and effect of legal instruments."); *Gregory v. Helvering*, 293 U.S. 465, 470 (1935) (finding that, although the business transaction was designed as a corporate reorganization, it was a conveyance, and noting that, to hold otherwise would "exalt artifice above reality"); *Trenkler v. United States*, 536 F.3d 85, 97 (1st Cir. 2008) (stating that, when distinguishing between a writ of coram nobis and a motion to vacate, set aside or correct the sentence under 28 U.S.C.A. § 2255, "courts must be guided by the precept that substance trumps form" (citation omitted)); *In re Genesis Health Ventures, Inc.*, 402 F.3d 416, 422 (3d Cir. 2005) (appealing to the principle that "substance trumps form" and stating that "[p]ayments made on behalf of a debtor, whether made directly or indirectly . . . constitute that particular debtor's disbursements"); *United Airlines, Inc. v. HSBC Bank USA*, 416 F.3d 609, 612 (7th Cir. 2005) (concluding that, when distinguishing between leases and secured credit in the context of § 365 of the Bankruptcy Code of 1978, substance prevails over form); *In re Charter Comm'ns, Inc.*, 393 F.3d 771, 783 (8th Cir. 2005) ("Whether a court is presented with a case or controversy is a question of substance, not form."); *Kashani v. Purdue Univ.*, 813 F.2d 843, 847 (7th Cir. 1987) (when determining whether an entity, like a university, is an agent of the state, courts "must look to substance rather than form"); *Advance Mach. Exch., Inc. v. Comm'r*, 8 T.C.M. (CCH) 84, at *15 (1949) ("Taxation deals with realities not semblances; with substance not form.").

140. *Aguiar v. U.S. Immigration & Customs Enforcement*, 510 F.3d 1, 16 (1st Cir. 2007).

In short, the argument presented in this Part is as follows. First, under the MSA, Medicaid-covered smokers make de facto payments to their states for their Medicaid coverage. Second, the payments made by Medicaid-covered smokers violate the Act. Therefore, the MSA violates the Act.

An analysis of Big Tobacco's actions following the MSA and the details of the economic terms of the MSA leads to the first premise. An analysis of the provisions of the Social Security Act that govern when a state may charge a Medicaid recipient a premium or other fee leads to the second premise.

A. The First Premise: De Facto Payments

1. Price Increases and Passing Costs

In response to the financial obligations incurred under the MSA, Big Tobacco increased the price of cigarettes. In the three years preceding the MSA, annual increases of the average price of a package of cigarettes were small—5 cents from 1995 to 1996, and 10 cents from 1996 to 1997.¹⁴¹ Yet, the day after Big Tobacco signed the MSA, industry leaders Philip Morris and R.J. Reynolds raised the price of a pack of cigarettes by 45 cents,¹⁴² the largest increase in the history of Big Tobacco.¹⁴³ Subsequent increases, likewise, were quite large. Between 1998 and 2002, for example, the average price increased by 108 percent, relative to a 28 percent increase from 1995 to 1998.¹⁴⁴

141. 42 THE TAX BURDEN ON TOBACCO: HISTORICAL COMPILATION 144, 146, 148 (Orzechowski & Walker eds., 2007) [hereinafter THE TAX BURDEN]; cf. DERTHICK, *supra* note 30, at 1 (stating the price of a pack of cigarettes in 1997 as \$1.90). Figures from *The Tax Burden* represent the weighted average of all brands of cigarettes, including generic brands, across the United States, and exclude sales tax and, in eight states (Alabama, Arkansas, Illinois, Missouri, New York, Ohio, Tennessee, and Virginia), exclude taxes imposed by municipalities.

142. Sylvia Nasar, *The Ifs and Buts of the Tobacco Settlement*, N.Y. TIMES, Nov. 29, 1998, § 4, at 1.

143. Barry Meier, *Cigarette Makers Announce Large Price Rise*, N.Y. TIMES, Nov. 24, 1998, at A20 (quoting David Adelman, Morgan Stanley analyst).

144. Rahul Rajkumar, Cary P. Gross & Howard P. Forman, *Is the Tobacco Settlement Constitutional?*, 34 J.L. MED. & ETHICS 748, 751 (2006). Media coverage of the increases was extensive. See, e.g., *Philip Morris is Raising Cigarette Prices by 3%*, N.Y. TIMES, July 29, 2000, at C3 (noting that, in 1999, Philip Morris raised prices to “help pay for rising legal settlement costs”); see also Gordon Fairclough, *Major Makers of Cigarettes Raise Prices*, WALL ST. J., Aug. 31, 1999, at A3 (describing 18 cent per pack price increase as “the second largest cigarette price increase in history”); Gordon Fairclough, *Philip Morris Boosts Prices of Cigarettes*, WALL ST. J., Jan. 17, 2000, at B12 (noting 13 cent per pack price increase); Gordon Fairclough, *Philip Morris, R.J. Reynolds Are Raising Cigarette Prices by Six Cents a Pack*, WALL ST. J., July 31, 2000, at A4 (observing 6 cent per pack price increase); *Philip Morris Raises Prices of Cigarettes 14¢ a Pack*, N.Y. TIMES, Apr. 26, 2001, at C4 (noting 14 cent per pack price increase). The price increases led to a class action brought on behalf of cigarette wholesalers, A.D. Bedell Wholesale Co. v. Phillip

Table II contains the weighted average price per package of cigarettes, which excludes state and federal taxes, from 1995 to 2007.

TABLE II. WEIGHTED AVERAGE PRICE PER PACKAGE OF CIGARETTES¹⁴⁵

Year	Weighted Average Price Per Pack (\$)
1995	1.80
1996	1.85
1997	1.95
1998	2.18
<i>Execution of MSA</i>	
1999	2.93
2000	3.12
2001	3.37
2002	3.72
2003	3.72
2004	3.74
2005	3.89
2006	3.93
2007	4.20

The timing of the price increases, as well as the lack of any other plausible explanation,¹⁴⁶ strongly suggests that tobacco

Morris, Inc., 263 F.3d 239 (3d Cir. 2001), and a class-action lawsuit brought on behalf of consumers, *Sanders v. Lockyer*, 365 F. Supp. 2d 1093, 1097 (N.D. Cal. 2005) (price-per-carton was raised by \$4.50 on the day the MSA was signed, and by \$7.70 in 2001).

145. THE TAX BURDEN, *supra* note 141, at 144–68 tbl.13B. The weighted average price per pack includes generic brand cigarettes.

146. Demand may have played a role, albeit a minor one, in the price increases. Generally, cigarette consumption began declining in the early 1980s. TRENDS IN TOBACCO USE, *supra* note 26, at tbl.2. Between 1990 and 2002, however, smoking rates for 18- to 20-year-olds increased by 36 percent and smoking rates for 21- to 24-year-olds increased by 30 percent. Further, there was only a marginal decrease in smoking rates for persons aged twenty-five and older during the same period. Frank A. Sloan & Justin C. Trogdon, *The Impact of the Master Settlement Agreement on Cigarette Consumption*, 23 J. POL'Y ANALYSIS & MGMT. 843, 846 (2004). Sloan and Trogdon estimate, based on counterfactuals, that the MSA reduced smoking rates for 18- to 20-year-olds and those over 65 years old by 13 percent, and reduced smoking rates for 21- to 64-year-olds by 5 percent. *Id.* at 852.

The inflation rate likewise fails to explain the increases: For the years surrounding the execution of the MSA and the industry's largest cigarette-price increase, the inflation rates were: 1995, 2.8 percent; 1996, 3.0 percent; 1997, 2.3 percent; 1998 and MSA, 1.6 percent; 1999, 2.2 percent; 2000, 3.4 percent; 2001, 2.8 percent; 2002, 1.6 percent. U.S. DEPT. OF LABOR, BUREAU OF LABOR STATISTICS, CONSUMER PRICE INDEX (2010), available at <http://www.bls.gov/cpi/#tables>. Further, when the inflation rate dropped to 1.6 percent in 1998, it was the first time it had been

companies transferred the costs of the MSA to smokers. For instance, one might look to an increase in the farm value of tobacco to explain the price increases. The farm value of tobacco is the average price that cigarette manufacturers pay for tobacco. This variable accounts for *less than 1 percent* of the overall increase in cigarette prices.¹⁴⁷ In fact, the farm value of tobacco decreased from 1998 to 1999, the same period during which Big Tobacco made the most drastic increase on cigarette prices.¹⁴⁸ From 1999 to 2006, the farm value of tobacco remained relatively stable. It then dropped to its lowest value in thirty-seven years in 2007 at \$520 million, the same year that marks the highest price per pack of cigarettes in the history of tobacco in the United States.¹⁴⁹ Thus, the farm value of tobacco cannot explain the price increases. Nor, for that matter, can the cost of production, which has remained stable at about \$0.16 per pack.¹⁵⁰

2. MSA Provisions that Protect the OPMs

It comes as no surprise that Big Tobacco passed the costs of the MSA to smokers; indeed, firms frequently pass costs to consumers.¹⁵¹ But the attorneys general who negotiated the MSA had even more reason to expect price increases: the terms of the MSA practically guaranteed such a result. Philip Morris, R.J. Reynolds, Brown and Williamson Tobacco, and Lorillard are all deemed “Original Participating Manufacturers” (“OPMs”) under the MSA.¹⁵² When the MSA was executed, only these companies and Liggett Group were signatories.¹⁵³ An OPM’s obligations under the MSA are tied to that OPM’s market share.¹⁵⁴ Thus, the more cigarettes an OPM sells, the

that low since 1965, and it was only one of two times it had been below 2 percent during that same period of time—in the other year, 1986, the rate was 1.9 percent. *Id.*

147. DERTHICK, *supra* note 30, at 1.

148. See THE TAX BURDEN, *supra* note 141, at 2 (showing drastic increase in cigarette excise taxes and slow decline in tobacco farm value).

149. *Id.* At the same time, the farm value was likely influenced by demand for cigarettes, which had been in steady decline since the 1980s. See *id.* at 2-3 (showing both the decreasing trend in farm value and the broader trend toward less consumption of cigarettes).

