1-2003

The Tenuous Nature of the Medicaid Entitlement

Timothy Stoltzfus Jost
Washington and Lee University School of Law, jostt@wlu.edu

The Tenuous Nature Of The Medicaid Entitlement

Federal rights remain under threat and must be strengthened.

by Timothy Stoltzfus Jost

ABSTRACT: Although Medicaid is regarded as a federal entitlement program, nowhere does the Medicaid statute explicitly recognize a federal right of action to enforce recipients' rights. Arguably, the Supreme Court, rather than Congress, first recognized the right of Medicaid recipients to protection of federal law. A controversial 2001 federal court decision, however, called into question the continuing existence of federally enforceable Medicaid rights. Although this decision has been reversed, it illuminates the tenuous nature of the Medicaid entitlement, as do recent Supreme Court decisions narrowing federal rights. Congress should amend the Medicaid statute to ensure the rights of Medicaid recipients.

THE BENEFICIARIES OF MEDICARE, one of our two great public health care financing programs, enjoy an entitlement to health care services that is solidly grounded in federal law and enforceable in the federal courts. The legal rights of Medicaid recipients, by contrast, have from the outset been far less clear and remain far more at risk. Indeed, a controversial 2001 federal court decision radically rejected the right of Medicaid recipients to a federal right of action enforceable in the federal courts. Although that case has now been reversed, recent Supreme Court decisions continue to leave Medicaid recipients' legal protection very much in doubt. These developments call into question the wisdom of the current structure of the Medicaid program, under which the federal government pays the bulk of program costs without explicitly guaranteeing recipients a federal right of action to protect their access to eligibility and services.

■ **Language of entitlement.** Medicare has always been a federal entitlement. Throughout Title XVIII, Medicare beneficiaries are referred to as "persons entitled to benefits," a phrase that appears more than 100 times in various forms in the current Medicare statute. Medicare beneficiaries are explicitly granted access to the federal courts to seek protection of their entitlements to eligibility and services.[1] The language of entitlement, on the other hand, is curiously absent from the original Medicaid statute. Medicaid began as an extension of the earlier Kerr-Mills legislation and was titled "Grants to States for Medical Assistance Programs." It provided

Timothy Jost is the Robert L. Willett Professor of Law at the Washington and Lee University School of Law in Lexington, Virginia. His book, Disentitlement?, *examining U.S. health care entitlements from a legal, comparative, and historical perspective, will be published by Oxford University Press in spring 2003.*

funds "for the purpose of enabling each State, as far as practicable under the conditions in such state," to furnish medical assistance to welfare recipients and the medically needy.[2] It clearly created an entitlement for the states but was more vague as to the rights and remedies it offered individual recipients.

The 1965 Medicaid statute, like Kerr-Mills, required states to provide administrative hearings to Medicaid recipients. In many states, decisions reached in these hearings would have been reviewable in state court.[3] But many states regarded welfare recipients as beneficiaries of charity rather than as entitled to rights. Moreover, state officers presiding over fair hearings generally lacked the power to find that state programs had violated federal law. What recipients and their advocates wanted and needed was a remedy in federal court.

■ **"Right of action" according to the Supreme Court.** Although the Medicaid statute was obviously intended to create federal rights for recipients, nowhere does it recognize a private right of action for them to enforce those rights or establish federal court jurisdiction over Medicaid claims. In a series of cases decided between 1968 and 1975, however, the Supreme Court recognized the existence of a right of action, enforceable in the federal courts, to enforce the requirements of federal welfare programs, including Medicaid.

In *King v. Smith*, the first of these, the Court stated: "There is of course no question that the Federal Government...may impose the terms and conditions upon which its money allotments to the States shall be disbursed, and that any state law or regulation inconsistent with such federal terms and conditions is to that extent invalid."[4] The Court also recognized that although the Social Security Act itself provided welfare recipients neither a private right of action nor access to the federal courts, recipients whose federal rights were violated by state welfare programs could sue in federal court under 42 U.S. Code, Section 1983. Section 1983 is a Reconstruction-era civil rights law that provides a remedy when state officials transgress rights created by federal law. Building on a series of civil rights cases that had elaborated Section 1983 law, the Court permitted welfare recipients to bypass state remedies and go directly into federal court.

