What Is Federalism in Health Care For?
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Introduction

Federalism is all the rage in health policy again. For the past eight years, President Obama's Affordable Care Act, which embraced federalism by designating the states as the ACA's frontline implementers, has been cited as a particularly prominent example of modern federalism.[1] Indeed, the ACA has been deemed a prototypical example of federalism in dozens of articles—many of them not only about health care.[2] With the new Administration, federalism has stayed at the forefront of the health care policy conversation. The bills proposed to replace the ACA, as well as the executive branch's administrative efforts, are heavy on state options and waiver opportunities.[3] But every

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[1] *See* Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 539-40 (2011) (describing some of the many modern federalism structures in the statute).

[2] *See, e.g.*, Josh Bendor & Miles Farmer, *Curing the Blind Spot in Administrative Law: A Federal Common Law Framework for State Agencies Implementing Cooperative Federalism Statutes*, 122 YALE L.J. 1280, 1287 (2013); Jessica Bulman-Pozen, *Executive Federalism Comes to America*, 102 VA. L. REV. 953, 969 (2016); Erwin Chemerinsky et al., *Cooperative Federalism and Marijuana Regulation*, 62 UCLA L. REV. 74, 118 (2015); Heather K. Gerken, Windsor*'s Mad Genius: The Interlocking Gears of Rights and Structure*, 95 B.U. L. REV. 587, 598 (2015); Michael S. Greve, *Our Federalism Is Not Europe's It's Becoming Argentina's.*, 7 DUKE J. CONST. L. & PUB. POL'Y, no. 1, 2012, at 17, 32; Orrin G. Hatch, King v. Burwell *and the Rule of Law*, 63 UCLA L. REV. DISCOURSE 2, 10 (2015); Gillian E. Metzger, *Agencies, Polarization, and the States*, 115 COLUM. L. REV. 1739, 1772 (2015); Hannah J. Wiseman, *Regulatory Islands*, 89 N.Y.U. L. REV. 1661, 1686-87 (2014).

[3] *See* S. Amend. 1030 to H.R. 1628, 115th Cong., 163 CONG. REC. S5682 (as proposed Sept. 13, 2017), https://www.congress.gov/crec/2017/09/13/CREC-2017-09-13.pdf; American Health Care Act of 2017, H.R. 1628, 115th Cong. (as passed by House, May 4, 2017), https://www.congress.gov/bill/115th-congress/house-bill/1628/text; *see also* Henry J. Kaiser Family Foundation, *Compare Proposals to Replace The Affordable Care Act*, https://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/ (last visited Jan. 28, 2018) (comparing all of the repeal bills).

Republican proposal likewise has kept the federal government in the picture, preserving many of the ACA's distinctive national-level interventions while also preserving the ACA's state-centricity.[4] At the same time, and despite the laser focus on state-federal relations under the law, little detail has emerged on how the ACA's federalism actually operates in practice and what, if anything, is noteworthy about it.

This study builds on a research effort conducted by the authors with colleagues at the University of Pennsylvania that tracked the details of ACA's federalism-related implementation from 2012-2017. The work was driven by many questions. Central among them were: Does the ACA actually effectuate "federalism," and what are federalism's key attributes when it is entwined with national statutory implementation? How did the ACA's federalism take shape and what was its purpose? A federal law on the scale of the ACA presented a rare opportunity to investigate how modern federalism works from a statute's very beginning.

The deep description that we develop in the pages that follow gives rise to an almost unmanageable number of questions about federalism theory. It deconstructs assumptions about federalism that theorists of all stripes make—and not just constitutional-law-oriented federalists, who focus on formal separation,[5] but also those who call themselves the "new school" federalists, who acknowledge and celebrate the importance of the state role in the administration of modern federal statutes.[6] The findings also uncover a theoretical muddle when it comes to health care law and policymaking: without a clear conception of the American health care system's goals, how can we know which structural arrangements serve it best, much less whether they are working?

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[4] *See* S. Amend. 1030 to H.R. 1628, 115th Cong., 163 CONG. REC. S5682 (as proposed Sept. 13, 2017), https://www.congress.gov/crec/2017/09/13/CREC-2017-09-13.pdf; American Health Care Act of 2017, H.R. 1628, 115th Cong. (as passed by House, May 4, 2017).

[5] *See* Heather K. Gerken, *The Supreme Court 2009 Term—Foreword: Federalism All the Way Down*, 124 HARV. L. REV. 4, 11-13, (2010) (describing the classic sovereignty account of federalism).

[6] *See, e.g.*, Heather K. Gerken, *Federalism and Nationalism: Time for a Détente?*, 59 ST. LOUIS U. L.J. 997, 1005 (2015) (arguing for a modern understanding of federalism that incorporates national power); Erin Ryan, *Response to Heather Gerken's* Federalism and Nationalism: Time for a Détente?, 59 ST. LOUIS U. L.J. 1147, 1152-53, 1159-60 (2015) (noting the importance of state-federal bargaining as the critical element of modern federalism); Ernest A. Young, *The Rehnquist Court's Two Federalisms*, 83 TEX. L. REV. 1, 130-36 (2004) (noting that federalism practically occurs through statutory doctrines such as preemption due to the Supreme Court's broad interpretation of Congress's enumerated powers).

Our key descriptive findings are outlined in the Summary directly following this Introduction. In brief, we find the ACA's federalism to be exceedingly *dynamic and adaptive*. The statute's framework turned out to be only a starting point for a vertical and horizontal process of intergovernmental bargaining, through which states and the federal government implement the law through copying, negotiating, and adapting. The statute's structural architecture is also decidedly *non-essentialist* from a federalism perspective:[7] that is, federalism's commonly cited attributes—including autonomy, variation, and experimentation—have been generated across virtually every kind of state-federal arrangement in the statute's implementation. Those federalism benefits, in other words, were not dependent on any architecture of either state-federal separation or entanglement.

As one example, take Medicaid, the public insurance program for low-income individuals. Some states expanded Medicaid eligibility precisely as the ACA's text laid out; others chose not to expand at all; still others negotiated (and renegotiated) waivers to tailor Medicaid to their liking, in ways less than ideal to the Obama Administration.[8] All of these states experienced autonomy; all of their choices generated policy localism and experimentation. Waiver states arguably simultaneously cooperated with the federal government and dissented. Were the waiver states more or less cooperative than other expansion states? Were they more or less autonomous than states that did not expand at all? In the end, it proved impossible to assign weights to the different ways that federalism attributes emerged and the structural architecture that produced them, because they emerged from virtually every possible state-federal arrangement under the law.

This does not mean that we conclude that federalism is an empty concept, or that it does not exist in the ACA. Instead, we stake out a new place on federalism's messy spectrum. On one end, some scholars insist on an all-or-nothing conception, one in which state power is derived from separation from the federal government and where the Constitution draws the critical lines.[9] At another point on the spectrum are those who see arrangements like the ACA and say federalism does not exist at all: they instead see mere decentralization and use of states in a subservient and managerial way.[10] Still others brand

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[7] See Judith Resnik, *Accommodations, Discounts, and Displacement: The Variabilty of Rights as a Norm of Federalism(s)*, 17 JUS POLITICUM 209 (forthcoming 2017) (rejecting as "essentialist . . . the presumption of the naturalness of federal or of state exclusivity, as if certain kinds of activities were intrinsically only to be left to a particular level . . . .").

[8] *See infra* Part IV.

[9] Gerken, *supra* note 5.

[10] *See* MALCOLM M. FEELEY & EDWARD RUBIN, FEDERALISM: POLITICAL IDENTITY AND TRAGIC COMPROMISE, at ix (2008) (suggesting that some aspects of modern federalism are actually just "managerial decentralization.").

themselves modern federalists and see state activity within federal frameworks as non-sovereign activity that serves *nationalism* and works as a safety valve for the expression of dissenting views.[11] Our data do not fully support any of those stories.

To the contrary, the data make clear that the ACA implementation is indeed a story about state leverage, intrastate governance, and state policy autonomy, even within a national statutory scheme. That these, and other common federalism values, were effectuated independently of any particular structural arrangement or formal separation may be difficult for some federalism aficionados to swallow, but it is a key conclusion of the paper and one we think offers a new perspective. It also complicates what it means to be an essential attribute of "federalism." For instance, our study illustrates that policy variation and experimentation—two oft-referenced federalism attributes[12]—were generated as much in the various nationally-run insurance exchanges as in the state-run exchanges. Those attributes thus do not seem unique to federalist arrangements, even though theorists typically call on federalism to produce them. Sovereignty does not seem absolutely necessary either, although it played a key role at times. And with respect to autonomy, full structural separation of states from the ACA (i.e., total nationalization) would have diminished state power far more than giving states the lead-implementation role that they had. More than anything else, we found that state participation and choice, rather than any particular structural allocation, gave states the most power under the ACA.

To be sure, aspects of ACA implementation will not resonate with federalism scholars at all. For starters, we begin with the view that national intervention in health care is unavoidable and that the ACA was not a unique interloper in an otherwise exclusive sphere of state authority. That will be anathema to the constitutional-law-tethered federalists. But as we illustrate, the ACA is only the latest instance in a long pattern of incremental, national health care interventions.[13] That history renders mostly irrelevant constitutional arguments about federalism in health care and the views of classic federalists who slice the world into separate compartments of federal and state authority.[14] Instead, state-federal allocation in health care has been, from the beginning, a feature of congressional design more than of any constitutional mandate requiring exclusive domains. One of us has called this "intrastatutory

[11] *See* Gerken, *supra* note 6.

[12] *See, e.g.*, Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 923–24 (1994) (recounting variation and experimentation as "instrumental argument[s] for federalism).

[13] *See infra* Part II.

[15] Gluck, *supra* note 1, at 538.

federalism": federalism arrangements produced by federal statutes themselves.[15]

Further, the ACA's deployment of the states, even as it empowered them, almost certainly has helped to enact and entrench the statute. That is a nationalist end, served by state-implementation means, and one that most would not associate with traditional federalism values. The existence of these vectors of state power and state service in the same story complicates it tremendously.

In the end, however, these different expressions and aims of federalism matter only once we define what federalism is supposed to be, and what it is for. Federalism is a term that today is difficult to pin down.[16] Our study underscores both how federalism has tended to stand in for so many different values—whether separation, checks and balances, variation, autonomy, or experimentation— as well as for many different types of structural arrangements , and how these attributes do not always line up coherently, even within the same statute.

Health care fits right into this modern federalism story. While state authority over areas of health care certainly remains, the major decisions about allocation of power in health care have now typically come not from states as the only accepted constitutional actors but rather from political and policy decisions by *Congress* to incorporate states into federal schemes. The question we set out to answer was whether this federalism actually succeeds in health law. We initially attempted to quantitatively measure the ACA's federalism in implementation, evaluating where federalism delivered and where it failed. Our efforts, however, were stymied by conceptual barriers in federalism and health care theory alike.

The first problem we encountered was a federalism-theory problem. It was impossible to weigh whether one type of structural arrangement was more autonomous, sovereign, experimental, or cooperative because, as noted, aspects of those attributes exist across all of the different state-federal allocations in the statute. Federalism scholars always argue for structural decisions based on the ends they wish to produce; our data question whether it is even possible to talk about ends as related to any particular kind of structure, and whether federalism has ever been properly defined by either side.

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[15] Gluck, *supra* note 1, at 538.

[16] *See* The Federalist Society, *Is Everyone Now For Federalism?*, YOUTUBE (Nov. 17, 2017), https://www.youtube.com/watch?v=SjP9SNKhAKo (discussing the ambiguity about what federalism is).

The second problem we encountered was a health-policy-theory problem: *What is federalism in health care even for?* Most of the health care policy literature has failed to engage this threshold question of why we are focused on state-federal allocation in health care in the first place.[17] (This problem could be generalized to most any field, we suspect, but we confine our analysis to health care.[18]) For instance, we might view health care federalism as being about federalism for *federalism's sake*—federalism for political or constitutional values—reserving some power over health care for states in the interest of state sovereignty and balance of power, regardless of the effect on health care coverage, cost, access, or quality. If so, we should examine if it does in fact accomplish those goals. If, on the other hand, health care federalism is a mechanism to produce particular *policy* outcomes, we should examine instead whether locating a particular facet of health care design in the states versus the federal government positively affects, for example, health care coverage, cost, access, quality, innovation, or some other health policy aim.

Complicating matters further is the lack of theoretical foundation in the field of health law in general. The field remains caught in centuries-old, unresolved tension between the so-called "social solidarity" model—every person should be guaranteed some minimal level of health care; and the "individual responsibility" model—a person gets only the health care she can pay for.[19] The ACA built on a fragmented system that compromises on both sets of values and, while the ACA pushed the needle toward solidarity by enacting policies aimed at universal coverage, it did not go all the way and still leaves the field without clear core principles.[20]

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[17] The most extensive treatment comes in the terrific 2003 Urban Institute volume, FEDERALISM AND HEALTH POLICY 6-7 (John Holahan et al. eds., 2003), which posits different reasons why federalism might be favored in health care. The authors conclude that: "U.S. health policy reflects a shared approach to federalism . . . . There is little agreement that either level of government would necessarily do better than the current arrangement." *Id.*

[18] *Cf.* Judith Resnik, *What's Federalism For?*, *in* THE CONSTITUTION IN 2020, at 269, 270 (Jack M. Balkin & Reva B. Siegel eds. 2009) (illustrating the variety of causes to which federalism has been turned in modern times).

[19] *See, e.g.*, Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 227 (2008) ("The peculiarly American mix of entitlement and personal responsibility in today's health reform proposals . . . mask deep divisions in beliefs about whether society or the individual ought to be responsible for health. Trying to have it both ways may make it impossible to agree on sustainable reform."); *see also* Abbe R. Gluck, *America Needs to Decide: Is Heath Care Something We Owe Our Citizens?*, VOX: THE BIG IDEA (Mar. 18, 2017, 9:36 AM), https://www.vox.com/the-big-idea/2017/3/6/14826974/health-care-aca-philosophy-republican-obamacare (describing current debates' failures to engage with the tension that Mariner identified).

[20] *See* Gluck, *supra* note 19.

As such, federalism becomes even more difficult to measure because the menu of potential health policy goals is not necessarily coherent. For instance, health policy that decreases costs for the federal government is not difficult to construct, and such a policy might also be deemed states' rights or federalism "friendly" if it pushes policy choices to the states. But such a policy could well reduce access to care, especially for the poor,[21] and it would not be state friendly if it increased the financial or regulatory burdens on states beyond what they could meet. As another example, health policy that allows for interstate variation might be a benefit of federalism, but it also leads to significant inequality when it comes to health care access across the country.[22] For some, a moral belief in equality might trump whatever other benefits (like policy variation) a federalist structure could generate. This is why, without a clear goal, it is impossible to know whether federalism is simply a structural preference regardless of its effect on health care or a substantive choice whose success warrants verification.

This Article unfolds as follows: Part I summarizes the study's key findings. The ACA's implementation was marked by structural dynamism, negotiation, administrative pragmatism, complex intrastate politics, and interstate horizontal competition and learning. Part II provides an abbreviated history of federalism and nationalism in health care and situates that history in modern theories of federalism. Part III details the ACA's federalism structure and provides background on our five-year study of the implementation of two of the ACA's key pillars, which were also its most state-centered components: the Medicaid expansion and the health insurance marketplaces (called "exchanges").[23] Parts IV and V offer a deep dive into the federalism features of Medicaid and exchange implementation respectively. Part VI circles back to the question of what federalism in health care is for and extrapolates lessons that can be learned.