150. DERTHICK, *supra* note 30, at 1.

151. See, e.g., Louis Aguilar, *Utility-Rate Avalanche Looms for Metro Area 38,000 Families Seek Aid; Average Bill to Hit \$170*, DENVER POST, Nov. 28, 2003, at A-01 (discussing utility companies passing the increased cost of natural gas on to consumers); Carin Rubenstein, *Cost of Living; As Gasoline Prices Rise, So Do Surcharges*, N.Y. TIMES, Oct. 23, 2005, at 14WC (discussing small business passing increased gasoline surcharges to consumers).

152. Master Settlement Agreement, *supra* note 19, at 10.

153. *Id.* at 147 (noting that all parties have agreed to the terms of the document).

154. *Id.* at 57.

more the company must pay the states; by the same token, selling fewer cigarettes leads to less money owed to the states.¹⁵⁵

This market-share provision created predictable incentives. If an OPM decreased the price of cigarettes, more consumers would purchase that company's cigarettes, thereby increasing its market share. If an OPM's market share increased, the amount it would be required to pay under the MSA would increase. And as an OPM's obligations under the MSA increased, its profits would decrease.¹⁵⁶ Conversely, an OPM could decrease its obligations under the MSA by raising the price of cigarettes, thereby decreasing market share and retaining greater profit. So, the OPMs collectively passed the costs of the MSA to smokers by increasing prices *without* the risk of being underpriced by another OPM.

Perhaps even more critically, the OPMs received protection from new entrants into the cigarette market. The MSA deems new entrants "Non-Participating Manufacturers" ("NPMs").¹⁵⁷ An NPM, by definition, was not an original party to the MSA. Unlike the OPMs, NPMs have no financial obligations under the MSA. An NPM could thus enter the cigarette market and price cigarettes well below the average OPM's price without facing any consequences under the MSA. As the NPM's market share increased due to its lower prices, its profits would also increase. NPMs could thus dominate the cigarette market, driving the OPMs out of business.

The Non-Participating Manufacture Adjustment ("NPM Adjustment") of the MSA addresses this problem. The NPM Adjustment provides that if the OPMs collectively lose more than 2 percent of the market share to an NPM, then the NPM Adjustment trebles the decrease in the OPMs' collective obligations.¹⁵⁸

155. *Id.*

156. THOMAS C. O'BRIEN, CONSTITUTIONAL AND ANTITRUST VIOLATIONS OF THE MULTISTATE TOBACCO SETTLEMENT 4 (2000).

157. Master Settlement Agreement, *supra* note 19, at 58; *see also* Thomas C. O'Brien & Robert A. Levy, *A Tobacco Cartel is Born, Paid For by Smokers*, WALL ST. J. May 1, 2000, at A36 (observing that Big Tobacco "managed to carve out a protected market for themselves – all at the expense of smokers and the tobacco companies that didn't sign the [MSA]").

158. *Id.* at 59; *see also* O'BRIEN, *supra* note 156, at 4 (construing the NPM Adjustment of the MSA as a provision that applies to the OPMs as a group). *But see* Freedom Holdings, Inc. v. Spitzer, 357 F.3d 205, 211 (2d Cir. 2004) (construing the NPM Adjustment of the MSA as a provision that applies to *individual* OPMs). The MSA defines "Base Aggregate Participating Manufacture Market Share" as the market share "of all present and former Tobacco Product Manufacturers that were Participating Manufacturers during the entire calendar year immediately preceding the year in which the payment in question is due minus [2 percent]." Master Settlement Agreement, *supra* note 19, at 60. So, the NPM Adjustment applies not only to OPMs, but also firms that were not originally signatories to the MSA, but successfully applied to become parties to it.

By itself, the NPM Adjustment would not deter new entrants into the cigarette market; it only would decrease the OPMs' obligations if NPMs enter the market. Yet the entrance of NPMs into the market would cause the amount of money the OPMs pay the states under the MSA to decrease significantly. This would financially devastate the states, which now rely on MSA payments for infrastructure, debt repayment, budget shortfalls, and a host of other programs.¹⁵⁹ But the MSA includes a provision to protect the states from the NPM Adjustment. The NPM Adjustment does not apply if the state enacts a "Qualifying Statute" that imposes financial penalties on new entrants.¹⁶⁰ For example, Tennessee's Qualifying Statute, which is based on the model statute provided in the MSA and is typical of others passed after the MSA's execution, covers "[a]ny tobacco product manufacturer selling cigarettes to consumers within the state of Tennessee."¹⁶¹ The statute forces all tobacco manufacturers to choose between two options: either (1) participate in the MSA and pay the states according to its market share, or (2) not participate in the MSA, but pay into an escrow fund amounts exceeding obligations under the MSA.¹⁶² The only other option, of course, is to drop out of the cigarette business altogether.¹⁶³

159. Frank A. Sloan et al., *Determinants of States' Allocations of the Master Settlement Agreement Payments*, 30 J. HEALTH POL. POL'Y & L. 643, 653 (2005).

160. Master Settlement Agreement, *supra* note 19, at 65.

161. TENN. CODE ANN. § 47-31-103(a) (West 2008). Tennessee's Qualifying Statute is based on the Model Statute provided in the Master Settlement Agreement, *supra* note 19, at Exhibit T. All settling states have Qualifying Statutes. John A. Tauras, Richard M. Peck & Frank J. Chaloupka, *The Role of Retail Prices and Promotions in Determining Cigarette Brand Market Shares*, 28 REV. INDUS. ORG. 253, 260 (2006); e.g., MASS. GEN. LAWS. ANN. ch. 94E, § 2 (West 2008); NEV. REV. STAT. ANN. §§ 370A.010 – 370A.160 (West 2008).

162. TENN. CODE ANN. § 47-31-103(a)(1)–(2). If an NPM chooses the first option and decides to participate in the MSA, then it only has payment obligations if its market share exceeds either its 1998 market share or 125 percent of its 1997 market share, whichever is greater. Master Settlement Agreement, *supra* note 19, at 60. If obligations are triggered, then the manufacturer must make annual payments in an amount computed similar to the OPMs' obligations. The formula is at Master Settlement Agreement, *supra* note 20, at 60. If the base amount due from OPMs for a given year is \$9 billion, and the SPM's market share for that year increased by 3 percent from its 1998 market share or 125 percent of its 1997 market share, whichever is greater, (i.e., the SPM had zero percent of the market pre-MSA), and the OPMs' market share in the preceding year was 97 percent, then the SPM will make a payment of around \$278 million (increased market share divided by the market share of the OPMs in the preceding year, multiplied by the base amount due from the OPMs).

If the NPM chooses the second option and refuses to participate in the MSA, then the NPM must deposit, on an annual basis, \$0.0188482 into an escrow account for each individual cigarette sold. This works out to more than what the NPM would have paid, if the NPM decided to participate in the MSA. O'BRIEN, *supra* note 156, at 24 n.20 (stating the amount paid into the escrow account would be "approximately 150 percent" of the amount the firm would pay under the MSA). *But see* Tauras et al., *supra* note 161, at 260 (stating the amount paid into the escrow account would be "equivalent" to the amount paid under the MSA). At the same time, however,

3. Passing Costs and De Facto Payments

How, though, does passing costs equal de facto payments? In other words, how does (A) “Big Tobacco passed the costs of the MSA to smokers” lead to (B) “Medicaid-covered smokers make de facto payments to the states for their Medicaid”?

The following hypothetical frames the question more clearly. Suppose a resident of Florida smokes Philip Morris cigarettes. Suppose further that this smoker is covered by Florida’s Medicaid plan. After the MSA, this smoker saw the price of his cigarettes increase to about \$4.20 per pack. Proposition (A) states that the smoker is bearing the cost of the MSA by paying more for cigarettes. Proposition (B) states that the smoker is paying Florida for her Medicaid coverage by paying more for cigarettes. On its face, (B) makes an entirely different statement than (A).

First, the transition from (A) to (B) assumes that some smokers receive Medicaid, which is true. In 2006, for example, 35 percent of Medicaid recipients, or 16.8 million people, smoked.¹⁶⁴ But the

the Tennessee statute, like others, provides that any excess amounts will be released back to the manufacturer. TENN. CODE ANN. § 47-31-103(a)(2)(B)(ii); Master Settlement Agreement, *supra* note 19, at app. T. The remaining money in the escrow account is released back to the manufacturer only to pay judgments and settlements resulting from lawsuits brought by the states, and any money remaining after twenty-five years from the date that money was deposited would also be disbursed back to the NPM. TENN. CODE ANN. § 47-31-103(a)(2)(B)(i)–(iii); Master Settlement Agreement, *supra* note 19, at app. T.

163. O’BRIEN, *supra* note 156, at 5.

164. TRENDS IN TOBACCO USE, *supra* note 26, at 9 (follow the subheading “Prevalence of Smoking Cessation Among Adults”); *cf.* U.S. DEP’T. OF HEALTH & HUMAN SERVS., NAT’L CTR. FOR HEALTH STATISTICS, SUMMARY HEALTH STATISTICS FOR U.S. ADULTS: NATIONAL HEALTH INTERVIEW SURVEY, 2008, at 66–69 tbls.24–25, available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_242.pdf [hereinafter SUMMARY HEALTH STATISTICS] (finding that 37 percent of adults under sixty-five years of age who are covered by Medicaid are current smokers). The percentage of Medicaid recipients under sixty-five years of age who smoke is higher than the percentage of the adult population, in general, who smoke. In 2006, only 20.6 percent of the adult population (eighteen years of age and older) smoked. TRENDS IN TOBACCO USE, *supra* note 26, at tbl.4. Smoking prevalence also declines with increased education. *Id.* at 4 (follow the subheading “Prevalence of Cigarette Use Among Adults: Smoking by Educational Attainment”). In 2005, 27 percent of smokers had less than twelve years of education, whereas only 9 percent of smokers had more than sixteen years of education. *Id.* at tbl.15.