Although the Court decided *King v. Smith* on statutory grounds, it reserved judgment on whether Section 1983 actions could be brought challenging state welfare provisions solely on the basis of Social Security Act violations in the absence of a constitutional claim.[5] The existence of a Section 1983 right of action for statutory violations was not finally established until more than a decade later, when the Supreme Court in *Maine v. Thiboutout* decided that Section 1983, which affords redress for violation of the "Constitution and laws," covered violations of the Social Security Act.[6] In *Wilder v. Virginia Hospital Association* in 1990, the Court held that providers also had a cause of action under Section 1983 against illegal state action.[7]

■ **"Right of action" according to Congress.** Congress has never amended the Medicaid statute to clarify the existence of a federal right of action, but on two occasions in the 1990s Congress confirmed the existence of such a right. In 1992 the Su-

preme Court decided a case limiting the reach of Section 1983.[8] Congress responded decisively, adopting Section 1130A of the Social Security Act, rejecting the Court's narrow reading of Section 1983 and restoring the law as it existed prior to the case. Further, in 1995 and 1996 the "Contract with America" Congress adopted legislation, subsequently vetoed by President Bill Clinton, repealing the Section 1983 right of action for Medicaid recipients and thereby acknowledging the existence of such a right.[9] Until recently, therefore, the right of Medicaid recipients to a federal right of action to enforce a federal Medicaid entitlement in the federal courts seemed secure.

■ **Another barrier to enforcing rights.** Recipients and providers asserting Medicaid rights also, however, confront another barrier: the Eleventh Amendment to the United States Constitution. The Eleventh Amendment forbids private suits against the states in federal courts. It has long been clear that this amendment forecloses recovery of damages against the states in federal court for violations of Medicaid program requirements.[10] Since 1908, however, the Supreme Court has held that the federal courts can enjoin a state officer from violating federal law without violating the Eleventh Amendment.[11] According to the *Ex parte Young* doctrine, because the Supremacy Clause prohibits the states from violating the federal law, any state officer who does so is acting outside of the state's authority and can be ordered by the federal court to stop. Until recently, therefore, it was settled that continuing violations of the Medicaid statute could be enjoined by the federal courts.

Medicaid: A Weak Entitlement

Although Medicaid has come to be accepted as a federal entitlement, with federal rights protected by the federal courts, it has never been a very robust one. Those recipients who fall into "mandatory" eligibility categories—Supplemental Security Income (SSI) recipients; recipients of the former Aid to Families with Dependent Children (AFDC) program, and, since the late 1980s, poor children and pregnant women—can claim eligibility as of right. They also have a right to services "with reasonable promptness."[12]

■ **Vague coverage.** The Medicaid statute is much vaguer as to what services this entitlement covers. Medicaid programs can cover almost any health care service but are only required to provide a short list of services, including hospital, physician, and skilled nursing facility care.[13] The main protection as to adequacy of services is a regulatory requirement that each service "must be of sufficient amount, duration, and scope to reasonably achieve its purpose."[14] Medicaid regulations also prohibit states from arbitrarily denying or reducing the amount, duration, or scope of a required service "solely because of the diagnosis, type of illness, or condition."[15]

■ **Requirements that may be waived away.** Several of the most important requirements of the statute can be waived by the Department of Health and Human Services (HHS), however, and virtually all program requirements can be waived for Section 1115 demonstration projects. The 1997 Balanced Budget Act (BBA) streamlined this waiver process and modified requirements that limited state managed

care initiatives, such as the "free choice of providers" requirement. The Bush administration's recent Health Insurance Flexibility and Accountability (HIFA) demonstration initiative gives the states even freer rein to disregard basic program requirements for some eligibility groups.[16]

■ **Even weaker rights for providers.** Medicaid providers have even weaker threads on which to hang their claims. Although the Supreme Court in *Wilder v. Virginia Hospital Association* recognized the right of providers to sue state Medicaid programs in federal court, few statutory provisions protect them from unreasonably low payment levels or arbitrary budget cuts.[17] For a time providers enjoyed some success under the 1976 Boren Amendment, which imposed limited substantive and procedural requirements on state Medicaid rate setting for hospitals and nursing facilities.[18] This provision was repealed by the 1997 BBA, leaving providers protected only by the general requirement that payments must be consistent with "efficiency, economy, quality of care" and sufficient to provide Medicaid recipients access to services to the extent that they are available to the general population.[19]