We conclude that the ACA's story substantiates the existence of some federalism attributes within federal administration under the right circumstances. For instance, state leverage and policy flexibility—including the leverage and flexibility to work to undermine the law--seem real when states have choices to make that are important to a statute's success. Those characteristics

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[21] *See infra* Part III.A.

[22] *See, e.g.*, Samantha Artiga et al., *The Impact of the Coverage Gap for Adults in States Not Expanding Medicaid by Race and Ethnicity*, HENRY J. KAISER FAM. FOUND. (Oct. 26, 2015), https://www.kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity (documenting significant health disparities in states that chose not to expand Medicaid).

[23] Many of the dynamics we describe play out in other areas of state-federal relationships in health regulation, but that was not the focus of our study, nor has federalism been at the forefront of those areas in such stark exposition as in the case of the ACA.

in turn serve state sovereignty, as we discuss. But other federalism attributes may not be dependent on states being involved at all—including the famous Brandeisian federalism values of experimentation and variation.[24] We saw those values emerge from nationally-run aspects of the ACA, too, and did not see any evidence that state-run components did any better. Perhaps these no longer should be thought of as classic "federalism" values at all.

We recognize that thus deconstructing federalism's key attributes poses dizzying complexities not only for conceptualization but also for legal doctrine. As one of us has detailed elsewhere, federalism doctrine has barely moved past the separate-spheres conception. But it must if the various values we associate with federalism are worth protecting, because they now emerge outside of separate-spheres design. Moreover, the values are many and are not always produced together by the same state-federal structural arrangement. Yet we continue to invoke federalism as single placeholder for all these different things. Recognizing these developments and concretizing what is essential to federalism is necessary to effectuate and evaluate it—not only in the ACA, but beyond.

I. Summary of Key Findings

Several findings from this study should be of particular interest to federalism experts, health-oriented or not. First, we found the ACA's federalism to be *dynamic*, *negotiated*, *adaptive*, and *horizontal.* It was marked by horizontal and vertical intergovernmental activity. States copied other states and leveraged the success of forerunners for more gains in later negotiations.[25] The federal government adapted each time, setting the stage for the next round of activity. This federalism was multidirectional, not an on-off switch: States have changed structural architecture in both directions, moving between state-led and federally-led models and vice versa.[26] State choices move in waves.[27]

Second, the ACA's federalism embraced a fascinatingly pragmatic and creative *hybrid* of national and state-level solutions that we have not seen theorized elsewhere in the federalism literature and that emerged only in

[24] *See* New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

[25] The account of the negotiations we offer substantiates much of Erin Ryan's work. *See generally* Ryan, *supra* note __, at 1159-60 (discussing the breadth and importance of bargaining between states and the federal government in the context of contemporary federalism).

[26] *See infra* Parts III, IV.

[27] *See infra* Parts III, IV.

implementation. The ACA's initial framework turned out to be a mere starting point for the ultimate allocation of authority. The hybrids that emerged also struck a middle ground between "one and 50 options"—the typical way in which we consider allocation of power questions, and the typical choice that Congress makes in statutory design in areas that implicate the states. The ACA implies that some lower number of structural options—four, eight, etc.—might be the sweet spot between variety and efficiency.[28]

We also found that many states were eager to accept the kind of federal help for which the federal government has particular economies of scale, including administrative and technical assistance, even as they wished to retain control over policy decisions.[29] These hybrid solutions had negative byproducts too. Most importantly, they jeopardized transparency. Some states that took advantage of this hybrid approach did so because it allowed them to *hide* the fact they were getting federal help from their constituents and, in some cases, even from parts of their own governments.[30] The hybrids thus gave red state officials cover to entrench the ACA but arguably came at a steep price when it comes to accountability. One official colorfully called it the "*secret boyfriend model*" of state-national relations: a relationship coveted by the states, but one that states were unwilling to admit publically for political reasons.[31]

Third, the ACA's federalism story highlights the importance of *intrastate* governance.[32] Each state is an individual republic of its own, even as most federalism scholars still talk about "the states" as a monolithic bloc.[33] But states had different laws going into the ACA, which shaped policy making decisions under the law. For instance, some states had generous pre-existing insurance requirements, which affected the design of their exchanges. Other states had laws about Medicaid policy, statutes which influenced governors in their negotiations over whether and how to expand that program in their own state under the ACA.

State actors also have significant differences among them.[34] State insurance commissioners (most of whom are elected) view health policy differently

[28] *See infra* Part II.C.

[29] *See infra* Part V.B.

[30] *See infra* Part V.B.2.

[31] Interview with Former Federal Executive Branch Health Care Officials 2, 3, and 4 (Aug. 5, 2016).

[32] *See infra* Parts IV.B, V.D.

[33] For an important exception, see Roderick M. Hills, Jr., *Dissecting the State: The Use of Federal Law to Free State and Local Officials from State Legislatures' Control*, 97 MICH. L. REV. 1201, 1203 (1999).

[34] *See infra* Parts IV.B, V.D.

from governors, who themselves take a different position from legislators, even those within the same party. The ACA's implementation saw many governors bucking legislators in their own party to take advantage of the ACA's benefits to their states—often using pre-existing features of state law to do so—underscoring the different priorities of different members of state government and the different structures of the state governments themselves. These internal dynamics within a particular state have a profound, and mostly unrecognized, influence on national policy.[35]

Fourth, Parts IV and V's deep dive into implementation deconstructs federalism's commonly touted attributes and so reveals the complications for empirically measuring federalism in health care and beyond. We suggest that many of the most common "federalism" questions are unanswerable or at least seriously oversimplified. Take for instance the popular topic of whether states are engaging in "cooperative" or uncooperative (disobedient) federalism, and the related question of whether certain structural arrangements serve state autonomy.[36] The ACA allowed states to choose whether to operate their own health insurance exchanges or to have the federal government do so for them.[37] Many believe that "blue" states cooperated by establishing their own state-run exchanges and that "red" states rebelled by defaulting to a federally-run exchange. This binary is too simplistic. When Oregon, for example, switched from a state-run to a federally-supported exchange[38] did it suddenly become "uncooperative"? Or was Oregon still cooperating by defaulting to the national exchange platform, even though the common wisdom is that red states that did the exact same thing were not cooperating and were more autonomous?

As for "rebellious" states, were they more sovereign, autonomous, and uncooperative in the context of the exchanges—even though, as a result of their refusal to implement the exchanges themselves, they paradoxically *welcomed* the federal government takeover of their insurance markets?[39] Or did other states instead better exert and increase their own sovereign power when they *implemented* the ACA themselves, typically making their own policy choices

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[35] Our account responds to Rick Hills' longstanding call to "dissect" the states and develop a federalism story that recognizes the differences both among the states and also among various governmental players within each state. *See* Hills, *supra* note 33, at 1203.

[36] *See* Jessica Bulman-Pozen & Heather K. Gerken, *Uncooperative Federalism*, 118 YALE L.J. 1256, 1258-59 (2009).

[37] *See infra* Part III.A.

[38] Louise Norris, *Oregon Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (Sept. 14, 2017), https://www.healthinsurance.org/oregon-state-health-insurance-exchange ("Oregon initially had a fully state-run exchange—Cover Oregon—but it was plagued with technological failures, and never worked as planned.").

[39] *See infra* Part V.

and passing state laws to do so? Regardless of the structural arrangement chosen, it is clear that states would have enacted far fewer health-care related laws, and been in control of far less health policy, had they been left out of the ACA entirely. In other words, constitutional federalism's preference for formalist and exclusionary structural arrangements would not have served the values here that they are supposed to serve. States exerted power, leverage, and checks on the federal government, in addition to being in control of policy, from within the statute. Not from outside of it.

In exploring all these topics, we build upon the recent wave of new federalism scholarship, work that has been occupied with mapping and explicating federalism across all subjects in an age of national power.[40] As should be clear, and as we elaborate in Parts IV and V, our data challenge areas of this research. The ACA's federalism does more than serve nationalist ends, as some new federalism scholars would argue. And it also gives the states more power than that account allows. At the same time, the ACA's story demolishes the utility of the concept of "cooperation" in federalism, beloved by modern federalism scholars, because the concept illuminates nothing in this context. Indeed, the ACA challenges even more broadly the very notion that any particular structural arrangement is required to produce most of the values we associate with "federalism" at all.

Finally, this article also responds to a particular wakness of general federalism scholarship by pausing to examine the deep details of the ACA's federalism in operation. As one of us has chronicled, federalism theory tends to be big on abstraction and low on concreteness.[41] Detailed exposition situated in both history and theory is wanting, and we hope to provide that here.

II. Health Care Federalism, Old and New

[40] *See*, *e.g.*, Jessica Bulman-Pozen, *Federalism as a Safeguard of the Separation of Powers*, 112 COLUM. L. REV. 459, 461 (2012) (arguing that states increasingly use cooperative federalism to challenge federal executive power and enforce federal statutes); Abbe R. Gluck, *Our [National] Federalism*, 123 YALE L.J. 1996, 1998 (2014) (arguing that modern federalism is a "National Federalism" created by federal statutory design); Greve, *supra* note 2, at 34-35 (highlighting American and Argentinian federalism as examples of federal states increasingly using cooperative federalism); *See also* Ryan, *supra* note **Error! Bookmark not defined.**, at 1151-55 (situating environmental law in a theory of federalism that collapses national and federal); Ernest Young, *Federalism as a Constitutional Principle*, 83 U. CIN. L. REV. 1057, 1067, 1076-77 (2015) (describing the enumerated powers strategy of protecting federalism through constitutional law and advocating for the importance of political and sociological forces in supporting modern federalism).

[41] *See* Gluck, *supra* note 40, at 1998 (arguing that when it comes to federalism theory and doctrine, "[w]e are still muddling through"); *see also* Robert A. Schapiro, *Toward a Theory of Interactive Federalism*, 91 IOWA L. REV. 243, 285 (2005) (arguing that modern federalism lacks "rules of engagement").

From the time the ACA was introduced, debates about the law's desirability have been entangled with debates about American federalism. Politicians, commentators, and scholars alike have portrayed the ACA as a federal takeover, a uniquely nationalist intervention in the terrain of state health policy.[42] Others have incorrectly theorized about the ACA's structural arrangements as a new and unique violation of constitutional lines of division between states and the federal government in health care.[43]

In fact, the ACA follows on a long history of national-level interventions in state health regulation by the federal government, many with similar structural features to the ACA itself. Nor is it the case that any of the recent proposals to repeal or replace the ACA would restore some erased constitutional dividing lines between state and federal. Indeed, each Republican proposal has kept intact the major federal programs and laws (for example, Medicaid, Medicare, and ERISA) and massive federal subsidies (the most important example being the employer tax deduction for health care that helps to insure 50% of all Americans).

Understanding this historical and legal context makes clear why we need to move past arguments about formal constitutional federalism to arguments about the policy and political choices—as well as concerns for states' rights—that go into allocation in modern federalism-based federal statutes. It also explains why this is a paper about "federalism" that does not begin with the possibility of a world in which the national government has no role in health care but, rather, takes the ACA's joint federal-state framework as given for the kind of structure we are likely to see going forward, regardless of what happens to the specifics of the ACA.

Interestingly, and consistent with the story we tell about the ACA, neither federalism nor nationalism have ever been fully embraced in health care policy. When it comes to federalism, long before the ACA, scholars had observed that classic federalism values such as states as "laborator[ies]" of "experiment[ation]"[44] had often been effectuated in health policy not by traditional federalism (the preservation of separate spheres of state authority) but by

[42] *See, e.g.*, Jonathan H. Adler, *Cooperation, Commandeering or Crowding Out?: Federal Intervention and State Choices in Health Care Policy*, 20 KAN. J.L. & POL'Y 199, 199 (2010) (arguing the ACA "extend[s] and deepen[s] federal regulation of health insurance"); Richard A. Epstein, *Bleak Prospects: How Health Care Reform Has Failed In The United States*, 15 TEX. REV. L. & POL. 1, 10-11 (2010); Melinda Henneberger, *'Frankly, It's Bull----': Kathleen Sebelius Is Fighting Mad About Obamacare Attacks*, KAN. CITY STAR (Oct. 13, 2017, 7:46 PM), http://www.kansascity.com/opinion/opn-columns-blogs/melinda-henneberger/article178823256.html ("'It's just nonsense' the way it's been portrayed as a government takeover of health care,' [Sebelius] said . . . .").

[43] *See infra* Part II.C.

[44] New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)

nationalism (federal laws setting a baseline and inviting state participation with funding nudges).[45] States have been limited in what they can accomplish alone in health care experimentation.[46] Disincentives, such as industry exit, prevent a single state from bearing all of the costs of innovation risk if it is one of the few making costly regulatory demands.[47] National statutes that allow for state experimentation *within federal law* often provide a steadier path toward experimentation.[48] The ACA offers a striking example: it was modeled on a major Massachusetts experiment, which the state did not undertake alone but rather with federal permission and funds (largely from the federal Medicaid program).[49]

On the other side, health care nationalism often is characterized as an oppressive interloper in state domains (and has been so characterized with respect to the ACA).[50] But history shows not only that states sometimes need federal intervention to make their own health care systems work—federal intervention typically comes in response to some state regulatory or market failure—but also that federal intervention, when it comes, tends to be focused and incremental. Although Congress has debated fuller-scale national programs[51] and has occasionally enacted laws that are sweeping (still never

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[45] Gluck, *supra* note **Error! Bookmark not defined.**, at 1750.

[46] *See id.* at 1764 (describing the ACA as a federal law incentivizing states to increase experimentation); Susan Rose-Ackerman, *Risk Taking and Reelection: Does Federalism Promote Innovation?*, 9 J. LEGAL STUD. 593, 594, 610-11 (1980) (analyzing the economic impacts of risky state experimentation and explaining lack of incentives for states to do so); Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 925-26 (1994) (noting that federal financial and organizational assistance aids states in overcoming the free rider problem); David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541, 582-83 (2008) (describing states' hesitation to experiment with welfare policies due to population mobility).

[47] *See* Super, *supra* note **Error! Bookmark not defined.**, at 557.

[48] *See* Gluck, *supra* note **Error! Bookmark not defined.**, at 1764; Rubin & Feeley, *supra* note **Error! Bookmark not defined.**, at 925-26.

[49] *See* Ryan Lizza, *Romney's Dilemma*, NEW YORKER (June 6, 2011), https://www.newyorker.com/magazine/2011/06/06/romneys-dilemma (detailing how Massachusetts's health reform was made possible by a Bush Administration Medicaid waiver).

[50] *See, e.g.*, Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J.F. 1, 4 (2017) ("[T]he ACA . . . wrests more regulatory authority from states than necessary.").

[51] *See, e.g.*, Henry J. Kaiser Family Found, National Health Insurance—A Brief History of Reform Efforts in the U.S. (Mar. 2009), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7871.pdf (summarizing health care reform movements and failures of the twentieth century in anticipation of the then-nascent Obama Administration's effort).

universal), it typically enacts compromise legislation that instills piecemeal or targeted federal reform.[52]

This strategy in turn has prevented a complete vision of health care nationalism from being realized. Uniformity and equality of access to health care are still wanting, and fragmentation of the American health care system remains a salient problem.[53] Federal intervention has tended to be highly incremental, and therefore incomplete. Take the ACA again as an example: Despite being a major federal intervention in health policy, the ACA perpetuated and entrenched the fragmentation of American health care by expanding the various and very differently structured health care programs already in existence—some state led, some federal, some mixed—rather than starting fresh with a single, integrated approach.[54]

The pattern is a recurring one of call and response between the states and the federal government. We present here some highlights of this long story.