In addition, Medicaid recipients are, in general, in poorer health than individuals with private insurance and individuals without insurance. *See* SUMMARY HEALTH STATISTICS, *supra*, at 19–20 (noting that Medicaid recipients were more likely to be told that they had heart disease, hypertension, and stroke than individuals with private insurance or individuals without insurance); *id.* at 21–22 (noting that Medicaid recipients had a higher incidence of emphysema, asthma, and chronic bronchitis than individuals with private insurance and individuals without insurance); *see also id.* at 28–39 (noting that Medicaid recipients had a higher incidence of diabetes, ulcers, kidney disease, liver disease, arthritis, chronic joint symptoms, migraine headaches, neck pain, lower back pain, or pain in the face or jaw, hearing trouble, vision trouble, and the absence of all natural teeth, than individuals with private insurance or individuals

transition from (A) to (B) requires more. To treat passing costs as de facto payments requires the application of the principle mentioned earlier: substance over form.¹⁶⁵ In form, the transaction involves three parties: Medicaid-covered smokers, tobacco companies, and the states. In substance, however, the transaction involves two parties: Medicaid-covered smokers and the states. The tobacco companies serve as a mere conduit through which a payment passes on its way to its MSA-mandated destination.

Similar situations have arisen in other contexts, and courts applying the substance-over-form principle have ignored the intermediary. In *Brown v. United States*, for example, the Ninth Circuit applied the “step-transaction doctrine,” a doctrine expressly sanctioned by the Supreme Court,¹⁶⁶ to ignore the intermediary in a payment to the IRS.¹⁶⁷ This doctrine collapses “formally distinct steps” into one in order to obtain a more “realistic” view of the transaction.¹⁶⁸ The doctrine is applied to transactions in which the intermediary serves as a mere conduit through the funds pass; in such cases, the intermediary serves as a “fleeting stop in a predetermined voyage toward a particular result.”¹⁶⁹ The *Brown* case itself involved an individual giving his spouse funds, who in turn had given the funds to the IRS as taxes on a gift.¹⁷⁰ The goal was to defer estate taxes.¹⁷¹ Yet, because the ultimate recipient of the funds—the IRS—had been decided before the funds were given to the spouse, the court ignored the intermediary and treated the transaction as one between the husband and the IRS.¹⁷²

Courts have adopted a variety of tests to determine the proper context for application of the step-transaction doctrine. The two most

without insurance). Poor families, in general, are two to three times as likely to have “fair or poor health” compared to non-poor families. *Id.* at 10.

165. *Aguilar v. U.S. Immigration & Customs Enforcement*, 510 F.3d 1, 16 (1st Cir. 2007).

166. *Comm’r v. Court Holding Co.*, 324 U.S. 331, 334 (1945); *Minn. Tea Co. v. Helvering*, 302 U.S. 609, 613 (1938).

167. 329 F.3d 664, 666–67 (9th Cir. 2003).

168. *Id.* at 671 (quoting *Comm’r v. Clark*, 489 U.S. 726, 738 (1989)).

169. *Id.* at 672.

170. *Id.* at 667–68.

171. *Id.* at 667.

172. *Id.* at 672. For other cases applying the step-transaction doctrine, see *Kornfeld v. Comm’r*, 137 F.3d 1231, 1235–36 (10th Cir. 1998) (applying form over substance doctrine in circumstances involving gifts to daughters and secretary); *Robino Inc. Pension Trust v. Comm’r*, 894 F.2d 342, 344 (9th Cir. 1990) (attributing gain to taxpayers instead of their trusts); *Stewart v. Comm’r*, 714 F.2d 977, 991 (9th Cir. 1983) (attributing income of corporation to its 100 percent owner).

common tests are the “end-result” and “interdependence” tests.¹⁷³ Under the end-result test, implicitly used in *Brown*, the doctrine applies when the distinct steps in the transaction were part of an overall attempt to accomplish, from the outset, the end actually achieved by the transaction.¹⁷⁴ In the words of the Supreme Court: “[A] given result at the end of straight path is not made a different result because reached by following a devious path.”¹⁷⁵ Under the interdependence test, the issue is whether “the individual steps in a series had independent significance or whether they had meaning only as part of the larger transaction.”¹⁷⁶ When each step in the overall transaction depends on the previous step and has no independent economic justification, the intermediary should be ignored.¹⁷⁷

Under either test, the step-transaction doctrine should apply to the transactions between Medicaid-covered smokers, Big Tobacco, and the states. Big Tobacco, as the intermediary, should be ignored in the transaction. The “end result” of the transactions is that payments are made to the states; indeed, this is why Big Tobacco increased the price of cigarettes.¹⁷⁸ Similarly, it is highly unlikely that Big Tobacco would have increased the price of cigarettes as much as it did had the MSA not been executed.¹⁷⁹ The two steps—increasing the price of cigarettes and paying the states—are dependent upon another. Thus, under

173. *Associated Wholesale Grocers, Inc. v. United States*, 927 F.2d 1517, 1522 (10th Cir. 1991); see also *Sec. Indus. Ins. Co. v. United States*, 702 F.2d 1234, 1244–45 (5th Cir. 1983) (citing both tests); *McDonald's Rests. of Ill., Inc. v. Comm'r*, 688 F.2d 520, 524–25 (7th Cir. 1982) (same); *King Enters., Inc. v. United States*, 418 F.2d 511, 516 (Ct. Cl. 1969) (same).

174. See *King Enters.*, 418 F.2d at 516 (“[S]eparate transactions will be amalgamated into a single transaction when it appears that they were really component parts of a single transaction intended from the outset to be taken for the purpose of reaching the ultimate result.”).

175. *Minn. Tea Co. v. Helvering*, 302 U.S. 609, 613 (1938).

176. *Sec. Indus. Ins. Co.*, 702 F.2d at 1246.

177. See *id.* at 1247 (explaining that under the independence test, courts examine the “tandem of transactional totalities to determine whether each step had a reasoned economic justification standing alone”). Intermediaries are ignored in other context as well. See, e.g., *Heyen v. United States*, 945 F.2d 359, 363–64 (10th Cir. 1991) (finding indirect gifts of stock and ignoring intermediate recipients who subsequently transferred stock to decedent's family members); *Am. Hosp. Ass'n v. Bowen*, 834 F.2d 1037, 1051 (D.C. Cir. 1987) (finding Department of Health and Human Services did not violate § 553 of the Administrative Procedure Act when the Department issued new directives through intermediary private agency); *Griffin v. United States*, 42 F. Supp. 2d 700, 707 (W.D. Tex. 1998) (noting that “the plaintiffs engaged in a clever and sophisticated scheme by which [the wife] was merely the intermediary through which the stock passed on its way to the ultimate beneficiary, the Trust” and disregarding the intermediary).

178. The first transaction should not be construed as the purchase of a package of cigarettes, but rather the payment of the increase.

179. Cf. *Sec. Indus. Ins. Co.*, 702 F.2d at 1247 (finding the “individual components so interrelated that no single step would likely have been taken had the others not followed”).

either test, the intermediary should be ignored and substance should prevail over form.

4. The Purpose of the Payments

Applying the step-transaction doctrine provides a more accurate view of the transaction.¹⁸⁰ Medicaid-covered smokers make de facto payments to the states. But proposition (B) goes even further and indicates that these payments are *for* Medicaid. The purpose of the payments is found in the states' complaints: the states sought to recoup the costs of both past and future medical treatment of tobacco-related disease in Medicaid-covered smokers.¹⁸¹ Thus, the purpose of the MSA is to fund the states' Medicaid expenditures on tobacco-related disease,¹⁸² and the transition to (B) is complete. Through the price increases on cigarettes, Medicaid-covered smokers make de facto payments to the states for their Medicaid coverage.

At this point, one may object that the first premise ignores an entire class of individuals: non-Medicaid-covered smokers. Further, one may object that non-Medicaid-covered smokers also make de facto payments to the states for the coverage of Medicaid-covered smokers. Moreover, the objection would continue, if Medicaid-covered smokers making de facto payments for their own coverage violates the Act (anticipating the second premise), then non-Medicaid-covered smokers making de facto payments for Medicaid-covered smokers' coverage violates the Act in a much more blatant way.

There are at least two possible responses to this objection. First, relative to non-Medicaid-covered smokers, an application of the principle that substance prevails over form shows that these payments

180. *Comm'r v. Clark*, 489 U.S. 726, 738 (1989).

181. See, e.g., *State ex rel. Stovall v. R.J. Reynolds Tobacco Co.*, No. 96-CV-919, ¶ 264(H) (Kan. Dist. Ct. Shawnee County Aug. 20, 1996) (seeking "damages and compensation . . . for past and future damages, including but not limited to health care expenditures"); *State v. Philip Morris, Inc.*, No. 95-7378, ¶ 217(F) (Mass. Super. Ct. Dec. 19, 1995), available at <http://www.library.ucsf.edu/tobacco/litigation/ma/8macomplaint.pdf> (same); *State ex rel. Montgomery v. Philip Morris, Inc.*, No. 97-CV-H05-5114, ¶ 373(I) (Oh. Ct. Common Pleas, Franklin County, May 8, 1997) (same); *McGraw ex rel. West Virginia v. Am. Tobacco Co.*, No. 94-1707, ¶ 155(a) (Cir. Ct. Kanawha County Sept. 20, 1994) (seeking "damages in an amount which is sufficient to provide restitution and re-pay the State for the sums the State has expended on account of the defendant's wrongful conduct, including, without limitation, costs for medical care").

182. These were *recoupment* suits, so perhaps the point goes without saying. Vandall summarizes the legal theory behind recoupment suits: "[T]he states should be able to sue in order to recover the costs of treating disease and illness caused by cigarette smoking." Vandall, *supra* note 9, at 478.

are de facto *taxes*.¹⁸³ As will be addressed in the second premise, relative to Medicaid-covered smokers, the principle demonstrates that these payments are de facto *premiums*. The two groups, in other words, are distinct in legally significant ways.¹⁸⁴

Second, even admitting the validity of this objection, it fails to impact the analysis offered in this Note. That is, this Note makes no claims of exclusivity; there are likely *other* problems with the MSA. Analyzing the MSA relative to other groups, like non-Medicaid-covered smokers, may reveal differences between that group and general taxpayers and thus violations of a unique sort. That analysis, however, is outside the scope of this Note, which is confined to the MSA relative to Medicaid-covered smokers.