Legal Challenges To Program Limitations

Nevertheless, recipients and providers have brought a steady stream of litigation in federal court challenging state Medicaid program limitations, with some success. During 1999 recipients and providers prevailed in 53 percent of the reported federal court cases that they brought against Medicaid programs, while in 2000 they won 48 percent of these cases.[20] Recipients were more successful than providers, prevailing 61 percent of the time in suits in 1999 and 2000, while providers prevailed only 35 percent of the time in 1999 and 38 percent in 2000.[21]

■ **"Westside Mothers": a setback.** In the spring of 2001, however, a widely reported federal court case rejected the long established understanding that the Medicaid program created federal rights enforceable in federal court. In *Westside Mothers v. Haveman*, Judge Robert H. Cleland, an activist conservative judge, rejected the principles of federal jurisdiction that had been accepted for decades in Medicaid cases.[22] *Westside Mothers* began as a routine challenge to Michigan's implementation of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program in the managed care context. The EPSDT program is one of the few services that state Medicaid programs must cover under federal law.[23]

Judge Cleland's lengthy opinion rejected root and branch the right of Medicaid recipients to sue the states in federal court to enforce federal program requirements. First, Judge Cleland held that under the Tenth Amendment, states are independent sovereigns. The federal government is, therefore, not able to compel states to comply with Medicaid requirements, except insofar as states voluntarily enter into a "contract" with the federal government to do so.

Judge Cleland held, moreover, that Medicaid recipients were powerless to enforce this contract in federal court. First, he held such litigation is precluded because of the states' sovereign immunity, protected by the Eleventh Amendment.

He rejected the applicability of the *Ex parte Young* doctrine, discussed above in the Medicaid cases. He held that Medicaid is a spending program and that federal laws adopted pursuant to the spending clause are not the supreme law of the land. Second, he held that *Ex parte Young* did not apply when a state officer is properly acting under authority of state law. Third, he held that federal courts are powerless under *Ex parte Young* to compel state officers to perform discretionary acts. At each step, Judge Cleland rejected a long tradition of doctrinal interpretation, often relying on quotes from concurring opinion or crystal ball gazing as to the tendencies of recent Supreme Court decisions.

Judge Cleland, however, did not simply rely on the state's Eleventh Amendment protection but also held that Medicaid recipients have no federal right to sue under Section 1983. Here, he returned to his basic premise that Medicaid is based on a contract between the federal and state governments. This contract, he contended, does not provide unambiguously for enforcement by recipients. Moreover, recipients have no right to sue as third-party beneficiaries of the federal-state contract because such beneficiaries were not permitted to sue to enforce contacts in 1871, when Section 1983 was adopted. Cleland's opinion, in sum, clearly and decisively rejected the existence of a federal right of action to protect Medicaid recipients and federal court jurisdiction to enforce this right.

The states immediately leapt on *Westside Mothers* as a way out of the Medicaid litigation that has long burdened them. The case was argued across the country in pending Medicaid litigation, but in decision after decision district court judges rejected the case as a radical change in established law.[24]

Finally, in May 2002 the issue reached the federal courts of appeal. On May 9 the conservative Fourth Circuit rejected North Carolina's Eleventh Amendment sovereign immunity defense, holding that the claim before it, challenging North Carolina's inadequate provision of Medicaid dental care, fell squarely within the *Ex parte Young* doctrine permitting prospective relief from an ongoing violation of federal law.[25] The court further repudiated *Westside Mothers*' holding that laws adopted under the spending power were not the supreme law of the land as a "novel position...at odds with existing, binding precedent."[26]

A week later the District Court decision in *Westside Mothers* itself was overturned by the Sixth Circuit Court of Appeals.[27] Although the panel that decided the *Westside Mothers* appeal included one of the most vocally conservative members of the often divided Sixth Circuit, the panel spoke with one voice, decisively rejecting Judge Cleland's decision on every ground.

The Medicaid program was not established through a mere contract, the court held, but rather by federal law, which is the supreme law of the land. A suit to prospectively enjoin violation of the law is properly brought within *Ex parte Young.* Supreme Court precedent also bound the court to recognize a right of action in Medicaid recipients under Section 1983 to enforce specific rights created under the Medicaid statute. The Court of Appeals opinion thoroughly rejected step by

step Judge Cleland's speculation as to the Supreme Court's future direction, relying instead on the Court's established precedents.