A. An Abbreviated History of Federal Interventions in Health Care

During the colonial era and beyond the Revolutionary War, medical care was the domain of state and local governments when not being addressed by private charities. But even in the early days of the Republic, the federal government established payments for veterans' war injuries and, later, hospitals for veterans' care (as well as merchant seamen).[55] A series of federal laws

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[52] *See, e.g.*, Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (2016) (requiring only emergency medical treatment in hospitals); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-178, 117 Stat. 2066 (codified at 42 U.S.C. § 1395w-101 (2016)) (adding prescription drug coverage to Medicare only).

[53] THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 9-15 (Einer R. Elhauge ed., 2010).

[54] *See infra* Part III.A.

[55] *See* BARBARA MCCLURE, CONG. RESEARCH SERV., 83-99 EPW, MEDICAL CARE PROGRAMS OF THE VETERANS ADMINISTRATION 1-4 (1983) (tracing the history of the VA); TIMOTHY STOLTZFUS JOST, DISENTITLEMENT?: THE THREAT FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 77 (2003) (tracing various early federal payments for health care, including merchant seamen). In 1811, Congress deducted a portion of naval sailors' pay to care for war veterans' injuries; in 1833, Congress opened a naval hospital; and in 1851 Congress established a home for disabled soldiers. *See* MCCLURE, *supra*, at 1-2. There were fewer than fifty federal buildings outside of Washington D.C. in 1850, including courthouses, and hospitals numbered among them. JUDITH RESNIK & DENNIS CURTIS, REPRESENTING JUSTICE: INVENTION, CONTROVERSY, AND RIGHTS IN CITY-STATES AND DEMOCRATIC COURTROOMS 140-143 (2011).

offered increasing responses to states' inability to provide for veterans,[56] whose medical needs became even more pressing after the Civil War.[57] Ultimately, veterans' health care was fully federalized; Congress created the United States Veterans Bureau in 1921 to provide medical care for battle-injured World War I soldiers, then later the Veterans Administration covered all medical care for veterans.[58] The same year, Congress passed the Sheppard-Towner Maternity and Infancy Act of 1921, which for the first time put the federal government into the area of health and the family by providing states with funds for pre-natal and newborn care.[59]

The turn-of-the-century industrialization, and later the Great Depression, World Wars, and an influx of the war-wounded illuminated the states' inability to handle the relatively new phenomenon of medical policy or payment alone.[60] Although wealthier states were able to increase spending to pay for their swelling medically needy populations, most other states had no means to add health care to the list of welfare programs that they already supported, so states sought federal funding to care for the indigent.[61] President Roosevelt failed to get healthcare included in the Social Security Act of 1935 and again attempted it during World War II, followed closely by Senator Wagner's proposed National Health Act of 1939, which would have directed federal funds through state administration.[62] President Truman likewise attempted to achieve national

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[56] *See* VETERANS ADMIN., 90TH CONG., MEDICAL CARE OF VETERANS 30 (Comm. Print 1967).

[57] *Id.* at 59-62.

[58] MCCLURE, *supra* note 55, at 2-3.

[59] Office of the Historian, *Historical Highlights: The Sheppard-Towner Maternity and Infancy Act*, U.S. HOUSE OF REPRESENTATIVES, http://history.house.gov/Historical-Highlights/1901-1950/The-Sheppard-Towner-Maternity-and-Infancy-Act (last visited Dec. 27, 2017). Thanks to Rick Hills for this insight.

[60] ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 5-36 (1974) (detailing various federal interventions to assist states with their traditional role of providing both welfare and medical assistance throughout the early twentieth century).

[61] *See* STEVENS & STEVENS, *supra* note 60, at 7 (describing how the Federal Emergency Relief Administration took over states' welfare responsibilities during the Depression); Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 444 (2011) (describing states' inability to pay for welfare medicine).

[62] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 266-77 (1982). One contemporaneous scholar described the Act as "merely another step, albeit a long step, in the orderly development of existing federal health work, while the federal grants for medical care, and the disability compensation program, cannot be thought of as radical innovations, for they, too, have a broad body of precedent." Harold Maslow, *The Background of the Wagner National Health Bill*, 6 LAW & CONTEMP. PROBS. 606, 618 (1939).

health coverage,[63] but fears of "socialized medicine" proved then, as they have continued to be, an insurmountable obstacle to universal, nationalized reform.[64] After Truman's national health program[65] was rejected, Congress took the smaller step of encouraging the construction of hospitals where medical needs were unmet through the Hill-Burton Act of 1946.[66] In return for this federal funding, new Hill-Burton hospitals had to provide care to low income individuals, formalizing so-called charity care.[67]

During this period, developments in the courts confirmed that health care could largely be handled—as a matter of law—as a national, rather than a state or local, problem. In 1944, the Supreme Court ruled that insurance was national commerce and could be regulated by Congress as such.[68] But Congress, in a moment unappreciated by most federalism scholars (especially those unwilling to recognize the concept of federalism as a congressional *option*), voluntarily gave that power back to the states with the passage of the McCarran-Ferguson Act of 1945.[69] That Act created a presumption that regulation of insurance remains with the states, unless Congress explicitly states otherwise (as it did in the ACA).[70]

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[63] Special Message to the Congress Recommending a Comprehensive Health Program, 1945 PUB. PAPERS 475, 477, 490 (Nov. 19, 1945)

[64] In addition, opposition to national health insurance and other national benefits was rooted in part in racism and the "Southern question," meaning that southern states were fearful that the federal government would use national health programs as a mechanism to desegregate. *See* DAVID G. SMITH & JUDITH D. MOORE, MEDICAID POLITICS AND POLICY 1965-2007, at 10 (discussing race as part of the reason that efforts to install national health insurance failed). In addition, the American Medical Association fought national health programs as "socialized medicine." *Id*. at 25. The Journal of the American Medical Association went so far as to call President Truman's proposal an "attempt to enslave medicine . . . ." *Id*.

[65] *See* Special Message to the Congress Recommending a Comprehensive Health Program, *supra* note 63.

[66] Public Health Service Act, Pub. L. No. 78-410, § 215, 58 Stat. 682, 690 (1944) (codified at 42 U.S.C. § 216 (2016)); Pub. L. No. 93-641, §§ 1525, 1602(6), 88 Stat. 2225, 2249, 2259 (1975) (repealed 1979); 42 C.F.R. § 124 (2016) (setting forth community obligations for hospitals that receive Hill-Burton funding).

[67] 42 C.F.R. § 124.501 (2016).

[68] United States v. Se. Underwriters Ass'n, 322 U.S. 533, 552-53 (1944).

[69] *See* 15 U.S.C. § 6701 (2016).

[70] *See* 15 U.S.C. § 6701(b) ("No person shall engage in the business of insurance in a State . . . unless such person is licensed as required by the appropriate insurance regulator of such State in accordance with the relevant State insurance law . . . ."); *id.* § 6701(d)(4) ("No State statute, regulation, order, interpretation, or other action shall be preempted . . . to the extent that . . . it does not relate to, and is not issued and adopted, or enacted for the purpose of regulating . . . insurance . . . .").

Concomitantly, in 1942, the War Labor Board ruled that World War II-related wage controls did not apply to fringe benefits such as pensions and insurance,[71] and a few years later the National Labor Relations Board upheld unions' engagement in collective bargaining for benefits such as health insurance.[72] Such federal policies motivated employers to offer greater benefits to lure much-needed war-effort employees, helped further by an Internal Revenue Service ruling in 1943 that employer-based health care would not be taxable income for the employee.[73] Labor unions used this valuable benefit as a bargaining tool[74] throughout the late 1940s and into the 1950s,[75] and the IRS further pushed the trend by ruling in 1954 that employer-sponsored health insurance was not taxable to employee or employer.[76]

This significant series of interventions in private health insurance, as we have previously written, has turned out to be one of the most overlooked and underappreciated federal interventions in the typically state-based terrain of health insurance.[77] Modern policy experts who oppose the "socialization" of medicine (especially when it comes to health care for the poor), rarely acknowledge the more-than $200 billion each year that the federal government spent long before the ACA, subsidizing the health insurance of working Americans.[78] Employer-sponsored health insurance benefits still account for about 55% of health insurance coverage today,[79] rendering this tax subsidy—for the wealthier, non-Medicaid population, no less—a major ongoing federal intervention.

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[71] *See* TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 59-60 (2007) (expressing skepticism that the War Labor Board was responsible for employer-sponsored health insurance but was rather one of a number of factors leading the federal government to support it).

[72] COMM. ON EMP'R-BASED HEALTH BENEFITS, INST. OF MED., EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 70-71 (Marilyn J. Field & Harold T. Shapiro eds., 1993), https://www.ncbi.nlm.nih.gov/books/NBK235989 (detailing the birth of employer-sponsored health insurance); JOST, *supra* note 55, at 77-80 (describing the events that lead to the rapid growth of employer-sponsored health insurance); STARR, *supra* note 62, at 311.

[73] *See* JOST, *supra* note 55, at 77-79.

[74] For a thorough discussion of the role of labor unions in the growth of employer-sponsored health insurance, see JOST, *supra* note 71, at 62-64.

[75] *See* STARR, *supra* note 62, at 311-13.

[76] *See* JOST, *supra* note 55, at 79.

[77] *See* Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 16-17 (2016) (detailing the "hidden" subsidy of tax benefits for employer-sponsored health insurance benefits).

[78] *But see id.* at 18 (explaining how the CBO values this subsidy).

[79] JESSICA C. BARNETT & MARINA S. VORNOVITSKY, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2015, at 4 (2016), https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf.

Ongoing medical access failures led Congress to enact the Social Security Act Amendments of 1950, which provided federal grants-in-aid to states in the form of vendor payments, which were capped payments for specific services such as hospital, skilled nursing, and physician care.[80] The legislation delegated payment delivery to states and contained few requirements other than specifying which health care providers could be paid with federal money, allowing states and localities to vary widely in their use of the funding.[81] Even though vendor payments offered cost-shifting to the federal government while reinforcing the state role in medical services, many states resisted participating, in part because vendor payments were available only for individuals receiving welfare benefits. But increased federal funding improved participation over time.[82] With medical care tied to welfare administration, stigmatization of the medically needy population was virtually automatic.[83]

Congress's next notable intervention was the Kerr-Mills Act of 1960, which offered the states additional money and included funding for elderly who were "medically indigent" at a matching rate rather than a capped allocation.[84] The Kerr-Mills Act continued the connection between welfare and medical payments for non-elderly indigent individuals, allowing states to determine eligibility and coverage.[85] In sum, Kerr-Mills offered incremental reform with more federal money and some federal standard setting, staving off grander federal intervention while preserving states' role in health care.[86] States were in a slightly better economic position for the existence of Kerr-Mills, but wide variation in state implementation led to confusion, inconsistencies, and disparities in coverage and care, and state cost-shifting to the federal government in ways unintended by the law.[87] Further, even though wealthier

[80] Social Security Act Amendments of 1950, Pub. L. No. 81-734, Title III, 64 Stat. 477, 548-58 (codified as amended at 42 U.S.C. §§ 301, 302, 306 (2016)) (repealed 1974).

[81] *See* STEVENS & STEVENS, *supra* note 60, at 23-24 (describing state "variations" in implementing vendor payments).

[82] *See* Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, HEALTH CARE FINANCING REV., Winter 2005-2006, at 45, 45-46 (describing how vendor payments were augmented by the federal government through the 1950s, which increased state uptake).

[83] *See* SMITH & MOORE, *supra* note 64, at 30.

[84] *See* Kerr-Mills Social Security Act, Pub. L. No. 86-778, § 707, 74 Stat. 924, 995-97 (1960) (codified as amended in scattered sections of 42 U.S.C.); Moore & Smith, *supra* note 82, at 46 ("A most important innovation in the Kerr-Mills Act was to extend medical benefits to a new category generally known as the medically indigent.").

[85] *See* Kerr-Mills Act Social Security Act § 707, 74 Stat. at 995-97; SMITH & MOORE, *supra* note 64, at 31.

[86] *See* Huberfeld, *supra* note 61, at 443-44.

[87] SUBCOMM. ON HEALTH OF THE ELDERLY, SPECIAL COMM. ON AGING, MEDICAL ASSISTANCE FOR THE AGED: THE KERR-MILLS PROGRAM 1960-1963, S. Rep. 22-449, at 1 (1963),

and heavily industrialized states were eager to take advantage of federal funds—New York, California, and Massachusetts accounted for more than half of enrollees—many poorer states were reluctant to participate.[88]

Poor states needed more funding for healthcare, but some did not have the necessary matching funds of their own to afford the federal assistance.[89] Many of these states—especially in the South—also had particular anxieties about federal intervention in areas involving both the family and minority populations.[90] This led those states to resist federal funding outright or to allow only limited participation,[91] and, with later federal reforms, to insist on structures that gave states control over their minority populations. This combination of distrust, conservative values, and racism also led states to demand a continued role for themselves in managing the federal distributions and preserving the political economy of the region.[92] It further allowed for less

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https://www.aging.senate.gov/imo/media/doc/reports/rpt263.pdf (giving a harsh assessment of Kerr-Mills' failure to assist the elderly shortly after enactment).

[88] *See* Moore & Smith, *supra* note 82, at 46-47.

[89] *See id.* (noting poorer states were stingy with welfare, which carried over to medical welfare); *see also* STARR, *supra* note 62, at 368-70 (laying out historical developments before Medicaid and noting that the most industrialized states were most likely to participate in federal funding).

[90] *See* Timothy Stoltzfus Jost, Remarks at the Medicare and Medicaid at 50 Conference at Yale Law School 6-7 (Nov. 7, 2014) (transcript on file with authors) (detailing racist motivations for Southern states to resist Medicaid's public health insurance for the poor at its inception and throughout Medicaid's history). Opposition to national health insurance and other national benefits was rooted in part in racism and the Southern drive for cheap agricultural labor, meaning that Southern states were fearful that the federal government would use national health programs as a tool to desegregate. In fact, Medicaid's devolution to states to determine eligibility and benefit levels can be directly traced to Senator Byrd's efforts to defeat any possible federal interjection into "the Negro question." *See* SMITH & MOORE, *supra* note 67, at 10 (discussing race as part of the reason that efforts to instill national health insurance have failed). And, part of the reason that Medicaid contains the very specific EPSDT requirement of a "comprehensive unclothed physical exam," *see* 42 U.S.C. §1396d(r)(1)(B)(ii), is that Southern doctors would not have touched African-American children without a federal rule telling them otherwise; when the Reagan Administration tried to remove this requirement in 1981, the director of EPSDT from Mississippi's Medicaid agency demanded that it remain for fear that "doctors [would] stop taking clothes off Black children to examine them," Email from Sara Rosenbaum, Professor of Health Law and Policy, George Washington Univ. School of Public Health, to Nicole Huberfeld, Professor of Health Law, Ethics & Human Rights, Bos. Univ. Sch. of Public Health and Sch. of Law (Aug. 25, 2017, 2:08 PM EDT) (on file with authors).

[91] *See* SMITH & MOORE, *supra* note 64, at 40 (noting that states in the South, the Southwest, and those with "rural or sparsely populated areas" were holdouts). After five years, ten states still opted out, and three states had authorized use of federal funds but had not allocated state funds required for the federal match. *See* Moore & Smith, *supra* note 82, at 47.

[92] *See* SUZANNE METTLER, DIVIDING CITIZENS: GENDER AND FEDERALISM IN NEW DEAL PUBLIC POLICY 61 (1998).

aggressive implementation by some states less eager to assist minority populations,[93] entrenching interstate coverage disparities.