B. The Second Premise: The Social Security Act

Private health-insurance companies usually require participants to pay an enrollment fee, a monthly premium, copayments, or coinsurance. In 2006, President George W. Bush signed into law the Deficit Reduction Act of 2005 (“DRA”), which amended the Act and made Medicaid more like private health insurance by allowing the states to impose certain charges under specified conditions.¹⁸⁵ One part of the DRA, codified at 42 U.S.C. § 1396o-1, authorizes the use of enrollment fees, premiums, and other cost-sharing programs such as copayments and coinsurance.¹⁸⁶ States impose enrollment fees and premiums regardless of whether the Medicaid recipient receives services or obtains medical treatment. By contrast, states impose copayments and coinsurance charges only if the recipient actually receives services or obtains treatment.¹⁸⁷

183. See, e.g., DERTHICK, *supra* note 30, at 220 (construing the MSA as a de facto tax imposed without legislation); W. Kip Viscusi, *Tobacco: Regulation and Taxation through Litigation*, in REGULATION THROUGH LITIGATION 23 (W. Kip Viscusi ed., 2002) (construing the MSA as a tax on cigarettes); W. Kip Viscusi & Joni Hersch, *Tobacco Regulation through Litigation: The Master Settlement Agreement* 1-2 (Nat’l Bureau of Econ. Research, Working Paper 15422, 2009) (describing the MSA as “imposing a de facto tax” on cigarettes and noting that the MSA was “pathbreaking in that it did not involve a damages payment that took a conventional form, but instead imposed the equivalent of a per pack cigarette tax that was called a ‘settlement’ payment”)

184. Viscusi & Hersch, *supra* note 183, at 1, for example, note that, under the MSA, a “tax was imposed without legislative approval, and national regulations were enacted without the usual rulemaking process.” See also DERTHICK, *supra* note 30, at 220 (observing the same).

185. 42 U.S.C.A. § 1396o-1 (West 2010); see also Robert Pear, *New Medicaid Rules Allow States to Set Premiums and Higher Co-Payments*, N.Y. TIMES, Nov. 26, 2008, at A25 (explaining that under the DRA states can establish a sliding scale for premiums and co-payments).

186. 42 U.S.C.A. § 1396o-1(a)(1).

187. ELICIA J. HERZ, MEDICAID COST-SHARING UNDER THE DEFICIT REDUCTION ACT OF 2005 (DRA) 1–3 (Congressional Research Services) (2007), available at <http://assets.opencrs.com/rpts>

Medicaid-covered smokers¹⁸⁸ make de facto payments for their Medicaid whether they actually receive treatment or not; the payments are built into the purchase of cigarettes. Thus, the de facto payments are best construed as de facto premiums, not de facto cost-sharing payments such as copayments or coinsurance. Further, the Act places restrictions on when states can impose a premium on Medicaid recipients. Thus, the issue is whether the de facto premiums paid by Medicaid-covered smokers fit within the restrictions in the law.¹⁸⁹

1. Premium Restrictions

Sections 1396o and 1396o-1 govern the use of premiums by the states. The general rule is flexible: “[A] State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services . . . and may vary such premiums and cost sharing among such groups or types”¹⁹⁰ Yet there are limitations on a state’s ability to impose premiums. Any premium must be “consistent with the limitations established under [§ 1396o-1].”¹⁹¹ Section 1396o-1 contains ten categories of individuals for whom premiums are either

/RS22578_20070125.pdf (introducing the differences between premiums and copayments under DRA).

188 As this Note was going to press, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (“PPACA”). Pub. L. 111-148, 124 Stat. 119 (Mar. 23, 2010) (to be codified at 42 U.S.C.A. § 18001) (West 2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (Mar. 30, 2010) (to be codified at 42 U.S.C.A. § 1305). Although the ramifications of healthcare reform on Medicaid-covered smokers, the MSA, and the tobacco industry are uncertain, it appears the law expands Medicaid coverage, as early reports indicated. *See, e.g.*, James R. Carroll, *Area Lawmakers Assess Bill Impact*, COURIER J. (Louisville), Mar. 22, 2010, at A1 (noting that the bill “[e]xpands the federal-state Medicaid insurance program”). Recent guidance from the Centers for Medicare and Medicaid Services addresses § 2001 of the PPACA, “Medicaid Coverage for the Lowest Income Populations.” Department of Health and Human Services, Centers for Medicare and Medicaid Services, Letter, SMDL No. 10-005, PPACA No. 1, Re: New Option for Coverage of Individuals under Medicaid (Apr. 9, 2010), *available at* <http://www.cms.gov/smdl/downloads/SMD10005.PDF>. Section 2001 of the PPACA amends § 1902(a)(10)(A)(i) of the Act by establishing a new, relatively broad category of individuals eligible for Medicaid coverage: Individuals “under 65 years of age, not pregnant, not entitled to, or enrolled for, [Medicare Part A], or enrolled for [Medicare Part B], and are not [described in a separate category], and whose income . . . does not exceed 133 percent of the poverty line . . . subject to subsection (k).” Pub. L. 111-148, § 2001(a)(1)(A)–(C). Subsection (k) gives states the option of providing assistance to this new category of individuals until compliance is mandatory in 2014. *Id.* Thus, assuming some new Medicaid recipients smoke, the number of Medicaid-covered smokers will increase.

189. I do not consider whether the de facto payments are enrollment fees because the de facto payments are ongoing, whereas an enrollment fee is a one-time fee imposed when the recipient initially enrolls in the state’s Medicaid plan.

190. 42 U.S.C.A. § 1396o-1(a)(1).

191. *Id.*

limited or prohibited. Seven of the categories for whom premiums are prohibited are quite distinct:

Individuals under 18 years of age that are required to be provided medical assistance under section 1396a(a)(10)(A)(i)¹⁹² of this title

Pregnant women.

Any terminally ill individual who is receiving hospice care

Any individual who is an inpatient in a [medical institution], if such individual is required . . . to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

Women who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) of this title and 1396a(aa) of this title.¹⁹³

Disabled children who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XIX) and 1396a(cc) of this title.¹⁹⁴

An Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.¹⁹⁵

The other three categories within § 1396o-1 are broad and defined in terms of income. First, for an “individual whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved,” § 1396o prohibits premiums for individuals within the categories listed at § 1396a(a)(10)(A) and (E)(i).¹⁹⁶ These two categories cover the overwhelming majority of Medicaid recipients, including, among many others, individuals receiving “aid or assistance under any plan of the State” such as Old Age Assistance, individuals who are blind or permanently and totally disabled, and individuals receiving Aid to Families with Dependent Children, or AFDC, benefits.¹⁹⁷ Section 1396a(a)(10)(A) also prohibits

192. This provision itself describes seven categories of individuals, including, for example, individuals receiving Supplemental Security Income benefits. See 42 U.S.C.A. § 1396a(a)(10)(A)(i)(I)–(VII) (listing the categories). Thus, premiums are prohibited for any individual who is (a) under eighteen years of age and (b) a member of one of the seven categories listed in this provision. *Id.* § 1396o-1(b)(3)(A).

193. These provisions describe certain breast and cervical cancer patients.

194. These provisions describe certain disabled children.

195. 42 U.S.C.A. § 1396o-1(b)(3)(A)(i)–(vii).

196. *Id.* § 1396o-1(a)(2)(A). In 2009, the Federal Poverty Line for a family of four was \$22,050. For a single individual, it was \$10,830. Annual Update of the HHS Poverty Guidelines, 74 Fed. Reg. 14, 4199-4201 (Jan. 23, 2009).

197. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(I). For the full list of individuals for whom premiums are prohibited under § 1396o, see §§ 1396a(a)(10)(A) and 1396a(a)(10)(E)(i). There is, of course, an exception to this rule: Under § 1396o(c), states may charge premiums for an individual “who is receiving medical assistance on the basis of § 1396a(a)(10)(A)(ii)(IX) of this title and whose family income . . . equals or exceeds 150 percent of the income official poverty line . . . applicable to a family of the size involved.” Further, individuals who receive medical assistance under § 1396a(a)(10)(A)(ii)(IX) are described in that section as individuals “who are described in

premiums for a number of individuals who would be eligible for aid or assistance from a state plan, but who are ineligible for a variety of reasons, including, for example, being in an institution or having earnings in excess of statutory limits.¹⁹⁸

Second, § 1396o-1 prohibits premiums for an "individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved."¹⁹⁹ Third, for an "individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved," § 1396o-1 allows premiums within certain limits.²⁰⁰ The total premium assessed on all individuals in the family, together with any other cost sharing the State may have imposed, cannot exceed "5 percent of the family income."²⁰¹

2. The Violation

For any Medicaid-covered smoker who is a member of one of the seven distinct groups, charging a premium constitutes a violation of § 1396o-1. For any Medicaid-covered smoker whose family income is between 100 and 150 percent of the poverty line, premiums also constitute violations of § 1396o-1. The same rule applies to any Medicaid-covered smoker whose income is less 100 percent of the poverty level. Finally, for any Medicaid-covered smoker whose income is greater 150 percent of the poverty line, the premium may constitute a violation of § 1396o-1, if the premium exceeds the 5 percent limit of the smoker's family income.

As established above, Medicaid-covered smokers are being charged just these sorts of premiums in the form of increased prices on their cigarettes resulting from the MSA. Because these increased costs function as de facto Medicaid premiums, they also serve as violations of § 1396o-1. Without some way to remedy this situation, states are effectively violating the Act on an ongoing basis through their adherence to the MSA arrangement.

subjection (l)(1) of this section and not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII)." 42 U.S.C.A. § 1396a(a)(10)(ii)(IX).

198. *Id.* § 1396a(a)(10)(ii)(IV), (XV).