As of this writing, although cases are still pending in other circuits, it is unlikely that these courts will deviate from the Fourth and Sixth Circuit holdings. Without a split in the circuits, the case is unlikely to reach the Supreme Court.

■ **The Supreme Court weighs in.** Two Supreme Court cases decided in June 2002, however, leave a continued cloud over the future rights of Medicaid recipients. The first, *Barnes v. Gorman*, involved the availability of punitive damages against a municipality under federal disability discrimination statutes.[28] Justice Antonin Scalia, writing for the Court, held that punitive damages were not available, relying on the argument that federal judicial remedies available under the discrimination statutes are limited to those afforded under the federal civil rights laws for spending clause programs. Scalia argued that spending clause legislation operates "much in the nature of a contract: in return for federal funds the [recipients] agree to comply with federally imposed conditions."[29] Because the "contract" in the case at bar did not unambiguously include the threat of punitive damages, they were not available.

A similar argument was, of course, relied on by Judge Cleland in holding that the federal Medicaid contract with the states did not include a federal right of action for recipients. Justice John Paul Stevens, joined by Justices Stephen G. Breyer and Ruth Bader Ginsburg, concurred in the result in *Barnes* but objected to the broad contract analogy argued by Scalia. They explicitly mentioned *Westside Mothers* as an example of judicial overreaching relying on the contract analogy.[30] Although Scalia himself acknowledged that spending clause programs, like Medicaid, are based on federal law and not only on contract, states will undoubtedly rely on *Barnes* to argue that their obligations under Medicaid are purely contractual, enforceable by the federal government and not by recipients or providers.

In the second case, *Gonzaga University v. Doe*, the Court held that Section 1983 does not provide a federal cause of action to enforce the Family Educational Rights and Privacy Act.[31] Justice William H. Rehnquist, writing for the Court, concluded: "[I]f Congress wishes to create new rights enforceable under §1983, it must do so in clear and unambiguous terms—no less and no more than what is required for Congress to create new rights enforceable under an implied private right of action."[32] Although the Court distinguished *Wilder* rather than overruling it, at least some federal Medicaid requirements may not create "clear and unambiguous" rights. One state has already relied on this decision to move to dismiss a case brought by Medicaid recipients.

Deficits Of State Control

Westside Mothers and these recent Supreme Court decisions point to the fundamental weakness of providing health care to the poor though a cooperative federal-state program. The 1935 Social Security Act created the Social Security retirement pension program as a national social insurance program, administered by

the federal government. It established public assistance programs for the indigent elderly and families as cooperative federal-state programs. Thirty years later Medicare followed the Social Security model, but Medicaid merely expanded programs that had been created in 1950 and augmented in 1960, providing medical assistance to supplement federal-state cash assistance.

The fact that Medicaid is a federal-state cooperative program, rather than a national program like Medicare, is an artifact of a history of which we should not be proud. It is in part the history of trying to keep poor people on relief under the thumb of local government, where their lives could be managed more closely.[33] It is also in part the history of racism, with which President Roosevelt had to come to terms to get his New Deal programs past Southern Democratics in Congress who insisted on control over who got welfare and how much.[34]

The primary continuing rationale for state involvement in Medicaid has been the "laboratories of democracy" argument, yet while a few states have creatively used their discretion under Medicaid to expand coverage or services, many others have used it to restrict eligibility, benefits, and provider payments, leaving many poor people uncovered or without access to high-quality care.

The State Children's Health Insurance Program (SCHIP) provides a useful illustration of what the state "laboratories" might do if the federal Medicaid entitlement were totally abolished. SCHIP was explicitly created as a nonentitlement program.[35] Significantly, none of the states that have created independent SCHIP programs have recognized explicit state entitlements to SCHIP coverage, and sixteen states expressly provide that SCHIP is not an entitlement.[36]

State control over Medicaid has brought us great disparities in eligibility, availability of services, and provider payments. The need of poor Americans for health care and their inability to pay for it do not vary depending on state of residence, as their Medicaid coverage does.[37] While geographic disparities in the Medicare program are considered to be a major policy problem, they are inevitable in Medicaid as it is currently structured.[38]