By the early 1960s, it was clear that more help was needed beyond existing state assistance for needy populations.[94] First introduced by President Kennedy, and enacted under the Johnson Administration's War on Poverty in 1965, Medicare offered a radically different approach for the elderly with a fully nationalized program for all elderly designed to offer what was then comprehensive health insurance (hospital and physician care, not just one or the other).[95] It was to be funded and administered entirely by the federal government with no role preserved for states.[96] This shift to a totally federalized scheme resulted in part from successful lobbying by the elderly, who did not want their access to medical care to fluctuate depending on the economic whims and welfare biases of the states.[97] But also, Medicare was enacted as a federal program because states did not want to be responsible for elderly medical needs, evidenced in part by slow uptake of prior programs.[98]

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[93] *See id*. at 75.

[94] Another example of incremental federal intervention was the 1964 law that allowed creation of community health centers as demonstration projects, *see* Economic Opportunity Act of 1964, Pub. L. No. 88-452, 78 Stat. 508, 518 which became a permanent feature of the federal health care landscape in 1975, *see* Special Health Revenue Sharing Act of 1975, Pub. L. No. 94-63, tit. 1, 89 Stat. 304. Community health centers were part of a larger federal War on Poverty and remain a key feature of care for low income populations today. *See generally* SARA ROSENBAUM ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, COMMUNITY HEALTH CENTERS IN AN ERA OF HEALTH SYSTEM REFORM AND ECONOMIC DOWNTURN: PROSPECTS AND CHALLENGES (2009), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7876.pdf (detailing the legacy and ongoing central role of community health centers in the healthcare system).

[95] *See* STEVENS & STEVENS, *supra* note 60, at 46-49.

[96] *See* SMITH & MOORE, *supra* note 64, at 47, 52. *See generally* 42 U.S.C. §§ 1395-1395lll (2016) (codifying Medicare).

[97] According to one presidential historian, Kennedy was "indignant that government officials like him received much better care than the average American. He acidly noted in private that his predecessor [Eisenhower] would deride the notion of government-sponsored care for older Americans as socialized medicine before 'getting into his limousine' to enjoy free treatment at [Walter Reed Medical Center]." Michael Beschloss, *After Health Bill's Defeat, What Trump Can Learn from L.B.J.*, N.Y. TIMES (Mar. 31, 2017), https://www.nytimes.com/2017/03/31/business/trump-health-care-lyndon-johnson-medicare.html.

[98] *See* SMITH & MOORE, *supra* note 64, at 41 (noting that "many states were too poor or unwilling . . . to put up matching funds" for Old Age Assistance and other medical welfare programs that predated Medicaid); STEVENS & STEVENS, *supra* note 60, at 30-33 (arguing that although Kerr-Mills was a way to shift the "burden of that aid from others to the federal government," the "states responded slowly to the new program").

The push for nationalization did not extend to the nonelderly poor.[99] Although the Medicaid Act was enacted with the same pen stroke as Medicare, Medicaid was structured differently, offering federal funding and statutory baselines while continuing shared state financing and a state-driven, welfare-based approach to health care that encoded a philosophy of aiding only the "deserving poor"[100]—and keeping state control over those populations—that continued until the ACA.[101] Medicaid was not part of the political push for Great Society programs that resulted in a uniform social safety net for the elderly. Instead, as a last minute practical compromise, Representative Mills proposed that Kerr-Mills be extended and expanded to influence states to cover welfare populations such as the blind, disabled, young children, and their parents[102]—in other words, the very same populations that had been deemed "worthy" of government assistance since the colonial era.[103] Thus, the distinction between social insurance and welfare that was originally encoded in the first Social Security Act was carried through into the statutory principles that underlie the differences between Medicare and Medicaid (and are still being debated today).[104]

Medicare has been modified from time to time, for example covering the permanently disabled in 1972,[105] or adding a major drug benefit in 2003,[106] but it tends to avoid the same kind of frequent tinkering seen elsewhere in health care law. On the other hand, Medicaid has seen much more significant modification over time, often reflecting the larger pattern of federal incremental intervention where state governance is failing. For example, Medicaid has been amended to increase coverage categories and financial

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[99] *See* PAUL E. PETERSON, THE PRICE OF FEDERALISM 27-34 (1995) (arguing that because state governments have pressures to avoid redistribution, those kinds of reforms focused on the poor are better suited to the national government). Medicare and Medicaid have always been linked for poor elderly who cannot pay out-of-pocket costs. Thanks to Sara Rosenbaum for this insight.

[100] *See* Huberfeld, *supra* note 64, at 436-46.

[101] *See* Jost, *supra* note 90 (discussing this progression and the link between state control of health care and continued limitations on serving all of the poor).

[102] *See* LAURA KATZ OLSON, THE POLITICS OF MEDICAID 24-25 (2010) (describing Mills' three-part plan for reform, with Medicaid building on Kerr-Mills).

[103] *See* Huberfeld, *supra* note 61, at 439-40.

[104] *See* Jost, *supra* note 90. *See generally* Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L., & ETHICS 67 (2015) (exploring the historically exclusionary approach to U.S. health care).

[105] Social Security Amendments of 1972, Pub. L. No. 92-603, tit. ii, § 201(a)(3), 86 Stat. 1329, 1371, *reprinted in* 42 U.S.C. § 1395j app. at 2591 (2016).

[106] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-152 (codified as amended at 42 U.S.C. § 1395w-101 (2016)).

eligibility levels over time. In the 1980s, for instance, eligibility was expanded to cover all children up to age eighteen and children up to age six at even higher levels of financial eligibility.[107] Also, in 1989, the singular EPSDT benefit (which ensures uniform, comprehensive medical benefits for children) was made mandatory for states, though it had been optional since 1967.[108] In each instance, the federal government was stepping in where states failed to serve certain populations' medical needs. Medicaid was decoupled from welfare in the 1990s after President Clinton's health care reform failed and the Gingrich plan for block grants was defeated, a legislative change that unenrolled vulnerable people (but that also set the stage for the ACA's expansion to all of the nation's poor in 2010).[109] Further, Medicaid laid both a foundation and acted as a foil for the State Children's Health Insurance Program of 1997 (then "SCHIP," now "CHIP"), a federal block grant that allows states to subsidize coverage for children at higher financial eligibility levels than Medicaid after the Clinton health plan failed to create comprehensive coverage in 1994.[110]

Every president from Theodore Roosevelt to Barack Obama tried to expand health care access.[111] After Medicare and Medicaid, in the early 1970s,

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[107] *See* SMITH & MOORE, *supra* note 64, at 133-36; Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1, 20-24 (2013) (detailing amendments to Medicaid that expanded eligibility, such as for pregnant women and children).

[108] 42 U.S.C. § 1396d(r) (2016) (defining the current EPSDT benefit). Congress realized that states were bypassing the optional EPSDT benefit and created a highly detailed list of rules for screening children regularly. *See* S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 589-90 (5th Cir. 2004) (detailing the history and purpose of EPSDT's 1989 switch to mandatory benefit).

[109] *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of the U.S. Code (creating the Temporary Assistance for Needy Families (TANF) program).

[110] *See* 42 U.S.C. § 1397aa-mm. (2016) (codifying the current CHIP program). *See generally* Sara Rosenbaum et al., *The Children's Hour: The State Children's Health Insurance Program*, HEALTH AFF., Jan./Feb. 1998, at 75 (discussing features of CHIP and expressing concern that the flexibility CHIP offered would lead states to move some Medicaid populations to CHIP, which offered fewer protections to beneficiaries).

[111] *See, e.g.*, PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 4 (2011) (noting a century of effort in health reform); STARR, *supra* note 62, at 235-449 (describing the history of efforts in American health care reform). Mr. Trump campaigned on a universal access platform, *see, e.g.*, Aaron Blake, *Trump's Forbidden Love: Single-Payer Health Care*, WASH. POST (May 5, 2017), https://www.washingtonpost.com/news/the-fix/wp/2017/05/05/trumps-forbidden-love-singe-payer-health-care/?utm_term=.0e2b908218a2 ("Everybody's got to be covered."), but quickly moved to undermine the ACA and repeal many of its most generous provisions, *see, e.g.*, Robert Pear et al., *Trump to Scrap Critical Health Care Subsidies, Hitting Obamacare Again*, N.Y. TIMES (Oct. 12, 2017), https://www.nytimes.com/2017/10/12/us/politics/trump-obamacare-executive-order-health-

President Nixon promoted a new format for private insurance that was modeled on organizations like Kaiser Permanente[112] (also embraced by President Obama in the ACA[113]). Nixon's Health Maintenance Organization Act of 1973[114] preempted conflicting state laws and offered funding to support the creation of health management organizations, commonly known as HMOs.[115] The Employee Retirement Income Security Act of 1974 (ERISA)[116] was also passed under the Nixon Administration. Although primarily conceived as a federal floor of rules addressing the problem of failed pensions, ERISA effectively (and mostly accidentally) nationalized the rules for a wide swath of health plans—those provided by employers who self-insure employee health benefits—immunizing them from state regulations.[117] ERISA has remained a major obstacle to state-based health policy reform.[118]

In the 1980s, Congress further expanded the federal baseline by enacting two important budget bills that transformed, in an effort to increase uniformity, Medicare physician payments[119] and the continuation of employer-sponsored health coverage at the termination of employment.[120] The second of these bills also contained a provision that prevents patient dumping and requires hospitals

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insurance.html?hp&action=click&pgtype=Homepage&clickSource=story-heading&module=first-column-region&region=top-news&WT.nav=top-news.

[112] *See* STARR, *supra* note 62, at 394-405.

[113] *See* Phil Galewitz, *Nixon's HMOs Hold Lessons for Obama's ACOs*, KAISER HEALTH NEWS (Oct. 21, 2011), https://khn.org/news/nixons-hmos-hold-lessons-for-obamas-acos/.

[114] Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified as amended at 42 U.S.C. §§ 300e-300e-17 (2016)).

[115] *See* Marjorie Smith Mueller, *Health Maintenance Organization Act of 1973*, SOC. SECURITY BULL., Mar. 1974, at 35, 35, 38.

[116] Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 and 29 U.S.C.).

[117] Randall R. Bovbjerg, *Alternative Models of Federalism: Health Insurance Regulation and Patient Protection Laws*, *in* FEDERALISM AND HEALTH POLICY, *supra* note 17, at 361, 365 (describing ERISA's increased preemptive sweep as more employers turned to self-funded health benefits).

[118] *See* Abbe R. Gluck et al., *ERISA: A Bipartisan Problem for the ACA and the AHCA*, HEALTH AFF. BLOG (June 2, 2017), http://healthaffairs.org/blog/2017/06/02/erisa-a-bipartisan-problem-for-the-aca-and-the-ahca (explaining that the Congress that passed ERISA did not foresee its major impact on health care and detailing impediments to state reform caused by the statute's reach); *see also*, *e.g.*, Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 947 (2016) (holding ERISA preempts Vermont's state all-payer claims database).

[119] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6104, 103 Stat. 2106, 2208 (terminating the "reasonable charge" method of reimbursing physicians in Medicare and replacing reasonable charges with a relative value scale (RBRVS) method of payment).

[120] *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 10002(a), 100 Stat. 82, 227-32 (1986) (codified as amended at 29 U.S.C. §§ 1161-1168 (2016)).

to treat patients who present with an emergency medical condition, commonly called the Emergency Medical Treatment and Labor Act (EMTALA).[121] President Reagan supported these federal interventions in traditionally state-based health care.[122]

After the Clinton health reform effort failed in 1993, prominent academics argued that states would have to pick up the mantle of health reform.[123] That largely did not occur. Instead, the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[124] next addressed ongoing private insurance market failures. HIPAA facilitated credit for insurance coverage when an employee moved from one job to another within a short period of time ("portability"), offered incentives for creating medical savings accounts to try to address the continually growing problem of uninsurance, and facilitated the growth of high risk pools in the states.[125] HIPAA did not preempt state laws regarding health insurance so long as they met the federal baseline of facilitating continued coverage for pre-existing conditions, thereby, like its predecessors, allowing states to continue in their historic role of regulating insurance but with federal statutory guiderails.[126] A number of the ACA's reforms are in fact amendments to these predecessor federal interventions, including ERISA and HIPAA, and in part respond to perceived failures in those statutes to improve health care markets and the difficulties for those with pre-existing conditions.[127]

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[121] *Id.*§ 9121(b), 100 Stat. at 164-65 (codified as amended at 42 U.S.C. § 1395dd (2016)).

[122] Though the Reagan Administration's support for these federal interventions might seem counterintuitive, the finances of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and EMTALA were consistent with President Reagan's desire to prevent any additional taxing or spending by the federal government. To wit: COBRA's cost was borne by a departed employee, who could be asked to pay up to 102% of the employer's cost of providing health insurance. *See id.* tit. x, sec. 10002(a), § 602(3), 100 Stat. at 228 (codified as amended at 29 U.S.C. §§ 1162(3) (2016)). EMTALA's cost was borne by hospitals, which were forced to comply with EMTALA requirements under the theory that other aspects of Medicare cross-subsidized EMTALA, which was not separately or specifically funded. *See id.* § 9121(b), 100 Stat. at 164-65 (codified as amended at 42 U.S.C. § 1395dd (2016)).

[123] *See* Jerry L. Mashaw & Theodore R. Marmor, Commentary, *The Case for Federalism and Health Reform*, 28 CONN. L. REV. 115, 117 (1995).

[124] Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of the U.S. Code).

[125] *See* JOST, *supra* note 55, at 188-89 (discussing HIPAA's features, including interaction with employer-sponsored health insurance and attempts at regulating failing small group markets).

[126] *See* Bovbjerg, *supra* note 117, at 367 (describing HIPAA's structure).

[127] *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1561, 124 Stat. 119, 262 (2010) (codified as amended at 42 U.S.C. § 300jj-51 (2016)) (amending the Public Health Services Act); *id.* § 1562(e), 124 Stat. at 270 (codified at 29 U.S.C. § 1185d

In 2003 Congress enacted the most noteworthy benefit amendment to Medicare since its creation—a prescription drug benefit, supported by the second President Bush.[128] A few years later, the Health Information Technology for Economic and Clinical Health (HITECH) Act implemented a part of HIPAA pertaining to electronic health records (EHRs) by setting federal standards and offering grants to states for improved electronic medical records.[129] Promoting EHRs was long a priority of the second President Bush, and HITECH was enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA)[130] at the beginning of the Obama Administration. ARRA also included increased federal funding for Medicaid to the states to help them overcome increased enrollment related to the Great Recession.[131]

This is a long history, and it does not even include the parallel development of federal intervention in and regulation of the terrain of pharmaceutical innovation and approval.[132] Notably, although certain health care reform ideas tend to be floated from the right or the left, this history is not nearly as politicized as common understanding would have it. To be sure, Democrats supported programs such as the Social Security Act, Medicare, Medicaid, and the ACA, but Republicans created the HMO Act of 1973, ERISA, COBRA, EMTALA, CHIP, and Medicare Part D.[133] Pressure for health care intervention occurs on nearly every Congress's watch.

B. Patterns of National Intervention

Some notable patterns appear. First, the states' consistent need for federal support in times of economic stress underscores the importance of countercy-

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(2016)) (amending ERISA); *id.* § 1104(a), 124 Stat. at 146, *reprinted in* 42 U.S.C. § 1320d app. at 2347 (2016) (amending HIPAA).

[128] *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101(a), 117 Stat. 2066, 2071-72 (codified at 42 U.S.C. § 1395w-101 (2016)).

[129] *See* American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, sec. 13101, § 3001, 123 Stat. 115, 230-34 (codified as amended at 42 U.S.C. § 300jj-11 (2016)); *id.* sec. 13301, § 3013, 123 Stat. at 250-52 (codified at 42 U.S.C. § 300jj-33 (2016)) (establishing standards for grants to states).