199. *Id.* § 1396o-1(b)(1)(A).

200. *Id.* § 1396o-1(b)(2)(A).

201. *Id.* For example, if a recipient's family had income of 160 percent of the poverty line, the maximum allowable monthly premium would be \$147.

IV. AVAILABLE REMEDIES

This Part addresses the remedies available to Medicaid-covered smokers. Part IV.A discusses the Secretary's power to revoke funding for states that fail to comply with the Act. Hurdles to effective enforcement of this remedy cast doubt on its value to Medicaid-covered smokers. Part IV.B addresses the possibility of a § 1983 action against the states. The value of this remedy depends primarily upon on whether the Act's premium provisions are construed as enforceable under Supreme Court precedent. While one may make a strong case for enforcement of the Act's premium provisions, the de facto status of the violation itself likely leaves Medicaid-covered smokers with a choice, addressed in Part IV.C: quit smoking or pay unlawful premiums for Medicaid.

A. The Secretary's Idle Power

If a state has a Medicaid program, its program must comply with the federal Medicaid statute.²⁰² The Act itself provides a remedy for violations by vesting authority in the Secretary of Health and Human Services ("Secretary") to withhold funds from states until they "comply substantially" with the Act.²⁰³ Despite the Secretary's power, there are several reasons why it is unlikely that this power will be exercised in regard to the MSA, some of which are not unique to the context of Medicaid-covered smokers.²⁰⁴ First, in relation to Medicaid, the Department of Health and Human Services primarily plays a fund-reimbursing role, which is inconsistent with the "antagonistic role of a rule enforcer" that penalizes a state by withholding funds.²⁰⁵ Second, the Secretary's only remedy under § 1396c is to withhold

202. J.K. *ex rel.* R.K. v. Dillenberg, 836 F. Supp. 694, 696 (D. Ariz. 1993).

203. 42 U.S.C.A. § 1396c (West 2010) ("If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan . . . finds . . . that in the administration of the plan there is a failure to comply substantially with any such provision; the Secretary shall notify such State agency that further payments will not be made to the State . . . until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State.").

204. See Lisa E. Key, *Private Enforcement of Federal Funding Conditions Under § 1983: The Supreme Court's Failure to Adhere to the Doctrine of Separation of Powers*, 29 U.C. DAVIS L. REV. 283, 292–93 (1996) (providing reasons why federal agencies fail to enforce compliance in the context of grant-in-aid programs, in general).

205. *Id.* at 292; see also Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement*, 58 VA. L. REV. 600, 620 (1972) ("The posture of the federal agency toward its grantees is not generally that of a referee calling fouls, but that of a coach giving support in the form of cash and expertise.").

federal funds from the states, which would ultimately result in the states' cutting Medicaid coverage—a harsh “remedy” for individuals dependent on that coverage for even the most basic medical care.²⁰⁶ Third, before the Secretary could withhold funds, a hearing would be required to determine if the state is in compliance.²⁰⁷ Given that no party to the MSA—either the state or the tobacco companies—has an incentive to present evidence of a violation at a hearing, the hearing requirement presents an additional hurdle to the Secretary's exercising § 1396c authority.

B. Section 1983 Action

Given the low probability that the Secretary will enforce compliance with the Medicaid statute's premium restrictions, Medicaid-covered smokers may instead wish to bring an action against their states under 42 U.S.C. § 1983, which prohibits the deprivation of rights secured by federal law by persons acting under color of state law.²⁰⁸

1. Section 1983 and the Social Security Act

The Supreme Court has often assumed, without analysis, that the Act confers rights enforceable through § 1983.²⁰⁹ In *Rosado v. Wyman*, for example, the Court held, without explanation, that “suits

206. Key, *supra* note 204, at 292–93. The harshness of this remedy is tempered by the Secretary's discretionary ability to withhold only funds that are related to the state's failure to comply. See 42 U.S.C.A. § 1396c (permitting the Secretary to “limit payments to categories under or parts of the State plan not affected by such failure” to comply).

207. 42 U.S.C.A. § 1396c.

208. *Id.* § 1983 (“Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects, or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . .”).

209. See Charles Davant IV, *Sorcerer or Sorcerer's Apprentice?: Federal Agencies and the Creation of Individual Rights*, 2003 WIS. L. REV. 613, 619 (noting that “the Court in the 1970s began to assume, without discussion, that plaintiffs could use § 1983 to enforce provisions of the Social Security Act”); see also *Miller v. Youakim*, 440 U.S. 125, 146 (1979) (holding that the Illinois policy of excluding foster care benefits to children residing with a relative was inconsistent with the Social Security Act and granting plaintiffs request for injunctive relief); *Van Lare v. Hurley*, 421 U.S. 338, 347–48 (1975) (granting injunctive relief against welfare regulation inconsistent with the Act); *Townsend v. Swank*, 404 U.S. 282, 291 (1971) (enforcing, without analysis, § 406(a)(2) of the Act). There was, however, dicta in a 1966 decision on which the Court may have been relying in the Social Security cases: In *City of Greenwood v. Peacock*, the Court noted that state actors may be liable for violations of “statutory rights” in addition to constitutional rights. 384 U.S. 808, 829–30 (1966); see also Davant, *supra*, at 619 (suggesting the same).

in federal court under [§] 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of the participating States.”²¹⁰ In *King v. Smith*, the Court generally cited in two footnotes a student note that relied on the broad language of § 1983.²¹¹ The student note provided that, “The ‘rights, privileges, and immunities’ language of section 1983 is deliberately broad, and a properly expansive construction would include the right to treatment by state welfare officials consistent with the federal statute.”²¹² Until 1980, this general citation was as much analysis as the Court would give.

The Court first provided a justification for inclusion of statutory rights, including rights conferred by the Social Security Act, in *Maine v. Thiboutot*.²¹³ In *Thiboutot*, the plaintiffs challenged an interpretation of the Act by the Maine Department of Human Services that decreased the plaintiffs’ welfare benefits by failing to account for money spent on certain dependent children.²¹⁴ The Court framed the issue as whether the phrase “and laws” in § 1983 “means what it says, or whether it should be limited to some subset of laws.”²¹⁵ Based on the “plain language” of the statute, including the absence of any phrases modifying “laws,” the Court held that the statute “undoubtedly embraces respondent’s claim that petitioners violated the Social Security Act.”²¹⁶

2. The *Blessing* Test

Throughout the 1980s, the Court moved away from its analysis in *Thiboutot* to one relying on a distinction between obligatory statutes, which confer rights enforceable through § 1983, and “merely precatory” statutes, which do not.²¹⁷ In *Wilder v. Virginia Hospital*

210. *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980) (quoting *Edelman v. Jordan*, 415 U.S. 651, 675 (1974)).

211. *Kling v. Smith*, 392 U.S. 309, 313 (1968) (citing Note, *Federal Judicial Review of State Welfare Practices*, 67 COLUM. L. REV. 84 (1967)).

212. Note, *supra* note 211, at 110.

213. 448 U.S. 1 (1980).

214. *Id.* at 3.

215. *Id.* at 4.

216. *Id.*

217. See, e.g., *Wright v. Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418, 423–24 (1987) (examining congressional intent in holding that the statute conferred a “right” enforceable under § 1983); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 18 (1981) (inquiring whether Congress “imposed an obligation on the States . . . or whether it spoke merely in precatory terms” when deciding whether the statute at issue—the Developmentally Disabled Assistance and Bill of Rights Act—conferred rights enforceable under § 1983; finding that the statute did not confer such rights).

Association, the Court held that § 1983 protects only deprivations of “rights, privileges, or immunities,” not all violations of federal law.²¹⁸ Whether a provision creates a federal right, the Court explained, depends on whether the provision was “intend[ed] to benefit the putative plaintiff.”²¹⁹ If the provision was so intended, then it creates an enforceable right, with two exceptions.²²⁰ First, the provision does not create an enforceable right if it merely reflects a nonbinding preference for a particular course of conduct.²²¹ Second, no enforceable right exists if the interest is too “vague and amorphous” to be enforced by courts.²²² Applying this test to the “reasonable and adequate” provision applicable to Medicaid reimbursement rates, the Court held that the Act created rights enforceable by healthcare providers through § 1983.²²³ Further, the Court held that neither exception applied, for the text of the provision itself was cast in mandatory terms and the reasonableness of a reimbursement rate was not beyond the competency of courts to adjudicate.²²⁴

The Court modified, albeit slightly, the *Wilder* test in *Blessing v. Freestone*.²²⁵ Rather than a general rule with two exceptions as in *Wilder*, the *Blessing* test states three factors for determining whether a statute creates a right enforceable through § 1983:

- First, Congress must have intended that the provision in question benefit the plaintiff.
- Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so “vague and amorphous” that its enforcement would strain judicial competence.
- Third, the statute must unambiguously impose a binding obligation on the States.²²⁶

The *Blessing* Court also required that § 1983 plaintiffs assert a right grounded in a *specific provision* of a law, not a law as an “undifferentiated whole.”²²⁷ “Only when the complaint is broken down into manageable analytic bites can a court ascertain whether each separate claim satisfies the various criteria we have set forth for determining whether a federal statute creates rights.”²²⁸ Rights not grounded in a specific provision of the statute may, like the right to “substantial compliance” asserted by the plaintiffs in *Blessing*, fail to

218. 496 U.S. 498, 509 (1990) (quoting *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989)).

219. *Id.* (citing *Golden State*, 493 U.S. at 106).

220. *Id.* (citing *Pennhurst*, 451 U.S. at 19; *Golden State*, 493 U.S. at 106, 110).

221. *Id.*

222. *Id.*

223. *Id.* at 509–10.

224. *Id.* at 512, 519.

225. 520 U.S. 329 (1997).

226. *Id.* at 340–41 (internal citations omitted).

227. *Id.* at 342.

228. *Id.*

meet the first requirement—that the provision in question be intended to benefit the plaintiff.