State control over Medicaid programs has resulted in endless gaming as states devise creative ways to increase federal cost sharing without increasing their own budgets. The provider tax/disproportionate-share hospital (DSH) payment scams of the late 1980s and early 1990s, and the abuses of upper payment limit (UPL) requirements in the late 1990s, increased the federal burden of the cost of the program without increasing state responsibility.[39] Interstate competition also has the potential for creating a "race to the bottom," as states restrain benefit growth for fear of attracting poor people from, or losing taxpayers to, other states, and discourages states from getting out in front of others in offering more generous programs.[40] Finally, state responsibility for Medicaid programs has produced program cuts when times are hard, because almost all states are constitutionally prohibited from running deficits, even though Medicaid is a countercyclical program and must thus be funded more rather than less generously during recessions.[41]

A universal national public health insurance program, which would give the poor equal rights to receive health care with dignity, does not seem to be on the political horizon. Federalization of the Medicaid program is not quite such a radical idea. The state Aid to the Aged, Blind, and Disabled program was federalized in 1972, and a proposal to federalize Medicaid was put forward by the Nixon administration.[42] With a national program would come, presumably, a federal right of action enforceable in the federal courts.

At the very least, however, Congress should explicitly recognize the federal right of action to enforce federal Medicaid requirements that it has long assumed exists, including jurisdiction in the federal courts to protect it. If it fails to do so, we face the serious risk of further judicial undermining of the rights of Medicaid recipients and their access to the courts. Medicaid will consume 145 billion federal dollars this year, 7 percent of the federal budget.[43] To lavish this amount of money on the states while denying any federal rights to Medicaid recipients, the intended beneficiaries of the program, seems not only unjust but also foolish.

NOTES

1. 42 U.S. Code, sec. 1395ff (b)(1)(A).
2. Public Law 89-97, sec. 121.
3. See Note, "Federal Judicial Review of State Welfare Practices," *Columbia Law Review* 67, no. 1 (1967): 84–129.
4. 392 U.S. 309, 333, note 34 (1968).
5. 392 U.S. at 312, note 3.
6. 448 U.S. 1, 4 (1980).
7. 496 U.S. 498 (1990).
8. *Suter v. Artist M,* 503 U.S. 347 (1992).
9. Congress has at least five other times rejected legislation that would have deprived Medicaid recipients of a federal right of action. See E. Chemerinsky, "Ensuring the Supremacy of Federal Law: Why the District Court Was Wrong in Westside Mothers v. Haveman," *Health Matrix* 12, no. 1 (2002): 139–156, 152.
10. *Edelman v. Jordan,* 415 U.S. 651 (1974).
11. *Ex parte Young,* 209 U.S. 123 (1908).
12. 42 U.S. Code Amended, sec. 1396a(a)(8). See *Doe v. Chiles,* 136 F.3d 709 (11th Cir. 1998) (finding that disabled people placed on a waiting list for intermediate care facility services were not provided services with "reasonable promptness").
13. 42 U.S. Code, secs. 1396a(a)(10)(A) and 1396d(a).
14. 42 CFR, sec. 440.230(b).
15. 42 CFR, sec. 440.230(c).
16. Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative," 17 September 2002, www.cms.hhs.gov/hifa/default.asp (23 October 2002). See, commenting on HIFA, E. Park and L. Ku, *Administration Medicaid and SCHIP Waiver Policy Encourages States to Scale Back Benefits Significantly and Increase Cost-Sharing for Low-Income Beneficiaries* (Washington: Center on Budget and Policy Priorities, 15 August 2001).
17. 496 U.S. 498 (1990).
18. Former 42 U.S. Code Amended, sec. 1396a(a)(13)(E).
19. 42 U.S. Code Amended, sec. 1396a(a)(30)(A).
20. Reported cases were identified using a Westlaw search of the ALLFEDS database for 1999 and 2000 cases including a citation to a provision of 42 U.S. Code 1396ff and the word *Medicaid.* Only cases in which a Medicaid agency was the defendant were included. Fraud and abuse and *qui tam* cases were excluded, as were cases challenging or seeking a share of tobacco tort litigation settlements. Cases involving purely

procedural issues such as class certification or attorneys' fees awards were also excluded. Cases were coded as either wins for the plaintiff or for the Medicaid agency. Cases in which both parties won on some issues were coded for computing win/loss statistics as favoring each party half and half.