[130] *Id.* §§ 13001-13424, 123 Stat. at 226-79 (codified as amended in scattered sections of 42 U.S.C.).

[131] *Id.* § 5000(a), 123 Stat. at 496, *reprinted in* 42 U.S.C. § 1396a app. at 3571-72 (2016).

[132] *See, e.g.*, Federal Foods and Drug Act of 1906, Pub. L. No. 59-384, 34 Stat. 768 (repealed 1938); *see also Milestones in U.S. Food and Drug Law History*, U.S. FOOD & DRUG ADMIN, https://www.fda.gov/AboutFDA/WhatWeDo/History (last visited Dec. 8, 2017) (detailing federal statutes regulating food, drugs, cosmetics and devices through the last century and more).

[133] *See supra* notes **Error! Bookmark not defined.**-131 and accompanying text.

clical spending in making some federal intervention almost inevitable.[134] During a recession, unemployment increases and health insurance coverage decreases, but income taxes decline at the same time, leading states to lose funding at the moment their citizenry most needs governmental supports.[135] Most state constitutions require balanced budgets,[136] so states seek federal money to fill their gaps because the federal government can engage in deficit spending and respond to states' needs.

Second, the same states do the same things over and over again.[137] Southern states and states with limited resources hold out; wealthier states like New York, Massachusetts, and California spend on social welfare programming but also maximize available federal money.[138] Discrimination based on race and class continues due to persistent echoes of welfare policy and stigmatization of the poor in health care reform efforts.[139] Even today, for example, we hear echoes of this history in calls to remove the so-called "able bodied" from Medicaid eligibility or to add work requirements when they are enrolled (most Medicaid-eligible households do contain workers).[140] The ACA

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[134] *See* David A. Super, *Rethinking Fiscal Federalism*, 118 HARV. L. REV. 2544, 2641-42 (2005) (describing how state political and budgetary structures make states ill prepared to support social services in financial emergencies and times of economic distress).

[135] *See id.* at 2629-39.

[136] *See* NAT'L CONFERENCE OF STATE LEGISLATURES, NCSL FISCAL BRIEF: STATE BALANCED BUDGET PROVISIONS 2 (2010), http://www.ncsl.org/documents/fiscal/StateBalancedBudgetProvisions2010.pdf.

[137] *See* Huberfeld, *supra* note 61, at 436-49 (discussing path dependence in health care policy, especially in Medicaid).

[138] A fuller description of this phenomenon in the context of the Kerr-Mills regime is provided above. *See supra* notes 84-102 and accompanying text.

[139] *See generally* Huberfeld & Roberts, *supra* note 77, at 41-59 (discussing how people who need public health insurance are subjected to "self-reliance scrutiny" while people who receive subsidies for purchasing private insurance are not, under the ACA as implemented).

[140] *See, e.g.*, RACHEL GARFIELD ET AL., HENRY J. KAISER FAMILY FOUND., UNDERSTANDING THE INTERSECTION OF MEDICAID AND WORK 1-3 (2018), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work; Phil Galewitz, *Medicaid Chief Says Feds Are Willing to Approve Work Requirements*, KAISER HEALTH NEWS (Nov. 7, 2017, 3:20 PM), https://khn.org/news/medicaid-chief-suggests-feds-are-willing-now-to-approve-work-requirements. CMS Administrator Seema Verma stated: "The thought that a program designed for our most vulnerable citizens should be used as a vehicle to serve the working-age, able-bodied adults does not make sense, but the prior administration fought state-led reforms that would've allowed the Medicaid program to evolve." *Id.* CMS issued guidance for states interested in adding work requirements as this paper was going to press. U.S. DEP'T OF HEALTH & HUMAN SERVS., SMD NO. 18-002, GUIDANCE ON OPPORTUNITIES TO PROMOTE WORK AND COMMUNITY ENGAGEMENT AMONG MEDICAID BENEFICIARIES (2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

rejected such castigatory thinking,[141] but new proposals aim to introduce work requirements and are being approved as this paper goes to press.[142]

Third, most of the federal interventions have been incremental and fragmented. This is a key place where federalism and health policy intersect. Political scientists have consistently demonstrated that Congress legislates across all areas (not just health care) in piecemeal fashion.[143] Many reasons exist for policy incrementalism, including the numerous barriers to lawmaking of any sort in Congress and the difficulty of attaining consensus in a polity as diverse and populous as ours.[144] But, as one of us has argued, a link exists between Congress's tendency toward policy incrementalism and the design of federal statutes that rely on state administration.[145] The historical backdrop of state social policy regulation creates both political and pragmatic incentives for Congress to rely on, rather than to displace, the embedded state administrative apparatus.[146] As a political matter, federalism-related concerns about big government and respect for traditional areas of state authority lead Congress to design federal schemes that give states large roles in administration. Politically, it seems like less of a displacement, and like less expansion of government, to structure federal programs this way.[147] Pragmatically, in addition to the lack of sufficient federal personnel, established state bureaucracies provide ready experts to implement new federal legislation.[148]

The result in health care is a policy design that has been criticized for being structurally fragmented in multiple ways.[149] All of the federal interventions discussed above have different structures. The Veterans Health Administration is structured differently from Medicare, even though both are purely national

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[141] *See* Huberfeld, *supra* note 104, at 67-68 (contrasting the universality principle of the ACA with exclusionary practices in health care laws that predated it).

[142] *See* Huberfeld & Roberts, *supra* note 77, at 5-6; *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS., Letter to Adam Meier from Brian Neale, Jan. 12, 2018, at https://kaiserhealthnews.files.wordpress.com/2018/01/kentucky-1115-memo-and-approval-ltr.pdf (approving Kentucky's application for a Section 1115 waiver with work requirements for newly eligible beneficiaries); GARFIELD ET AL., *supra* note 140, at 4 (listing states that proposed work requirements).

[143] For the classic statement of this point, see generally Charles E. Lindblom, *The Science of "Muddling Through,"* 19 PUB. ADMIN. REV. 79 (1959), documenting the incremental and piecemeal nature of American policymaking and offering reasons to explain this phenomenon.

[144] *See id.* at 84-85.

[145] *See* Gluck, *supra* note 1, at 572-74.

[146] *See id.* at 572.

[147] *See id.* at 572-73.

[148] *See id.* at 572.

[149] *See* ELHAUGE, *supra* note 53.

programs; Medicaid's state-federal partnership is uniquely structured in its open-ended match for state spending,[150] and block grants to states in programs such as HITECH, CHIP, and the ACA's exchanges are each differently designed.[151] A huge chunk of the private insurance market rests on the employer tax deduction—yet another entirely different structure of federal financing.[152]

This fragmented structure leads different populations in our system to access health care in different ways, variation that fosters disparities and inefficiencies. Likewise, rather than wipe the slate clean to build a new, unified system from the ground up, the ACA's main components are drawn from these preexisting programs, each one the product of an incremental legislative moment. And because those earlier efforts also largely depended on state bureaucracies, the incremental way in which Congress has intervened in health care has reinforced the states' role, even within a more robust national framework.[153]

C. Theoretical Underpinnings of Health Care Federalism

Before the enactment of the ACA, the most important works in health care federalism dated to the late 1990s/early 2000s and were largely autopsies of the Clinton health reform effort. That scholarship was marked by a then-new recognition that federalism in health policy could no longer be understood through the classic constitutional model: an either/or separate spheres model that asks *which* government (state or federal) has control over a particular facet of health policy.[154] With failed national reform in the rearview mirror, a consensus among federalism scholars emerged that some kind of joint state-

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[150] *See* 42 U.S.C. § 1396-1 (2016).

[151] *Compare* 42 U.S.C. § 300jj-31 (2016) (providing HITECH funding for health care entities), *with* 42 U.S.C. § 300jj-33 (2016) (offering grants to states to develop HIT), *and* 42 U.S.C. § 1397aa & dd (2016) (creating CHIP as a federal block grant offered annually to states). For discussion of Exchange design, see Part V below.

[152] *See* MATTHEW RAE ET AL., HENRY J. KAISER FAMILY FOUND., TAX SUBSIDIES FOR PRIVATE HEALTH INSURANCE 1 (2014), http://files.kff.org/attachment/tax-subsidies-for-private-health-insurance-issue-brief ("The largest tax subsidy for private health insurance—the exclusion from income and payroll taxes of employer and employee contributions for employer-sponsored insurance (ESI)—was estimated to cost approximately $250 billion in lost federal tax revenue in 2013.").

[153] *See* Gluck, *supra* note 1, at 572-74.

[154] *See generally* Bovbjerg, *supra* note 117, at 361-89 (describing states' and federal government's roles in developing particular health care policies); Robert F. Rich & William D. White, *The American States, Federalism, and the Future of Health Care Policy*, *in* HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES 293-96 (Robert F. Rich & William D. White eds., 1996) (predicting a move "toward a reduced federal role and an increased state role in setting [health] policy, as well as in administering and financing it.").

federal model would be necessary.[155] Although proposal specifics varied, they coalesced around arguments for a system in which at least some minimum standards were set by the federal government and in which states could benefit from federal funds.[156] Being relatively new theoretical and policy terrain, the earlier scholarship did not go much farther than that. Specifically, little, if anything, was written on the kind of negotiating relationships that mark collaborative federalism schemes, or on other dynamics of implementation, including complications posed by intrastate politics or the salient role for Congress in any model in which the federalism is structured by an overarching national law.[157]

Fast forward to the recent attempts at "postmortems" on the ACA and Republican proposals to replace it. Federalists critical of the ACA argue for a return to "states' rights" in health care.[158] Some depict the ACA as an unconstitutional violator of state authority.[159]

These characterizations are deeply mistaken as a matter of both basic constitutional law and federalism theory. They also distract from the main questions. Federalism scholars who criticize the ACA in the name of the Constitution do not propose in its stead a wholesale return of insurance market governance or oversight of low income populations (Medicaid) to states, nor do they advance a theory of why the federal government is legally restricted in so regulating.[160] Instead, each counterproposal, in the name of constitutional "states' rights," would *retain* a supervisory, preemptive role for the federal government. For example, the bill that passed the House in May 2017, the

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[155] *See, e.g.*, Holahan et al., *supra* note 17, at 6-7.

[156] *See* Bovbjerg, *supra* note 117, at 380-83; Mashaw & Marmor, *supra* note 123, at 117-18; Rich & White, *supra* note 154, at 293-300.

[157] This scholarship has only recently begun to emerge in other fields. *See, e.g.*, Ryan, *supra* note **Error! Bookmark not defined.**, at 1152-55 (discussing intergovernmental bargaining in modern environmental federalism).

[158] *See* Bagley, *supra* note **Error! Bookmark not defined.**, at 2-3 (describing the states' rights federalism narrative).

[159] *See, e.g.*, Sally C. Pipes, *Obamacare Runs Roughshod Over Separation of Powers*, U.S. NEWS (Mar. 3, 2015, 12:23 PM), https://www.usnews.com/debate-club/should-the-supreme-court-strike-down-obamacare-subsidies-in-king-v-burwell/obamacare-runs-rougshod-over-separation-of-powers; Jay Sekulow, *Supreme Court Again Rewrites ObamaCare*, AM. CTR FOR L. & JUST. (June 25, 2015), https://aclj.org/obamacare/supreme-court-again-rewrites-obamacare-without-constitutional-authority ("It is troubling that the high court backed the Obama Administration's overreach in its ongoing effort to rewrite or suspend portions of the ACA (Affordable Care Act), in violation of the separation of powers."); Ilya Shapiro, *President Obama's Top Ten Constitutional Violations of 2015*, NAT'L REV. (Dec. 23, 2015), http://www.nationalreview.com/article/428882/obama-violates-constitution-let-us-count-ways-2015-edition (arguing that the ACA is a "constitutional abuse[]").

[160] *See* sources cited *supra* note 159.

"American Health Care Act," made cuts but still would have retained the Medicaid program and the basic requirements on insurers to insure all Americans without discriminating based on health risk.[161] The Graham-Cassidy proposal in the Senate, in many ways the most radical proposal offered, would have given the states more choices about how to spend federal dollars to satisfy federal policy floors, but still funded state health policy and retained federal requirements in the form of continuing the federal Medicaid program and imposing federal requirements on state insurance markets.[162]

This is *not* a different kind of "federalism" from the ACA. The difference lies only in the policy *choices*—whatever baseline Congress sets and how much discretion Congress gives states within the statutory framework—all made within a national superstructure with delegated state-led elements. That argument is not about constitutional federalism, or any other fundamental structural difference.[163] It is, rather, about policy choices within the same structural paradigm that we currently have: a statute-based, state-federal cooperative regime.

In other words, the suggested models for federalism post-ACA *are the same models* as the ACA's federalism. Every proposal involves a federal superstructure that allows for state variation within a proscribed framework.[164] Recognition of this point is key, because it illustrates the irrelevance of classic dual-sovereignty federalism theory in the health care sphere. Instead, we have a recognition dating to 1944 that Congress has the power, when it desires to use it, to regulate insurance markets.[165] This is not to say that Congress may not always choose the right means, but when structured correctly and legally

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[161] *See* American Health Care Act of 2017, H.R. 1628, 115th Cong. §§ 111-117 (as passed by House, May 4, 2017). The bill included more flexible waiver options with respect to what benefits must be covered. Anna Edgerton et al., *House Passes Obamacare Repeal in Razor-Thin GOP Victory*, BLOOMBERG (May 4, 2017, 12:36 PM PDT), https://www.bloomberg.com/news/articles/2017-05-04/house-passes-obamacare-repeal-in-razor-thin-republican-victory.

[162] *See* S. Amend. 1030 to H.R. 1628, 115th Cong., 163 CONG. REC. S5682-95 (as proposed Sept. 13, 2017); *see also* Sarah Kliff, *Graham-Cassidy: The Last GOP Health Plan Left Standing, Explained*, VOX (Sept. 13, 2017, 2:47 PM EDT), https://www.vox.com/policy-and-politics/2017/8/1/16074746/cassidy-graham-obamacare-repeal.

[163] For one example of this misunderstanding, *see* Bagley, *supra* note **Error! Bookmark not defined.**, at 17, arguing that the ACA's prohibition of charging older people more than three times more for insurance than younger people violates federalism because that is a "value judgment" and that such judgments should be left to the states but with nationally set baselines.

[164] *See, e.g.*, H.R. 1628 (leaving federal requirements in place but giving states additional flexibility).

[165] *See* United States v. Se. Underwriters Ass'n, 322 U.S. 533, 553 (1944) (upholding Congress's power to regulate the business of insurance under the Commerce Clause).

Congress can constitutionally regulate.[166] The substance of the current Republican proposals proves the consensus on that point. It also reveals an apparent consensus that some federal intervention is in fact warranted—or that, at a minimum, once it is given it is hard to take away (points supported by our history above). The question now is what that intervention should be, not which governments should be involved.

This is where we see weaknesses in arguments of colleagues like our friend Professor Nicholas Bagley, who argues, in this vein, that it would "spell[] the end of federalism" if federal intervention in health policy (like the ACA's) were justified solely by virtue of unwise or unjust policymaking by the states.[167] In direct tension with such statements, commentators like Bagley himself *still* argue for Congress to set some baselines—precisely because those scholars disagree with some aspects of state policy, want some policy decisions nationalized, and wish to have and eat the cake alike.[168] The fact is that health care statutes today squarely align in their structure with other federal laws like the Clean Air Act and Occupational Safety and Health Act of 1970 (OSHA), which set national baselines in the face of state regulatory failures but still preserve key roles for states as thought leaders.[169] That is modern federalism, and it is precisely how Congress now regulates in many areas once traditionally considered state domain.