3. *Gonzaga* and Congressional Intent

While the *Blessing* test remained settled law throughout the 1990s, beginning in 2001, the Court shifted emphasis to the first prong of the test: whether Congress intended to confer an enforceable right.²²⁹ In *Gonzaga University v. Doe*, the Court explained that congressional intent to confer individual rights can be inferred from the “text and structure” of the statute.²³⁰ More specifically, the Court now looks for rights-creating language that is focused on the “individuals protected,” not the “persons regulated.”²³¹ Provisions that focus on aggregate activity are also insufficient.²³² Once rights are established, they are “presumptively enforceable.”²³³

4. Medicaid Rights Post-*Gonzaga*

a. *The Equal-Access Provision*

Circuit courts applying *Gonzaga* to the provisions of the Social Security Act have reached differing results as to whether a particular provision confers rights enforceable through § 1983. The so-called “equal-access provision” of the Social Security Act, § 1396a(a)(30), has been held by all but one circuit not to confer rights enforceable through § 1983.²³⁴ The equal-access provision requires that “care and services are available under the plan at least to the extent that such

229. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282, 284–86 (2002); see also *Westside Mothers v. Olszewski*, 454 F.3d 532, 541 (6th Cir. 2006) (noting that the *Gonzaga* Court “acknowledged the continuing relevance of the *Blessing* test ‘to guide judicial inquiry into whether or not a statute confers a right’ ” (quoting *Gonzaga*, 536 U.S. at 282)). This is the same inquiry applied in the implied right of action context. *Gonzaga*, 536 U.S. at 285.

230. 536 U.S. at 286.

231. *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001).

232. *Cf. Gonzaga*, 526 U.S. at 282 (quoting *Blessing*, 520 U.S. at 343) (“Because [Title IV-D of the Social Security Act] focused on ‘the aggregate services provided by the State,’ rather than ‘the needs of any particular person,’ it conferred no individual rights and thus could not be enforced by § 1983.”).

233. *Id.* at 284. The specific provision on which the *Gonzaga* plaintiff relied, 42 U.S.C.A. § 1232g(b)(1), which is part of the Federal Education Rights and Privacy Act, addresses the Secretary of Education, directing the Secretary to withhold funds if a school has a policy or practice of disclosing information without parental consent. This is “two steps removed” from the kind of language that confers individual rights, the Court stated. *Id.* at 287. In addition, the FERPA provision addresses the *policies and practices* of schools, “not individual instances of disclosure.” *Id.* at 288. The plaintiff in *Gonzaga* was left without a remedy. *Id.* at 287–88.

234. See *infra* note 239 and accompanying text.

care and services are available to the general population in the geographic area.”²³⁵ The First Circuit, in *Long Term Care Pharmacy Alliance v. Ferguson*, was the first circuit to address this provision and, relying on *Gonzaga*, held that it did not confer rights on medical providers enforceable through § 1983.²³⁶ The court noted that the provision has no “rights creating language,” “identifies no discrete class of beneficiaries,” and “focuses . . . upon the state as ‘the person regulated rather than individuals protected.’”²³⁷ Moreover, the generic nature of the criteria in the equal-access provision—“avoiding overuse, efficiency, quality of care, geographic equality”—suggest that enforcement was to remain the sole province of the Secretary.²³⁸ The majority of other circuits soon followed suit.²³⁹

b. The Availability Provision

Not all provisions of the Social Security Act have suffered such a fate in the circuit courts. The availability provision, § 1396a(a)(10), requires that a state’s Medicaid plan “provide for making medical assistance available . . . to all [qualified] individuals.”²⁴⁰ The Third, Fifth, and Ninth Circuits have addressed the provision, and all three agree that it confers rights enforceable through § 1983.

235. 42 U.S.C.A. § 1396a(a)(30) (West 2010).

236. 362 F.3d 50, 58 (1st Cir. 2004); *see also* Gardella, *supra* note 15, at 733–35 (discussing the case).

237. *Long Term Care*, 362 F.3d at 57 (internal citations omitted).

238. *Id.* at 58. The importance of generic guidelines for measuring compliance was not introduced by the *Gonzaga* majority, but rather by Justice Breyer in his concurring opinion in that case. Given the multitude of interpretations possible, such flexible guidelines, according to Justice Breyer, manifests a congressional intent to vest enforcement solely in the agency administering the program (e.g., the Secretary). Precluding private enforcement through § 1983 in such cases tends to “avoid the comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional inappropriate application of the statute in a private action for damages.” *Gonzaga*, 536 U.S. at 292 (Breyer, J., concurring).

239. *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 703 (5th Cir. 2007); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542–43 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005). The Eighth Circuit is the only circuit to both address the enforceability of the equal-access provision and hold that it is enforceable. *See Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005, 1015–16 (8th Cir. 2006) (noting that the beneficiaries of the provision “are both the recipients of the services and the recipients of the state’s payment,” and stating that “[t]he statute is clear on its scope: to ensure payments are not too high, but yet high enough to secure the participation of enough clinics so that needy children receive equal access to health care”).

240. 42 U.S.C.A. § 1396a(a)(10).

The Third Circuit, in *Sabree ex rel. Sabree v. Richman*, was the first circuit to address this provision after *Gonzaga*.²⁴¹ Applying the *Blessing* test, the *Sabree* court held that Congress intended to benefit the plaintiffs, a class of developmentally disabled Medicaid recipients who had been denied access to an intermediate-care medical facility.²⁴² The right to treatment in such a facility was sufficiently “specific and enumerated” to meet the second prong of the test, and the provision was mandatory, binding the states to provide medical assistance to the plaintiffs.²⁴³ Applying *Gonzaga*, the *Sabree* court held that the provision contained adequate rights-creating language. Comparing the availability provision to two paradigmatic rights-creating statutes, Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972, the *Sabree* court found it “difficult, if not impossible, as a linguistic matter” to distinguish the “[a] State plan must provide” of the availability provision from the “no person shall” of the two paradigm statutes.²⁴⁴ Moreover, the availability provision does not focus on the person regulated but, rather, the Medicaid recipients—that is, the “individuals protected.”²⁴⁵ The court thus concluded that Medicaid recipients have, in the availability provision, a right enforceable through § 1983.²⁴⁶

The Fifth Circuit, in *South Dakota ex rel. Dickson v. Hood*, also held that the availability provision creates a right enforceable through § 1983.²⁴⁷ Like the *Sabree* court, the *Dickson* court compared the provision’s language to the paradigmatic statutes and held that it contains sufficient rights-creating language.²⁴⁸ The plaintiff in *Dickson*, a sixteen-year-old Medicaid recipient with spina bifida, also asserted a specific right to a medical device deemed necessary by the recipient’s healthcare provider.²⁴⁹ This right was far from “vague and

241. 367 F.3d 180 (3d Cir. 2004); see also Devi M. Rao, Note, “Making Medical Assistance Available”: Enforcing the Medicaid Act’s Availability Provision Through § 1983 Litigation, 109 COLUM. L. REV. 1440, 1463–67 (2009) (discussing the provision and the three circuit court decisions addressing it).

242. *Sabree*, 367 F.3d at 190.

243. *Id.* at 189–90.

244. *Id.* at 190; see also 42 U.S.C.A. § 2000d (West 2010) (“No person in the United States shall, on the ground of race, color, or national origin, . . . be subjected to discrimination under any program or activity receiving Federal financial assistance.”); 20 U.S.C.A. § 1681(a) (West 2010) (“No person in the United States shall, on the basis of sex, . . . be subjected to discrimination under any education program or activity receiving Federal financial assistance . . .”).

245. *Sabree*, 367 F.3d at 190 (quoting *Alexander v. Sandoval*, 532, U.S. 275, 289 (2001)).

246. *Id.* at 192.

247. 391 F.3d 581, 607 (5th Cir. 2004).

248. *Id.* at 602–03.

249. *Id.* at 584, 605.

amorphous.”²⁵⁰ The *Dickson* court’s analysis went further than *Sabree* in considering the statutory context of the provision. As part of the Act’s requirements for all state Medicaid plans, the provision is addressed to the states. This focus on the states, the court nonetheless noted, is insufficient to foreclose enforcement through § 1983, given § 1320a-2’s express statement as to enforceability.²⁵¹ Satisfying both *Blessing* and *Gonzaga*, the *Dickson* court held that the availability provision was enforceable through § 1983.²⁵²

c. Other Enforceable Provisions

Post-*Gonzaga* courts have held that other provisions of the Social Security Act are also enforceable through § 1983. In *Bryson v. Shumway*, the First Circuit held that § 1396a(a)(8) is enforceable through § 1983.²⁵³ Under this provision, a state’s Medicaid plan “must” provide medical assistance “with reasonable promptness to all eligible individuals.”²⁵⁴

In *Gean v. Hattaway*, the Sixth Circuit held that § 1396a(a)(3) is enforceable through § 1983.²⁵⁵ This provision requires a state’s Medicaid plan to “provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.”²⁵⁶ Finally, in *Rabin v. Wilson-Coker*, the Second Circuit held that § 1396r-6 is enforceable through § 1983.²⁵⁷ Under § 1396r-6, which applies to recipients whose Medicaid is terminated, “each State plan approved under this subchapter must provide that each family which was receiving aid . . . in at least 3 of the 6 months immediately preceding the month in which [Medicaid was terminated] shall . . . remain eligible for assistance under the plan . . . during the immediately succeeding 6-month period.”²⁵⁸

250. *Id.* at 605 (quoting *Blessing v. Freestone*, 520 U.S. 329, 340 (1997)).

251. *Id.* at 603. The provision reads: “In an action brought to enforce a provision of [the Act], such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan.” 42 U.S.C.A. § 1320a-2 (West 2010).

252. The Ninth Circuit relied on both *Sabree* and *Dickson* in *Watson v. Weeks*, 436 F.3d 1152, 1160–61 (9th Cir. 2006), holding that the availability provision is enforceable through § 1983.

253. 308 F.3d 79, 88 (1st Cir. 2002).

254. 42 U.S.C.A. § 1396a(a)(8) (West 2010).

255. 330 F.3d 758, 773 (6th Cir. 2003).

256. 42 U.S.C.A. § 1396a(a)(3).