21. Both recipients and providers were much less successful, however, in the courts of appeals, where state Medicaid agencies won 83 percent of the reported cases in 1999 and 81 percent in 2000.
22. 133 F. Supp. 2d 549 (E.D. Mich. 2001).
23. 42 U.S. Code, secs. 1396d(a)(4)(B) and 1396d(r).
24. See, for example, *OKAAP v. Fogarty,* 2002 WL 1271782 (May 21, 2002); *Rancourt v. Concannon,* 175 F. Supp. 2d 60 (D. Me. 2001); *Bryson v. Shumway,* 177 F. Supp. 2d 78 (D. N. H. 2001); *Memisovski v. Patla,* 2001 WL 1249614 (N.D. Ill, Oct. 17, 2001); *Markva v. Haveman,* 168 F. Supp. 2d 695 (E.D. Mich. 2001); and *Boudreau v. Ryan,* 2001 WL 840583 (N.D. Ill. May 2, 2001).
25. *Antrican v. Odom,* 290 F.3d 178 (4th Cir. May 9, 2002).
26. Ibid. at 188.
27. *Westside Mothers v. Haveman,* 289 F.3d 852 (6th Cir. 2002).
28. *Barnes v. Gorman,* 122 S.Ct. 2097 (2002).
29. 122 S.Ct. at 2100.
30. 122 S.Ct. at 2104, n.3.
31. *Gonzaga University v. Doe,* 122 S.Ct. 2268 (2002).
32. 122 S.Ct. at 2279.
33. S. Sugarman, "Welfare Reform and the Cooperative Federalism of America's Public Income Transfer Programs," *Yale Law and Policy Review* 14, no. 1 (1996): 125–147.
34. See R. Lieberman, *Shifting the Color Line: Race and the American Welfare State* (Cambridge: Harvard University Press, 1998), 118–176; and J. Quadagno, "From Old-Age Assistance to Supplemental Security Income: The Political Economy of Relief in the South, 1935–1972," in *The Politics of Social Policy in the United States,* ed. M. Wier et al. (Princeton: Princeton University Press, 1988), 235–263.
35. 42 U.S. Code, sec. 1397bb(b)(4).
36. S. Rosenbaum et al., "Devolution of Authority and Public Health Insurance Design: National SCHIP Study Reveals an Impact on Low-Income Children," *Houston Journal of Health Law and Policy* 1, no. 1 (2001): 33–61.
37. Families USA, *Disparities in Eligibility for Public Health Insurance: Children and Adults in 2001* (Washington: Families USA, February 2002).
38. See J.E. Wennberg, E.S. Fisher, and J.S. Skinner, "Geography and the Debate over Medicare Reform," 13 February 2002, www.healthaffairs.org/WebExclusives/Wennberg_Web_Excl_021302.htm (24 July 2002).
39. See T. Coughlin and D. Liska, *The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues* (Washington: Henry J. Kaiser Family Foundation, October 1997); and L. Ku, *Limiting Abuses of Medicaid Financing: HCFA's Plan to Regulate the Medicaid Upper Payment Level* (Washington: Center for Budget and Policy Priorities, September 2000).
40. F. Piven, "Comment on Interstate Competition and Welfare Policy," in *Welfare Reform: A Race to the Bottom?* ed. S. Schram and S. Beer (Washington: Woodrow Wilson Center Press, 1998), 43–48; and D. Kenyon, "Health Care Reform and Competition among the States," in *Health Policy, Federalism, and the American States,* ed. R. Rich and W. White (Washington: Urban Institute, 1999), 253–276, 264–268.
41. See V. Smith and E. Ellis, *Medicaid Budgets under Stress: Survey Findings for State Fiscal Year 2000, 2001, and 2002* (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2001); and Kaiser Commission, *The Role of Medicaid in State Budgets* (Washington: Kaiser Commission, November 2001).
42. T. Conlan, *New Federalism: Intergovernmental Reform from Nixon to Reagan* (Washington: Brookings Institution, 1988), 151.
43. Budget of the United States Government, Fiscal Year 2003, Table S-2, w3.access.gpo.gov/usbudget/fy2003/pdf/bud34.pdf (24 July 2002).