A few other points need to be made here, because they tend to be over-looked by formalist federalists writing about health care. One important reason that health care reform tends to be driven from above, through federal law, is that state-level reform through either legislatures or courts is not likely, even though such local reforms have driven national reforms in other areas, such as same-sex marriage.[170] When it comes to legislative reform, it is very difficult for states to experiment in health policy without federal assistance both in funding and in standard setting. Experimenting is risky and expensive. In the case of demanding insurance standards, costs will rise and insurers may

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[166] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588 (2012) (holding that Congress could pass the individual insurance mandate as a tax rather than under its Commerce Clause power).

[167] *See* Bagley, *supra* note **Error! Bookmark not defined.**, at 9.

[168] *See e.g.*, *id.* at 3, 19-20; *see also* Health Reform Roundtable, Convergence Ctr. for Policy Resolution, A Bipartisan Answer to "What Now?" for Health Reform 2 (2017), http://www.convergencepolicy.org/wp-content/uploads/2017/06/FINAL-Roundtable-statement-8.7.17.pdf (publicizing a bipartisan group advocating for state flexibility and federal "guardrails").

[169] *See generally* Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-78 (2016) (2016); Clean Air Act, 42 U.S.C. §§ 7401-7761q (2016).

[170] *See, e.g.*, Bagley, *supra* note **Error! Bookmark not defined.**, at 2-3 (suggesting the marriage context is an apt comparison).

withdraw from state markets with such requirements.[171] (Remember Massachusetts's experiment in universal coverage was funded and facilitated by a Medicaid demonstration waiver; it was not a solo state experiment.)[172] Indeed, those very facts are frequently cited in policy literature as a reason why states do not experiment in health policy at the level that traditional federalism theory would predict.[173] State health policy is pushed, collectively, in a race to the bottom, not lifted to the top toward reform.[174]

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[171] *Cf., e.g.*, Frank J. Thompson, *New Federalism and Health Care Policy: States and the Old Questions*, *in* HEALTH POLICY IN TRANSITION: A DECADE OF HEALTH POLITICS, POLICY AND LAW 79, 80-81 (Lawrence D. Brown ed. 1987) (discussing why states have been stingy rather than generous in experimenting with health policy).

[172] *See* John Holahan & Linda Blumberg, *Massachusetts Health Care Reform: A Look at the Issues*, 25 HEALTH AFF. w432, w432, w436, w443 (2006), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.w432 (discussing the technical and political elements that made Massachusetts's universal coverage possible).

[173] *See, e.g.*, Gluck, *supra* note **Error! Bookmark not defined.**, at 1764 ("The dearth of state-led policy experimentation is due to, among other things, the disincentives for a single state to bear all the costs of innovation and the risk that businesses will leave a state if it regulates in a more costly manner than others."); Rose-Ackerman, *supra* note **Error! Bookmark not defined.**, at 610-11; Rubin & Feeley, *supra* note **Error! Bookmark not defined.**, at 925-26. *See generally* Super, *supra* note **Error! Bookmark not defined.**, at 563 (recognizing "the process of establishing democratic experimentalism in the first place may be problematic").

[174] Here we strongly disagree with Bagley who overlooks this argument in saying no collective action problem exists in health care just because people do not move for health benefits. *See* Bagley, *supra* note **Error! Bookmark not defined.**, at 5 ("But the welfare magnet story justifies federal intervention only if lots of sick people move to get health insurance. . . . People don't lightly move and they rarely do so for health reasons."). Most people who lack health insurance earn less than the national average income—around $50,000—and most are below 250% of FPL, so they have no economic means to move, let alone for medical care. *See* Henry J. Kaiser Family Found., Key Facts About the Uninsured Population 4 (2017), http://files.kff.org/attachment/Fact-Sheet-Key-Facts-about-the-Uninsured-Population; *see also* David Schleicher, *Stuck! The Law and Economics of Residential Stagnation*, 127 YALE L.J. 78, 122-27 (2017) (arguing it has become harder for poor people to move). Literature consistently shows welfare benefits play a significant role in locational choices. *See* Rebecca M. Blank, *The Effect of Welfare and Wage Levels on the Location Decisions of Female-Headed Households*, 24 J. URB. ECON. 186, 188, 207-08 (1988) (finding "locational choices of female household heads are significantly affected by welfare-benefit levels" and that "[w]elfare and wages both have significant effects upon locational choice"); Paul E. Peterson & Mark Rom, *American Federalism, Welfare Policy, and Residential Choices*, 83 AM. POL. SCI. REV. 711, 725 (1989) (arguing states will cut benefits to avoid the costs of being magnets for low income populations and finding that "people make major decisions as to whether they should move or remain where they are, they take into account the amount of welfare provision a state provides and the extent to which that level of support is increasing"); *see also* Super, *supra* note **Error! Bookmark not defined.**, at 547. *See generally* PAUL E. PETERSON & MARK C. ROM, WELFARE MAGNETS: A NEW CASE FOR A NATIONAL STANDARD (1990). Further, while people cross state lines (or international borders, if they are close enough) for medical purposes, crossing borders is about proximity and opportunity, not failure for states to race to the bottom

With respect to recourse to state courts for state-level reform, no state constitution or state law offers a *positive* right to health care.[175] By contrast, every state constitution contains other positive rights, which have helped to drive such social policy change as marriage equality.[176] Some state constitutions even contain other special welfare rights that the U.S. Constitution does not (the U.S. Constitution does not contain a right to health care either[177]), including the right to basic education.[178] Judicial remedy through state constitutional law therefore does not provide an alternative to federal statutory reform.[179]

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because all is well in state health law and policy. *See, e.g.*, Brief of Amicus Curiae, Commonwealth of Massachusetts (Supporting Petitioners and Addressing Whether Enacting Minimum Coverage Provision of ACA Authorized by Article I) at 1, 5-9, Nat'l Fed'n of Ind. Bus. v. Sebelius, 567 U.S. 519 (2012) (No. 11-398), 2012 WL 160239 (describing the experience of the one state with universal coverage, enacted years before the ACA and thus allowing for data showing that free-riding will occur *without* regulatory nudges such as the individual mandate); Thompson, *supra* note 172, at 80-81 (arguing states have neither commitment nor capacity to experiment effectively in health care). Moreover, business and capital might move in response to health care costs, and insurers that sell cross-border policies could undercut states' minimum benefits rules.

[175] *See, e.g.*, Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325, 1328, 1347, 1391-92 (2010).

[176] *See, e.g.*, Goodridge v. Dep't of Pub. Health, 798 N.E.2d 941, 948-49, 969 (Mass. 2003) ("The Massachusetts Constitution is, if anything, more protective of individual liberty and equality than the Federal Constitution; it may demand broader protection for fundamental rights; and it is less tolerant of government intrusion into the protected spheres of private life.").

[178] *Compare* Plyler v. Doe, 457 U.S. 202, 221 (1982) ("Public education is not a 'right' granted to individuals by the Constitution."), *and* San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 35 (1973) ("Education, of course, is not among the rights afforded explicit protection under our Federal Constitution."), *with* Serrano v. Priest, 487 P.2d 1241, 1244 (Cal. 1971) ("[T]he right to an education in our public schools is a fundamental interest . . . ."), *and* Leandro v. State, 488 S.E.2d 249, 255 (N.C. 1997) ("We conclude that Article I, Section 15 and Article IX, Section 2 of the North Carolina Constitution combine to guarantee every child of this state an opportunity to receive a sound basic education in our public schools.").

[179] Bagley also argues that racism is not a reason to consider nationalization *See* Bagley, *supra* note **Error! Bookmark not defined.**, at 8 ("The case [for federal reform based on racism concerns] is harder to sustain than it may at first appear.") American health care has a long, deep history of discrimination that has infiltrated and stymied many efforts at universalism in health care reform; so much so, that groups like the NAACP were even leery of the Clinton health reform effort. *See generally* Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 80 (2003) (exploring the complex relationship between segregation, other forms of racism, social movements, and health care reform in the United States). These historic patterns are still relevant. *See* Mark A. Hall, *States' Decisions Not to Expand Medicaid*, 92 N.C. L. REV. 1459, 1464 (2014) (finding parallels to the civil rights era—opposition to the President and loathing for

In short, we should be wary of arguments for "federalism" or "states' rights" couched constitutional arguments when they are really arguments about policy disagreements and statutory design. The ACA's federalism is about how states react to and act within a framework of a national law that offers states options about how and whether to participate. Whether or not the ACA survives, the Republican proposals in 2017 largely strengthened this dynamic, keeping the federal superstructure and giving states choices within it—again in the name of that slippery concept called "federalism."[180] Although supporters of the bills being floated in Congress and some health policy wonks may wish that the ACA's specific policy choices were different, none are advocating a truly different brand of federalism than that which already exists in the ACA. Our observations about ACA implementation—its dynamism, its negotiated and horizontal character, its reliance on hybrid state-federal partnerships, and the role of internal state politics—will be even more relevant if the state options within national reform expand under the Trump Administration.

III. Federalism Under the ACA

Like other federal interventions before it, the ACA responded to regulatory gaps and market failures in health care by focusing largely on weaknesses in (mostly state-run) insurance markets. Uninsurance had reached an historic high of more than 16% during the first year of the Obama Administration, a trend that was exacerbated by the Great Recession, and the uninsured were concentrated among people earning less than 250% of the federal poverty level.[181] Fewer employers offered health insurance as an employment benefit,

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redistributive tax policy were factors (in addition to implicit racism) in opposing Medicaid expansion and the ACA); MARK A. HALL & EDWIN SHOAF, MEDICAID EXPANSION COSTS IN NORTH CAROLINA: A FRANK DISCUSSION 11 (2016), http://hlp.law.wfu.edu/files/2016/01/Expansion-Issues-final-2b.pdf (evaluating the economic value of expansion to North Carolina to encourage "dispassionate" assessments). Tim Jost has documented the racism underlying resistance to Medicaid expansion, concluding that "states [wanted to] keep control over the poor." Jost, *supra* note 90. Jost has further argued: "If you look at the map today, it is many of the same states today that are rejecting Medicaid expansion whose senators blocked federal standards for public assistance almost eighty years ago, and, I would argue, for the same reason." *Id.* Relatedly, the Urban Institute published a study of state-based limits on welfare benefits, and barring other factors, the study found that race drives state decision-making in generosity of funding and imposing behavioral restrictions. *See* HEATHER HAHN ET AL., URBAN INST., WHY DOES CASH WELFARE DEPEND ON WHERE YOU LIVE? HOW AND WHY STATE TANF PROGRAMS VARY 23-33 (2017), https://www.urban.org/sites/default/files/publication/90761/tanf_cash_welfare_final2_1.pdf (finding state TANF policy decisions are significantly related to race).

[180] *See, e.g.*, sources cited *supra* note 159.

[181] *See* ROBIN A. COHEN ET AL., CTRS. FOR DISEASE CONTROL, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY-MARCH 2016 4, A1, A7, A14 (2016), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf (providing charts and tables showing long-term trends in insurance coverage before and after the ACA by

and those that did increased employee cost-sharing over time.[182] Additionally, individual and small group health insurance markets were for many inaccessible, especially to the lower- and middle-income uninsured, because of high prices and exclusionary policies designed to prevent coverage of subscribers who were not "healthy."[183] Though Medicaid had expanded since 1965 to include additional populations over time, it still offered an incomplete safety net, with many populations not covered in most states.[184] As of 2006, only about 45% of the nation's poor uninsured were eligible for Medicaid.[185] Those excluded from insurance coverage often would seek care in emergency rooms[186]—a poor substitute for systematic care that was increasingly expensive.

A. The ACA's Federalism as Drafted

The ACA responded to these gaps in coverage with an overarching philosophy that one of us has called "universality"—universal access to health care through universal access to insurance coverage, even for most populations historically excluded due to health status or financial status.[187] (Some populations were left out, notably millions of undocumented immigrants; legal

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measuring health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the National Health Interview Survey); *see also* RACHEL GARFIELD ET AL., HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER; KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED IN THE WAKE OF NATIONAL HEALTH REFORM 3-4 (2016), http://files.kff.org/attachment/Report-The-Uninsured-A%20Primer-Key-Facts-about-Health-Insurance-and-the-Unisured-in-America-in-the-Era-of-Health-Reform (discussing the landscape of uninsurance before the ACA); Andrew Villegas & Phil Galewitz, *Uninsured Rate Soars, 50+ Million Americans Without Coverage*, KAISER HEALTH NEWS (Sept. 16, 2010), https://khn.org/news/census-uninsured-rate-soars.

[182] *See* STARR, *supra* note 111, at 79-80, 155-56.

[183] *See generally* Jessica L. Roberts & Elizabeth Weeks Leonard, *What Is (and Isn't) Healthism?*, 50 GA. L. REV. 833, 837-38, 842-44 (2016) (considering which types of health-based distinctions are unjustifiable discrimination, deemed "healthism").

[184] *See supra* notes 105-107 and accompanying text.

[185] *See* STAN DORN, AARP PUB. POLICY INST., MILLIONS OF LOW-INCOME AMERICANS CAN'T GET MEDICAID: WHAT CAN BE DONE? 5-6 (2008), https://assets.aarp.org/rgcenter/health/2008_13_medicaid.pdf (discussing the proportion of low-income adults ineligible for Medicaid).

[186] The practice was so common that President George W. Bush said, "People have access to health care in America. After all, you just go to an emergency room." Rachel Weiner, *Romney: Uninsured Have Emergency Rooms*, WASH. POST (Sept. 24, 2012), https://www.washingtonpost.com/news/post-politics/wp/2012/09/24/romney-calls-emergency-room-a-health-care-option-for-uninsured/?utm_term=.b6b51e016a13 (recounting this statement and reporting that candidate Mitt Romney made a similar comment).

[187] *See* Huberfeld, *supra* note 104, at 67-69.

immigrants were left out of Medicaid, too.[188]) The statute's two central mechanisms to accomplish this goal turned out to be its most federalism-oriented: expanding Medicaid coverage to populations long excluded from categorical eligibility (namely, non-elderly childless adults (including men) up to 138% of the federal poverty level (FPL)) and facilitating individual access to insurance in the private market by subsidizing insurance purchases and creating individual insurance markets—"health insurance exchanges"—to make options more transparent for consumers and to ensure that insurance so purchased met a minimum standard of coverage.[189]

Universality under the ACA does not mean uniformity, however. Nationalizing the whole system under a single structure would probably be the easiest way to achieve universality, but it was not politically palatable in 2009 and was not consistent with Congress's documented preference to legislate incrementally, discussed above.[190] Instead, the ACA built on what came before, maintaining but buttressing both the private markets and Medicaid.

From a federalism perspective, the two central mechanisms of the statute—the Medicaid expansion and the exchanges—were not drafted to be structurally the same. The Medicaid expansion was intended to be more "national"; and the private insurance reforms were envisioned to be largely state-led. However, as detailed below, politics and law intervened to make the ACA's federalism in implementation almost the mirror image of its federalism as drafted.

The Medicaid expansion that the ACA enacted did not take Medicaid away from the states but did nationalize the program in the important sense that it mandated eligibility expansion to populations that prior to the ACA had been covered only at a state's option.[191] The ACA ended Medicaid's limitation to

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[188] *See id.* at 68 n.7 (noting exclusion of undocumented immigrants); *see also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1312(f)(3), 124 Stat. 119, 183-84 (2010) (codified at 42 U.S.C. § 18032(f)(3) (2016)); *Coverage for Lawfully Present Immigrants*, HEALTHCARE.GOV, https://www.healthcare.gov/immigrants/lawfully-present-immigrants (last visited Dec. 31, 2017) (explaining that legal immigrants can get coverage through ACA exchanges but that many must wait five years prior to receiving Medicaid coverage).