257. 362 F.3d 190, 202 (2d Cir. 2004).

258. 42 U.S.C.A. § 1396r-6.

Given all of the enforceable rights already established in the Act, what about the prohibitions on premiums? In the absence of precedent on the premium provisions, how would a court decide?

d. The Premium Provisions

Medicaid-covered smokers have a strong argument, based on both pre- and post-*Gonzaga* precedent, that the premium provisions are enforceable through § 1983. The pre-*Gonzaga* Supreme Court cases of *King*, *Townsend*, *Van Lare*, and *Rosado* all endorse the view that § 1983 actions are “proper to secure compliance with the provisions of the Social Security Act on the part of the participating states.”²⁵⁹ Although pre-*Gonzaga* cases are not as persuasive as those decided after *Gonzaga*, they remain quite relevant. In *Watson v. Weeks*, decided in 2006, the Ninth Circuit joined the Third and Fifth Circuits in holding that the availability provision is enforceable through § 1983.²⁶⁰ On the *Watson* court’s view, however, it was joining not only the Third and Fifth Circuits, but also the Sixth, Seventh, and Eighth Circuits—all of which decided the issue before *Gonzaga*.²⁶¹ Likewise, in *Dickson*, the Fifth Circuit stated that its decision that the availability provision is enforceable through § 1983 “is amply supported by” pre-*Gonzaga* decisions.²⁶²

After *Blessing*, the § 1983 analysis is provision-specific. Unlike other Medicaid-based § 1983 actions, a claim based on unlawful premiums would not be restricted to a single provision. The Act contains a multitude of premium provisions, each applicable to its own category of recipients.²⁶³ Thus, an action brought by Medicaid-covered smokers would likely include several classes of plaintiffs, depending upon the categories of premium provisions implicated. As an example, one class might consist of all Medicaid-covered smokers whose family income is greater than 100 percent of the poverty level, but less than 150 percent of the poverty level. For this class, the unlawful premium would violate § 1396o-1(b)(1)(A). Once the provision is selected in

259. *Edelman v. Jordan*, 415 U.S. 651, 675 (1974) (citing *Rosado v. Wyman*, 397 U.S. 397, 422–23 (1970)).

260. 436 F.3d 1152, 1161 (9th Cir. 2006).

261. *See id.* at 1159–60 & n.8 (“In holding that this statutory provision creates a right enforceable by section 1983, we join five federal circuits that have already so held.” (citing the pre-*Gonzaga* cases *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir. 2002); *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 293 F.3d 472 (8th Cir. 2002); *Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993))).

262. 391 F.3d at 604 (citing *Mitchell v. Johnson*, 701 F.2d 337, 344 (5th Cir. 1983); *Pediatric Specialty Care, Inc.*, 293 F.3d at 479; *Miller*, 10 F.3d at 1319–20).

263. *See infra*, tbl.3.

accord with the appropriate category of Medicaid recipient, the *Blessing* test, along with *Gonzaga*'s emphasis on congressional intent, would be applied to the provision to determine whether the recipients have an enforceable right.

The analysis would begin with the text of the provision. For relevant purposes, there are four premium provisions:

TABLE III. PREMIUM PROVISIONS UNDER 42 U.S.C. § 1396o-1²⁶⁴

Subsection (b)(3)(A)(i)-(vii) (The Seven Discrete Categories)	"No premiums shall be imposed under this section with respect to [the seven categories of individuals described at (i)-(vii)]."
Subsection (b)(1)(A)	"In the case of an individual whose family income" is between 100-150 percent of the poverty line, "no premium may be imposed under the plan."
Subsection (b)(2)(A)	"In the case of an individual whose family income" exceeds 150 percent of the poverty line, "the total aggregate amount of premiums and other cost sharing . . . may not exceed 5 percent" of the family income.
Subsection (a)(2)(A)	"[I]n the case of individuals described in" subsections (A) or (E)(i) "who are eligible under the plan . . . no enrollment fee [or] premium . . . will be imposed under the plan."

Several aspects of the § 1983 analysis would apply equally to all four provisions. All of the provisions, for example, are requirements of a state's Medicaid plan; they direct the states to establish a plan in accord with their restrictions. Under § 1320a-2, this is not enough to deem the provisions unenforceable through § 1983.²⁶⁵ In addition, a reviewing court would likely apply the second prong of the *Blessing* test similarly across provisions. Medicaid recipients would assert the right to receive medical assistance without a premium or for a premium within statutory limits. Neither right is so "vague and amorphous" that enforcement of the right would "strain judicial competence."²⁶⁶ If a right to "reasonable and adequate" reimbursement

264. 42 U.S.C.A. § 1396o-1 (West 2010).

265. *Id.* § 1320a-2.

266. *Blessing v. Freestone*, 520 U.S. 329, 340 (1997) (quoting *Wright v. Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418, 431-32 (1987)).

rates is sufficiently clear to adjudicate,²⁶⁷ then so is a right to premium-free Medicaid or Medicaid with a premium within statutory limits, given the amount of debate possible over reasonableness.²⁶⁸

The third prong of the *Blessing* test would likewise apply similarly across the four premium provisions: Do each of the provisions “unambiguously impose a binding obligation on the States”?²⁶⁹ All four provisions satisfy this prong with mandatory language.²⁷⁰ This language is comparable to that of the language of the two paradigmatic rights-conferring statutes, “No person . . . shall,”²⁷¹ as well as other enforceable Medicaid provisions where, for example, the state’s plan “must provide” for hearings or “must provide” temporary assistance.²⁷² Put simply, the premium provisions forbid a state from imposing a premium in any of the prohibited categories²⁷³ or a premium greater than 5 percent in the applicable category.²⁷⁴

Analysis of the first prong of the *Blessing* test, unlike the second and third prongs, may differ depending on the specific premium provision at issue. Yet even here there are similarities across all four provisions. To satisfy the first prong, “Congress must have intended that the provision in question benefit the plaintiff.”²⁷⁵ All four of the premium provisions benefit the prospective plaintiffs—the Medicaid recipients who, by virtue of the provisions, are either not forced to pay a premium for their medical assistance or have their premiums capped at 5 percent of their family income. Further, the premium provisions arguably do *not* benefit the states: prohibiting or limiting premiums means less money to fund the states.

Provisions found unenforceable also shed light on the requirements for enforcement. In the context of the (unenforceable) equal-access provision, the *Long Term Care* court noted that §

267. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 519 (1990).

268. *Cf. Blessing*, 520 U.S. at 343 (holding that a right to “substantial compliance” with the requirements of the Social Security Act is unenforceable).

269. *Id.* at 341.

270. With emphasis on the key language, 42 U.S.C.A. § 1396o-1(b)(3)(A) (West 2010) states that “[n]o premiums shall be imposed.” § 1396o-1(b)(1)(A) states that “no premium may be imposed,” and § 1396o-1(b)(2)(A) states that the premium “may not exceed”

271. 42 U.S.C.A. § 2000d (West 2010); 20 U.S.C.A. § 1681(a) (West 2010).

272. *Id.* §§ 1396a(a)(3), r-6(a)(1)(A).

273. There are three broad categories of recipients for whom premiums are prohibited: (1) the individuals described in § 1396o-1(b)(3)(A)(i)–(vii), (2) the individuals described in § 1396o-1(b)(1)(A), and (3) the individuals described in 1396o-1(a)(2)(A).

274. That is, the individuals with family income exceeding 150 percent of the poverty line. 42 U.S.C.A. § 1396o-1(b)(2)(A).

275. *Blessing v. Freestone*, 520 U.S. 329, 340 (1997).

1396a(a)(30) “identifies no discrete class of beneficiaries.”²⁷⁶ By contrast, the premium provisions are rooted in “discrete class[es] of beneficiaries.” The best example of such classes is § 1396o-1(b)(3)(A)(i)-(vii), which describes seven distinct categories of recipients with detailed characteristics. Subsection (iv), for example, identifies the rather specific class of recipients who are in a medical institution, “if such individual is required, as a condition of receiving services in such institution under the state plan, to spend for costs of medical care all but a minimum amount of the individual’s income for personal needs.” Even the broader provisions identify discrete classes of recipients—namely, individuals whose family income falls within one of three distinctly defined groups relative to the poverty line. Therefore, the premium provisions focus on distinct classes of recipients; no aggregate concerns are present.²⁷⁷

In several post-*Gonzaga* decisions, rights-creating language has been the linchpin to enforceability.²⁷⁸ These cases have relied on the *Gonzaga* Court’s emphasis on the “[n]o person shall” language in the two paradigmatic statutes. In *Sabree*, the court found sufficient similarity between the “[n]o person shall” of the paradigm statutes and the “[a] State plan must provide” of the availability provision.²⁷⁹ The *Dickson* court agreed.²⁸⁰ The premium provisions contain similar mandatory language. In addition, the language of the premium provisions focuses primarily on the “individuals protected”—the various categories of Medicaid recipients—and only secondarily on the “person regulated”—the states.²⁸¹ Much like the language of the paradigm statutes, the premium provisions are “specific, mandatory, [and] individually focused.”²⁸²

Medicaid-covered smokers have a viable argument for § 1983 enforcement of their right to either premium-free Medicaid or premiums within the statutory limits. By failing to comply with the premium restrictions in §1396o, Medicaid-covered smokers have been deprived of the federal right secured by the Social Security Act.

276. *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004).

277. *Cf. Gonzaga Univ. v. Doe*, 536 U.S. 273, 288 (2002) (relying in part on the “aggregate” focus of FERPA in holding that the statute is not enforceable through § 1983); *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005) (relying in part on the “aggregate” focus of the equal-access provision when holding that it is unenforceable through § 1983).

278. *See, e.g., Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir. 2004).

279. *Id.*

280. *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602 & n.28 (5th Cir. 2004).

281. *Cf. Alexander v. Sandoval*, 532 U.S. 275, 289 (2001) (noting that “[s]tatutes that focus on the person regulated rather than the individuals protected” suggest no intent to confer individual rights).

282. *Sabree*, 367 F.3d at 188.