[189] *See* Patient Protection and Affordable Care Act § 1321(a), 124 Stat. at 186 (codified at 42 U.S.C. § 18041(a) (2016)) (detailing exchange structure); *id.* § 2001(a)(1), 124 Stat. at 271 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2016)) (creating a new Medicaid eligibility category). The Health Care and Education Reconciliation Act created a 5% income disregard, raising eligibility for the new category to 138% of FPL. *See* Pub. L. No. 111-152, §§ 1004(b), (e), 124 Stat. 1029, 1034, 1036 (2010) (codified at 42 U.S.C. § 1396a (2016)).

[190] *See supra* Parts ___.- III.B.

[191] *See* Patient Protection and Affordable Care Act § 2001(a)(1), 124 Stat. at 271 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2016)); Health Care and Education Reconciliation Act

the "deserving poor" by requiring that states expand eligibility to *all* adults under age sixty-five (when Medicare kicks in) with income up to 138% of the federal poverty level. The ACA funded the eligibility expansion completely from 2014-2017, and after that decreases the federal match slightly, paying for 90% of the expanded population costs by 2020.[192] Even at 90%, the supermatch is more generous than the matching rates states have received historically, which are tied to per capita income and range from 50% to about 80%.[193] The ACA as drafted did not authorize partial expansion of eligibility, so states could not expand eligibility in a more limited fashion and still receive the supermatch.[194] The idea was to make more uniform and comprehensive the coverage that had become so distant for most of the nation's poor by the time of the 2008 election.

With respect to the insurance markets, the House of Representatives' proposed bill would have created a nationally-run ACA insurance market for the privately insured population. But the Senate insisted on a "federalist" structure.[195] The ACA as enacted therefore gave states the right of first refusal to run their own insurance exchanges.[196] The exchanges were new marketplaces, creatures of federal law introduced by the ACA (but pioneered in Massachusetts).[197] They not only aimed to increase insurance coverage through a baseline of coverage and information that would be delivered to subscribers, they also enabled federal tax credits that subsidized the purchase of private

§§ 1004(b), (e), 124 Stat. at 1034, 1036 (codified at 42 U.S.C. § 1396a(e)(14) (2016)) (increasing eligibility cap by an additional five percent).

[192] 42 U.S.C. § 1396d(y) (2016).

[193] *See* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MACSTATS: MEDICAID AND CHIP DATA BOOK 17-19 fig.6 (2017), https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-CHIP-Data-Book-December-2017.pdf (showing Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) for fiscal years 2014-2018).

[194] *See* Patient Protection and Affordable Care Ac ,§ 2001(a)(1), 124 Stat. at 271 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2016)). Wisconsin has a Medicaid waiver for "BadgerCare," which is equivalent to a partial expansion, but it predated the ACA and has been renewed after the ACA so that coverage can continue despite noncompliance with the ACA. *See* Sara Rosenbaum, *Wisconsin's 1115 Medicaid Demonstration: What Will Policymakers Learn?*, COMMONWEALTH FUND (June 9, 2016), http://www.commonwealthfund.org/publications/blog/2016/jun/wisconsin-1115-medicaid-demonstration.

[195] *Compare* America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong. § 201(A) (as reported to House, Oct. 14, 2009), *with* Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 1321 (as passed by Senate, Dec. 24, 2009).

[196] Patient Protection and Affordable Care Act § 1321(b), 124 Stat. at 186 (codified at 42 U.S.C. § 18041(b) (2016)).

[197] *See* JOHN MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 113, 128 (2011).

health insurance for individuals earning between 100-400% of the FPL.[198] Unlike the ACA's nationalized Medicaid eligibility provisions, the exchange provisions were written to put states in the driver's seat, giving states priority to create their own exchanges and broad discretion in how exchanges could be structured for a given state's existing insurance market.[199] The federal government would provide a fallback should the states decline (or fail) to run their own exchanges.[200]

Less relevant to the federalism narrative but important to understanding these reforms and their political context is the ACA's minimum coverage requirement—the infamous "individual mandate" challenged in the Supreme Court in 2012.[201] The individual mandate required all individuals to obtain insurance coverage or pay a tax (with a few exceptions); the Republican tax bill of 2017 repealed that penalty, largely rendering the mandate a nullity.[202] The mandate was designed to bring more customers into the private insurance markets to sustain those markets in the face of the ACA's dramatic new requirements on the insurance industry. [203]

B. The ACA's Flipped Federalism as Implemented

We will never know what the ACA's intended federalism structure would have looked like after implementation. One high-level former federal official told us that state administrative officials of all political persuasions were moving steadily toward Medicaid expansion and exchange implementation,

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[198] Patient Protection and Affordable Care Act tit. 2, 124 Stat. at 271-353."Patient Protection and Affordable Care Act, 42 U.S.C. §36B (2016)" [The tax credits are in Title I, §1401, the cite for which is 42 U.S.C. §36B. §1402 is the cite for CSRs, which are not same thing.]

[199] *See* Patient Protection and Affordable Care Act § 1321(b), 124 Stat. at 186 (codified at 42 U.S.C. §§ 18031, 18041(b) (2016)).

[200] *Id.* § 1321(c), 124 Stat. at 186 (codified at 42 U.S.C. § 18041(c) (2016)).

[201] *See id.* § 1501, 124 Stat. at 242-43 (codified at 42 U.S.C. § 18091 (2016)), I.R.C. § 5000a (2016) (repealed 2017); Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 530-32 (2012) (challenging the constitutionality of the individual mandate)).

[202] *See* Patient Protection and Affordable Care Act § 1501, 124 Stat. at 242-43 (codified at 42 U.S.C. § 18091 (2016), I.R.C. § 5000a (2016)), *repealed by* Tax Cut and Jobs Act of 2018, Pub. L. No. 115-97, § 11081, 131 Stat. 2054.

[203] The ACA requires insurers to cover everyone, regardless of health risk, at essentially equal prices with variation allowed in limited categories (e.g. age, tobacco use, and geography)—a 180-degree deviation from the way the industry has traditionally measured risk and reaped profits. By deepening the risk pool, the mandate enlarged the private insurance customer base, which was supposed to bring healthier customers into the risk pool, lower prices, and help sustain the insurance industry in the face of the new requirements. *See* Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUBLIC HEALTH REPS. 130, 130-135 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3001814; *see also* MCDONOUGH, *supra* note 197, at 121-22 (2011).

despite strong rhetoric from state politicians, immediately following the statute's enactment.[204] But the Supreme Court's decision in *NFIB v. Sebelius* was a game changer.[205]

NFIB was largely framed as a constitutional challenge to the ACA's insurance mandate.[206] The Court, however, surprised most legal experts[207] by sustaining the mandate as a permissible exercise of Congress's taxing power but declaring the Medicaid expansion an unconstitutionally coercive exercise of the spending power.[208] The Court consequently interpreted the Medicaid expansion as optional for the states.[209] The result was to introduce a powerful element of state leverage—and with it state-federal bargaining—into ACA implementation.

Following *NFIB*, as we detail below, many states—especially red states—stopped plans already in progress to expand Medicaid immediately.[210] They later worked through both intrastate negotiations, *i.e*. between governors and legislatures, and through external negotiations with HHS to create individualized deals for their expansions.[211] This change of events also gave Medicaid section 1115 demonstration waivers, which allow states to seek federal approval to deviate from statutory Medicaid requirements, heightened significance under the ACA, as 1115 became the primary vehicle for such negotiating.[212] Congress did not write new Medicaid waivers into the ACA,

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[204] Interview with Former Federal Executive Branch Health Care Official 5 (Oct. 6, 2016).

[205] *Id.*

[206] *See, e.g.*, Brief for Private Respondents on the Individual Mandate at 1, 7-12, Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012) (No. 11-398), 2012 WL 379586.

[207] *But see* Abbe R. Gluck, *The 10th Amendment Question*, N.Y. TIMES: ROOM FOR DEBATE (Mar. 28, 2010, 7:00 PM), https://roomfordebate.blogs.nytimes.com/2010/03/28/is-the-health-care-law-unconstitutional (exploring the Tenth Amendment question prior to oral argument in *NFIB*); Nicole Huberfeld, *Jumping Ahead to Coercion*, CONCURRING OPINIONS (Dec. 9, 2011), https://concurringopinions.com/archives/2011/12/jumping-ahead-to-coercion.html (same).

[208] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 574-75, 587-88 (2012) (upholding the constitutionality of the individual mandate).

[209] *See id.* at 587-88.

[210] *See infra* Part IV___.

[211] *See id.* ___.-___., .

[212] Section 1115 allows HHS to approve a state waiver proposal that furthers the "objectives" of the Medicaid Act while maintaining federal budget neutrality. 42 U.S.C. § 1315 (2016). This provision was part of the early provisions in the Social Security Act, which the Medicaid Act amended, before Medicaid became a program. *See* 42 U.S.C.A. § 1315 (historical notes). Budget neutrality is not a statutory requirement but rather an informal policy that HHS applies. MaryBeth Musumeci, ET AL., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, HENRY J. KAISER FAMILY FOUND., (Feb. 1, 2018) http://files.kff.org/attachment/Issue-Brief-Section-

and it did not need to: HHS always has had authority to allow deviation from Medicaid requirements by approving an 1115 waiver.[213] But *NFIB*, in giving states more choices, opened the door to 1115 waivers becoming a central element of Medicaid expansion implementation, and thus allowed states to negotiate for special programmatic features that embraced policies that deviated from the ACA's principle of universality.

NFIB also reinvigorated an atmosphere of state autonomy and sprouted acts of political resistance that bled outside of Medicaid policy and into the realm of exchange implementation. Despite the fact that the states' rights faction in Congress insisted on the state-run exchanges in the first place, it became an act of political loyalty for states to refuse to implement the ACA, including refusing to run an exchange.[214] The results of the 2010 state elections bolstered this effect, as many state houses changed from Democrat to Republican control—Democrats lost control of at least one chamber in eleven states—and Republicans also scored a net gain of five governors' offices.[215]

This political positioning ironically extended the federal enterprise in insurance much farther than the ACA's drafters had envisioned, because it required the *federal* government to run the exchanges in those states.[216] What we call "federalism for federalism's own sake" became the dominant approach as states paradoxically refused to run their own exchanges, even though state-based exchanges would have been the natural choice for states acting in their "autonomous" or "sovereign" interests.[217]

1115-Medicaid-Demonstration-Waivers-The-Current-Landscape-of-Approved-and-Pending-Waivers

[213] *See* 42 U.S.C. § 1315 (2016) *see also* SMITH & MOORE, supra note 64, at 332. The language in 42 U.S.C. § 1315(a) specifically refers to § 1396a, the provision in the Medicaid Act that delineates what states must include in a State Plan to participate.

[214] *See* Anna Yukhananov, *U.S. State Officials in Stealth Mode on Health Exchanges*, REUTERS (Sept. 16, 2012, 7:10 AM), http://www.reuters.com/article/us-usa-health-states-exchanges/u-s-state-officials-in-stealth-mode-on-health-exchanges-idUSBRE88F07G20120916 (describing political opposition faced by Republican insurance administrators tasked with implementing the ACA).

[215] *Compare* Nat'l Conference of State Legislatures, 2010 State and Legislative Partisan Composition, http://www.ncsl.org/documents/statevote/LegisControl_2010.pdf (detailing the partisan compositions of governors and state legislative houses prior to the 2010 election, as of Jan. 31, 2010), *with* Nat'l Conference of State Legislatures, 2011 State and Legislative Partisan Composition (2011), http://www.ncsl.org/documents/statevote/LegisControl_2011.pdf (detailing the same data following the 2010 election, as of January 31, 2011).

[216] MCDONOUGH, *supra* 197, at 128.

[217] *See generally* Thomas R. McCoy & Barry Friedman, *Conditional Spending: Federalism's Trojan Horse*, 1988 SUP. CT. REV. 85, 86-87, 123-26 (1989) (anticipating that states operating within federal spending statutes enacted after the Supreme Court's decision in *South Dakota v. Dole* would make decisions that would have unpredictable political ramifications).

This amplification of state resistance produced parallel federal-state negotiations in the exchange context. Unlike Medicaid, no statutory provision facilitates an "exchange demonstration waiver,"[218] but HHS still worked closely with states, informally when necessary, on modifications to the ACA's envisioned exchange structure to bring as many states successfully into ACA implementation as possible.[219] Choices ranged from matters of exchange operation (eligibility and enrollment, health plan management, and consumer assistance), to the platform of the consumer web portal (federal or state), the choice of benchmark plan for determining the essential health benefits to be provided by health plans in the exchange, the number and location of geographic rating areas, the choice of methods for reinsurance and risk adjustment, and responsibility for reviewing health plan rates and compliance with the medical loss ratio requirements.[220] HHS even gave states choices not envisioned by the statute: For instance, as detailed below, HHS allowed states to retain authority over certain key components of the exchanges, even as HHS ran some components themselves.[221] These developments led to significant variation across states, not just in states that chose to operate their own exchanges—where variation might be expected—but also in states that had a "nationally-run" exchange.

Thus, although states were always meant to play vital roles in both of the ACA's core reforms, the statute was not implemented in the way that Congress envisioned those elements. Medicaid has always been structured under the "use it or lose it" model of cooperative federalism, and the ACA continued that: If a state declines federal Medicaid funds, no Medicaid program exists in that state. In contrast, the exchanges were to be a nationwide feature established by the ACA that could operate along two parallel tracks, state and federal. States that declined to exercise their right of first refusal to set up exchanges were to have them nonetheless, through federal operation.

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[218] ACA § 1332, discussed in Part V below is different. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1332, 124 Stat. 119, 203-06 (2010) (codified at 42 U.S.C. § 18052 (2016)).

[219] *See infra* Part III.B.

[220] *See* Ctr. Healthcare Res. & Transformation, Guide to State Requirements and Policy Choices in the Affordable Care Act (2011), http://www.chrt.org/document/guide-to-state-requirements-and-policy-choices-in-the-affordable-care-act; Nat'l Conference of State Legislatures, Health Insurance Exchanges or Marketplaces: State Profiles and Actions (2017), http://www.ncsl.org/Portals/1/Documents/Health/Health_Insurance_Exchanges_State_Profiles.pdf.; *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, HENRY J. KAISER FAM. FOUND. (Feb. 29, 2012), https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr.

[221] *See infra* Part III.B.

But after *NFIB*, the Medicaid expansion became optional, even though Congress had intended to nationalize it. And the exchanges became more national than federalist--at least in terms of formal structural arrangement-- as political resistance led many states to reject the very power over the exchanges they had asked for. In short, the Court's decision in *NFIB* turned the federalism architecture of the ACA on its head.

C. Study Methodology

The scale of the ACA and the fundamental changes it made in American health care structure and finance are reasons enough to study it. The flipped federalism of the ACA's implementation makes it all the more interesting. The detail in the following two Parts is both empirical and theoretical. By grounding our inquiry in real-world detail, our project responds to the frequent criticism that federalism scholarship is too abstract.[222]

Our data derive from three different research methods. First, beginning in July 2013, we collaborated with the HIX 2.0 Project at the University of Pennsylvania to systematically code and evaluate variations in states' implementation of the exchange and Medicaid expansion aspects of the ACA. The HIX 2.0 Project, which is no longer active, aimed to construct quantitatively coded datasets to support research on the impact of variations in state health law and policy choices on outcome measures of significance, such as the rate of uninsurance, the number of insurers active in a state market, and health insurance prices.[223] We identified for the investigators categories to track that would be relevant for federalism in both the Medicaid and exchange contexts. Second, we independently tracked federal-state activity in each state, using publicly available sources, including government materials. We tracked factors ranging from program design, to political party in office, to the legal means—law, executive order, etc.—by which the new programs were implemented in any individual state. Finally, we interviewed implementers themselves—current and former state and federal officials who ranged from state governors to insurance commissioners to high-ranking members of the Obama Administration. We also interviewed leaders in major healthcare nonprofit and trade groups that were known to be working closely with state and federal officials on implementation. The interviews are the subject of a separate article;[224] for purposes of this article, their relevance was in corroborating the federalism story that emerged from the tracking data.