At the same time, the underlying violation is based on a de facto payment. The de facto status of the payment may ultimately undermine the strength of the § 1983 claim because, to even recognize the violation, a reviewing court must apply the principle that substance prevails over form. Some courts may be reluctant to apply this principle, despite its common use in other contexts. Finally, relative to the two paradigmatic rights-conferring statutes, a reviewing court may see the premium provisions as ambiguous, and, as the *Gonzaga* court said, nothing “short of an unambiguously conferred right” will support a § 1983 action.²⁸³

C. A Choice for Medicaid-Covered Smokers

The first step in the de facto premium transaction occurs when the Medicaid-covered smoker purchases cigarettes at the MSA-inflated price. Obviously, if the Medicaid-covered smoker stopped purchasing cigarettes, no de facto premiums would be paid. But cigarettes are addictive.²⁸⁴ In 1988, the surgeon general concluded that “[t]he pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine.”²⁸⁵ Smokers agree: in 2006, 85 percent of smokers reported that cigarettes are addictive.²⁸⁶ If Medicaid-covered smokers are addicted to nicotine, the viability of a solution that relies upon Medicaid-covered smokers quitting their addictive habit is dubious.

One way of measuring the effect of addiction on a smoker’s ability to quit is cigarettes’ price elasticity of demand (“PED”), which measures the degree to which an increase in price reduces demand for

283. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002).

284. U.S. DEP’T OF HEALTH & HUMAN SERVS., THE HEALTH CONSEQUENCES OF SMOKING: NICOTINE ADDICTION, A REPORT OF THE SURGEON GENERAL 9 (1988) [hereinafter NICOTINE ADDICTION], available at http://profiles.nlm.nih.gov/NN/B/B/Z/D/_nnbbzd.pdf. The Surgeon General’s criteria for drug dependence included “highly controlled or compulsive use,” “psychoactive effects,” “drug-reinforced behavior,” “use despite harmful effects,” “relapse following abstinence,” “recurrent drug cravings,” “tolerance,” “physical dependence,” and “pleasant (euphoriant) effects.” *Id.* at 7. The addictive nature of tobacco led earlier researchers to conclude that tobacco use is unfit for economic analysis because addiction is irrational. See, e.g., Thomas C. Schelling, *Self-Command in Practice, in Policy, and in a Theory of Rational Choice*, 74 AM. ECON. REV. 1, 6 (1984) (remarking that “a theory based on stable preferences and rational choice cannot illuminate without some modification” addictive behavior such as smoking); Gordon Winston, *Addiction and Backsliding: A Theory of Compulsive Consumption*, J. ECON. BEHAV. & ORG. 295, 314–15 (1980).

285. NICOTINE ADDICTION, *supra* note 284, at 9.

286. TRENDS IN TOBACCO USE, *supra* note 26, at 8 (follow the subheading “Prevalence of Smoking Cessation Among Adults”).

cigarettes.²⁸⁷ The PED for cigarettes varies by study. The range is between -0.14 and -1.23, although most are between -0.3 and -0.5.²⁸⁸ None, though, are zero, indicating that, while demand for cigarettes may be higher when prices increase than demand for a nonaddictive product, addicted consumers remain responsive to price increases.²⁸⁹ A PED of -0.5 indicates that a 5 percent increase in price results in a 2.5 percent decrease in demand.²⁹⁰ And a PED of -0.3 indicates that a 5 percent increase in price results in a 1.5 percent decrease in demand.²⁹¹ By any measure, the demand for cigarettes is inelastic, though not perfectly so.

The elasticity studies on cigarettes indicate that the proffered solution is, in fact, a viable one. Perhaps this goes without saying. Medicaid-covered smokers *can* quit smoking. Data on quit success rates confirm this, as well. In 2006, 45.7 million adults were former smokers.²⁹² Among the population of people who have smoked, approximately 50 percent have quit.²⁹³ The lingering issue, however, is whether Medicaid-covered smokers should be confronted with the decision to either quit smoking or pay unlawful de facto premiums for Medicaid coverage.²⁹⁴ Moreover, imposing this decision on Medicaid-

287. See, e.g., Alexander Ding, *Youth Are More Sensitive to Price Changes in Cigarettes than Adults*, 76 YALE J. BIOLOGY & MED. 115, 116 (2003) (explaining demand elasticity of cigarettes as the "price elasticity of demand," which "represents the responsiveness of demand to changes in price"); Dahlia K. Remler, *Poor Smokers, Poor Quitters, and Cigarette Tax Regressivity*, 94 AM. J. PUB. HEALTH 225, 227 (2004) (explaining demand elasticity of cigarettes). A PED of zero indicates that demand is completely unresponsive to an increase in price, which would be unusual. Demand in such cases is perfectly inelastic. Ding, *supra*, at 116. A PED between zero and one indicates that, while demand is responsive to price, it is not proportionately so: a 5 percent increase in price, for example, leads to a 2 percent decrease in demand (PED = -0.4). Demand in such cases is inelastic. A PED of one indicates that demand is proportionately responsive to price: a 5 percent increase in price leads to a 5 percent decrease in demand. Demand in such cases is unitary. Finally, a PED greater than one indicates that demand is disproportionately responsive to price: a 5 percent increase in price leads to a 7 percent decrease in demand (PED = -1.4). Demand in such cases is elastic. Remler, *supra*.

288. Frank J. Chaloupka & Kenneth E. Warner, *The Economics of Smoking*, in 1B HANDBOOK OF HEALTH ECONOMICS 1539, 1546 (A.J. Culyer & J.P. Newhouse eds., 2000) (reviewing studies through 2000). More recent research has found even lower PEDs for cigarettes in the adult population: -0.15 and -0.19. Ding, *supra* note 287, at 119.

289. See Remler, *supra* note 287, at 227 (noting that the PEDs "imply[] that cigarette consumption is fairly insensitive to price but certainly not completely insensitive").

290. *Id.* (describing the impact PED has on the relationship between price and demand changes for cigarettes).

291. *Id.*

292. TRENDS IN TOBACCO USE, *supra* note 26, at 8 (follow the subheading "Prevalence of Smoking Cessation Among Adults").

293. *Id.*

294. See Jonathan Gruber, *Smoking's Internalities*, REG., Winter 2003, at 55 ("For groups that are particularly price sensitive, higher pricing is an effective self-control device because it will have more of the desired effect of reducing their smoking."); David A. Hyman, *Tobacco*

covered smokers raises a difficult question: Do states act properly when they impose such a choice, acting in the best health interest of smokers, or is this merely a veiled attempt to override revealed preferences—that is, paternalism gone too far? The answer to this highly charged question should prove fertile ground for future scholarship and debate.

V. CONCLUSION

At first glance, the MSA seems like a fair deal struck by sophisticated parties with relatively equal bargaining power. Big Tobacco, which for years went without publicly paying a dime to those harmed by its products, now makes hefty annual payments to all fifty states, the District of Columbia, and five U.S. territories. This relieves the burden on innocent taxpayers, who otherwise would continue to fund the treatment of tobacco-related disease through the states' Medicaid programs.

Upon closer examination of the substance of the MSA, however, a different form of transaction appears. Big Tobacco again appears unscathed. Tobacco companies simply pass the costs of the annual payments on to addicted consumers, some of whom are on Medicaid. The additional money that Medicaid-covered smokers pay for cigarettes merely goes through Big Tobacco as a conduit, on its way to its MSA-designated destination, the states. As in other contexts, the step-transaction doctrine should apply to the transactions taking place between Medicaid-covered smokers, Big Tobacco, and the states.

The troubling part of the transaction arises from the purpose of the payments, which can be gleaned from the complaints filed by the states against Big Tobacco. Medicaid-covered smokers, who by definition are financially and medically needy, make payments for their own Medicaid coverage. Upon evaluating these *de facto*

Litigation's Third-Wave: Has Justice Gone Up in Smoke?, 2 J. HEALTH CARE L. & POL'Y 34, 42 (1998) (“[W]e are prepared to tax 100 percent of consumers to keep cigarettes out of the hands of the 2 percent that are underage. The massive disjunction between means and ends is neither necessary nor proper.”); Thaddeus Mason Pope, *Balancing Public Health Against Individual Liberty: The Ethics of Smoking Regulations*, 61 U. PITT. L. REV. 419, 423 (2000) (“Tobacco regulations, particularly those aimed at directly restricting or prohibiting consumption under certain circumstances, clearly interfere with the liberty of tobacco-consuming individuals.”); George P. Smith II, *Cigarette Smoking as a Public Health Hazard: Crafting Common Law and Legislative Strategies for Abatement*, 11 MICH. ST. J. MED. & L. 251, 260 (2007) (“With government actions that seek to not only promote health and prevent injury and disease come inevitable interferences with personal liberties and economic freedoms.”); W. Kip Viscusi, *The New Cigarette Paternalism*, REGISTER, Winter 2002, at 63 (noting that increasing taxes on cigarettes to provide smokers with incentives to quit would “override the revealed preferences of smokers on the basis of hypothetical failings in individual choice”).

premiums according to the restrictions put in place by § 1396o of the Social Security Act, the MSA's violation of federal law becomes apparent. Medicaid-covered smokers pay de facto premiums for their Medicaid coverage when, under the Act, most should be paying none at all.

Perhaps even more troubling is the absence of a solution that does not involve forcing Medicaid-covered smokers to choose between continuing their smoking habit and paying unlawful premiums. The Secretary of Health and Human Services is unlikely to exercise authority under § 1396c to withhold funds from the states. Doing so would contradict the supportive and cooperative role the Secretary plays in the Medicaid program. And these are de facto payments to begin with: to even recognize the violation caused by these payments, a court must look beyond the surface of the MSA and apply the principle that substance should prevail over form. And while Medicaid-covered smokers have a viable argument to support a § 1983 action, a reviewing court may be hesitant to allow such a claim based on a violation of a provision that is less clearly a rights-creating statute than the two paradigmatic statutes. Medicaid-covered smokers may face a bleak choice: quit smoking or pay unlawful premiums for their Medicaid coverage.

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