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[222] *See* sources cited *supra* note 41.

[223] The HIX 2.0 research had a very long time horizon, so its dataset could not be put to use immediately.

[224] For a more comprehensive account of the interviews, *see* Abbe R. Gluck & Nicole Huberfeld, *The New Health Care Federalism on the Ground*, 15 IND. HEALTH L. REV. 1 (2018).

The initial goal of all of these methods was to measure state "cooperation," "autonomy," "variation," and "sovereignty" in the statute as well as what impact these traditional federalism attributes may have on health policy-making. As noted, we ultimately were not able to quantitatively assess the federalism attributes as we had intended. The richness and complexity of the data, as detailed in the next two Parts, revealed aspects of cooperation, autonomy, sovereignty, and variation occurring within all of the different structural arrangements in the ACA--even structural arrangements perceived to be in opposition to one another. Assigning weights to measure these attributes relative to one another (for instance, whether a state expanding Medicaid as the ACA lays out is more or less autonomous than a state expanding Medicaid via waiver) proved impossible, at least in this initial foray. Those observations changed our focus and gave rise to the theoretical analysis in the paper.

IV. The Medicaid Expansion

The Medicaid expansion is a story of dynamic, adaptive, horizontal, negotiated, and republican (small "r") federalism. Even though the Medicaid expansion became an option for the states after *NFIB*, it has not operated like an on/off switch. It has been in constant motion. Some opt-out states—even those that initially proclaimed resistance—have moved gradually to expansion, and many opt-in states have renegotiated deals with HHS even after flicking the "on" switch years before.[225] Leaders among states have emerged organically, creating horizontal state dynamics that changed implementation.[226] For instance, states like Arkansas and Indiana became red-state thought leaders by pushing unconventional waiver elements and, in the process, taught other states how to negotiate and what could be gained.[227] A clear learn-and-response pattern materialized, resulting from these negotiations within states, among states, and between states and the federal government. Intrastate features pervaded the process, with governors and legislators of the same (typically Republican) party at odds on whether and how to expand.[228]

Classic federalism accounts, including the way in which the Court itself often describes federalism, tend to make zero-sum assumptions about federalism's sovereignty tradeoffs. The federal government's gain is portrayed as the states' loss, and vice versa.[229] Our research illustrates that has not been

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[225] *See infra* Parts ___.-___.

[226] *See infra* Parts ___.-___.

[227] *See infra* Parts ___.-___.

[228] *See* Part V.B.

[229] S*ee generally* Stephen Gardbaum, *The Nature of Preemption*, 79 CORNELL L. REV. 767, 812-14 (1994) (exploring exclusivity through the lens of preemption); Theodore W. Ruger, *Preempting the People: The Judicial Role in Regulatory Concurrency and its Implications*

the case with the Medicaid expansion. Our interviews with high-level current and former state and former federal officials confirmed that, largely because the Obama Administration adopted a very long time horizon—the administration's basic goal was to get the ACA entrenched and fix it later—states (often with shorter-term goals) achieved significant victories in their federalism negotiations.[230] With the Administration eager to get as many states to expand Medicaid as possible, states were able to negotiate special deals that enabled them to do so. Both sides viewed themselves victorious.

A. Four Waves of Dynamic, Negotiated, and Horizontal Medicaid Expansion

Our data illustrate that the Medicaid expansion occurred in four discernable waves.

1. Early, Generous Implementers: The First Wave

The first wave began in 2012, before the ACA's Medicaid implementation date of January 1, 2014. The ACA permitted early expansion, although at a state's usual federal funding match (not the ACA's post-2014 very generous supermatch).[231] The draw of early expansion was that it offered federal funds for the new expansion population, an economic boon for a handful of states that had already covered childless adults with no federal funds before the ACA.[232] Led by Minnesota, states including California, Colorado, Connecticut, New Jersey, and Washington (and the District of Columbia) expanded to childless adults by April 2012.[233] These early adopters largely aligned with the ACA's

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for Popular Lawmaking, 81 CHI.-KENT L. REV. 1029, 1038-46 (2006) (tracing history of exclusive spheres of power in Supreme Court jurisprudence).

[230] Interview with State Policy Organization Officers 1, 2, 3, and 4 (June 6, 2016); Interview with Former Federal Executive Branch Health Care Official 1 (June 21, 2016); Interview with Former Governor (Aug. 4, 2016).

[231] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 2001(a)(2), 124 Stat. 119, 274 (2010) (codified at 42 U.S.C. § 1396a(k)(2) (2016)) (permitting expansion before 2014, when the supermatch kicked in).

[232] *Id.*; *see also* LARISA ANTONISSE ET AL., HENRY J. KAISER FAMILY FOUND., THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: UPDATED FINDINGS FROM A LITERATURE REVIEW 1 (2017), http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings ("Analyses find positive effects of expansion on multiple economic outcomes . . . .").

[233] *States Getting a Jump Start on Health Reform's Medicaid Expansion*, HENRY J. KAISER FAM. FOUND. (Apr. 2, 2012), http://kff.org/health-reform/issue-brief/states-getting-a-jump-start-on-health. Colorado's early expansion post-dates this account, but the state had a demonstration waiver that permitted early expansion. *See* Ctrs. for Medicare & Medicaid Servs., No. 11-W-00280/8, Colorado Adults Without Dependent Children (AwDC) Demonstration 1 (2012), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/co/co-awdc-ca.pdf (expanding Medicaid to childless adults for the period between April 1, 2012 and December 31, 2013Some states implemented expansion through "state plan amendments" (SPAs), and some amended

universal coverage goal; yet, some first wave states obtained section 1115 demonstration waivers to expand more generously *beyond* the ACA.[234]

2. *NFIB* and the Second Wave

The *NFIB* decision, which came down on June 28, 2012, initiated the second wave.[235] Some states that had been waiting to see if the ACA would be declared unconstitutional expanded almost as soon as the decision upheld the law. Due to the timing of the state budget cycle, and a desire for consultant studies to prove the potential benefits of opting in, many others did not formally opt in until 2013. The second wave states largely relied on State Plan Amendments (SPAs)— amendments to their existing Medicaid programs—for expansion and did not negotiate or seek special concessions from HHS, at least not at first.[236]

Notably, during the second wave, governors were likely to take the lead, often at odds with their own legislatures or their state's national representatives in Congress. For example, Arizona's Governor Brewer,[237] Kentucky's

existing demonstration waivers. Others sought 1115 waivers to enroll individuals who earn more than the ACA's baseline of 133% FPL, such as Massachusetts, which had already enacted universal health insurance coverage. *See States Getting a Jump Start*, *supra*

[234] Carol Backstrom, Medicaid Dir., Minn. Dep't of Human Servs., Minnesota PMAP+ Section 1115 Waiver Renewal Request 1-2 (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mn/Prepaid-Medical-Assistance-Project-Plus/mn-pmap-waiver-renewal-req-08092013.pdf; Ctrs. for Medicare & Medicaid Servs., No. 11-W-00251/3, Childless Adults Section 1115 Demonstration 1-2 (2010), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/dc/dc-childless-adults-ca.pdf (District of Columbia); Ctrs. for Medicare & Medicaid Servs., No. 11-W-00194/1, Global Commitment to Health Section 1115 Demonstration 1-2 (2010), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-waiver-auth-01012011-12312013.pdf (Vermont); N.Y. State Dep't of Health, No. 11-W-00114/2, Application for Partnership Plan Waiver Extension: New York State Medicaid Section 1115 Demonstration, 42-47 (2014), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-partnership-plan-pa.pdf.[no, they do not count]

[235] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

[236] *See State Medicaid & CHIP Profiles*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/by-state/by-state.html (last visited Jan. 1, 2018) (documenting each state's SPAs and waivers in Medicaid). SPAs are subject to less scrutiny than 1115 demonstration waiver applications because they are merely a description of how the state is meeting the mandatory elements of the Medicaid Act; the Medicaid expansion was drafted in the ACA as a mandatory element. *See* 42 U.S.C. § 1396a(a)(10)(A)(VIII) (2016) (listing mandatory categories of eligibility for Medicaid enrollment).

[237] Governor Brewer signed legislation expanding Arizona's Medicaid program on June 17, 2013 after calling a surprise emergency legislative session designed to force Medicaid expansion. *See* Mary K. Reinhart, *Brewer Signs into Law Arizona's Medicaid Program*, ARIZ. REPUBLIC (June 18, 2013, 12:36 AM),

Governor Beshear,[238] and North Dakota's Governor Dalrymple[239] pushed—and in some cases explicitly defied and circumvented—their legislatures to achieve Medicaid expansion. We detail those intrastate dynamics in the next Part.

At the same time, some states recognized that *NFIB* gave them leverage that the ACA as drafted did not originally contemplate. They began exploring what kind of concessions they could extract in a world of now-optional Medicaid expansion that would look beyond a traditional, "cooperative," SPA approach.[240] The Annual Meeting of the National Governors Association that was held just one month after *NFIB* was crucial to this exploration; after state-to-state conversations at that meeting, holdout states started to investigate expansion options in earnest.[241]

HHS fed this interest. Although the Secretary of HHS initially provided lean guidance after *NFIB*,[242] within a few months she informed states that they

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http://www.azcentral.com/news/politics/articles/20130617brewer-signs-law-arizona-medicaid-program.html.

[238] *See* Caroline Humer, *Kentucky Governor Announces Medicaid Expansion Under Obamacare*, REUTERS (May 9, 2013, 4:05 PM), http://www.reuters.com/article/us-usa-healthcare-kentucky-idUSBRE94817R20130509; Beth Musgrave & Jack Brammer, *Beshear Says Kentucky Will Join Obamacare Plan to Expand Medicaid*, LEXINGTON HERALD LEADER (May 9, 2013, 1:00 PM), http://www.kentucky.com/news/politics-government/article44423271.html.

[239] *See* Nick Smith, *Lawmakers Pan Medicaid Expansion*, BISMARCK TRIBUNE (Apr. 12, 2013), http://bismarcktribune.com/news/columnists/nick-smith/lawmakers-pan-medicaid-expansion/article_5b029c2a-a368-11e2-802e-001a4bcf887a.html; Jeffrey Young, *North Dakota Medicaid Expansion Favored by Republican Governor*, HUFFINGTON POST: THE BLOG (Jan. 15, 2013, 4:15 PM ET), https://www.huffingtonpost.com/jeffrey-young/north-dakota-medicaid-exp_b_2481572.html.

[240] *See* Letter from Dan Grippen, Nat'l Governors Ass'n, to Secretary Sebelius, Sec'y, Dep't of Health and Human Servs. (July 2, 2012), https://www.nga.org/cms/nga-letters/affordable-care-act-sebelius; *see also RGA Letter on Medicaid and Exchanges to President Obama*, REPUBLICAN GOVERNORS ASS'N (July 10, 2012), https://www.rga.org/rga-letter-on-medicaid-and-exchanges-to-president-obama.

[241] *See* Michael Cooper, *Many Governors Are Still Unsure about Medicaid Expansion*, N.Y. TIMES (July 14, 2012), http://www.nytimes.com/2012/07/15/us/governors-face-hard-choices-over-medicaid-expansion.html; Lisa Lambert, *At Annual Meeting, U.S. Governors Come Out Swinging over Medicaid*, REUTERS (July 14, 2012), http://www.reuters.com/article/2012/07/14/usa-governors-medicaid-idUSL2E8IE18D20120714 (noting that Medicaid was the dominant topic at that annual meeting); *see also* Interview with Former Governor, *supra* note **Error! Bookmark not defined.**.

[242] *See* Letter from Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs., to Governors 1 (July 10, 2012), http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf. Secretary Sebelius recognized the states' watching and waiting in her response letter to state governors. *Id.*

could opt in at any time without being penalized or locked in.[243] That meant states could opt in or opt out of expansion on a timeline and in a manner different from that initially envisioned by the ACA.[244]

3. Waivers, Concessions, and the Third Wave

HHS's expressed flexibility stimulated the third wave, which was led by Arkansas, the first state to obtain a section 1115 demonstration waiver to implement Medicaid expansion in September 2013.[245] The Arkansas waiver included a pioneering concession that allowed Arkansas to move toward privatizing the Medicaid market by funneling the newly-eligible Medicaid population into private insurance available through the exchange rather than enrolling them in traditional Medicaid.[246] Thus, this demonstration project made Arkansas Medicaid expansion beneficiaries the first to be enrolled in private coverage using federally-funded premium assistance[247] for purchasing private insurance with benchmark coverage in the exchange.[248]

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[243] Ctrs. for Medicare & Medicaid Servs., Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid 12 (2012), http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

[244] *Id.* Some guidance documents are no longer available, though they are referenced on the HHS website; some were included in the December 12, 2012 memorandum. States that expand "partially," for example up to 100% of the FPL, are not eligible for the supermatch. *See id*. at 12.

[245] *See* Letter from Mike Beebe, Governor, State of Ark., to Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs. 1 (Aug. 2, 2013), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-submission-ltr-08022013.pdf; Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Andy Allison, Dir., Ark. Dep't of Human Servs. 1 (Sept. 27, 2013), http://posting.arktimes.com/media/pdf/arkansassignedapprovalltr.pdf (approving the Arkansas Demonstration Waiver for three years).

[246] *See* Letter from Marilyn Tavenner to Andy Allison, *supra* note **Error! Bookmark not defined.**, at 1.

[247] Premium assistance waivers were obtainable before the ACA, but the few that existed had low enrollment because no private insurance was *actually* available to low-income workers. *See* Teresa A. Coughlin & Stephen Zuckerman, *State Responses to New Flexibility in Medicaid*, 86 MILBANK Q. 209, 227-28 (2008) (discussing minimal uptake for premium assistance waivers during the second Bush administration); Sara Rosenbaum & Benjamin D. Sommers, *Using Medicaid to Buy Private Health Insurance—The Great New Experiment?*, 369 NEW ENG. J. MED. 7, 8 (2013) (noting that employer-sponsored insurance was the only private insurance to be purchased with premium assistance before the ACA and was not accessible for most low-income workers). The ACA's exchanges made it so that low-income populations could obtain private insurance with premium assistance due to wider availability of small group and individual insurance and financial assistance through premium tax credits. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1401, 124 Stat. 119, 213-20 (2010) (codified as amended at I.R.C. § 36B (2016)). Further, new rules such as the prohibition on pre-existing condition exclusions, *id.* § 1201, 124 Stat. at 154-61 (codified at 42 U.S.C. § 300gg-3 (2016)) (amending Public Health Service Act § 2704(a)), and the

Arkansas publicized its negotiations with HHS, generating intense curiosity among other states exploring expansion.[249] Some states strategically started to wait out other states' waiver negotiations, feeling they could benefit from piggybacking on early-moving states' efforts and get even more, as evidenced by the progression of states opting-in to expansion. One high-level former federal official we interviewed noted that states perceived the Obama Administration as so eager to expand Medicaid that every state wanted to be "last in line" to negotiate a waiver so that they could benefit from prior states' concessions and successes.[250] The succession of waivers following Arkansas's bears that out and shows the strategy was effective.

Iowa announced interest in a waiver soon after Arkansas did.[251] Iowa benefited from Arkansas's application by seeking to negotiate even more concessions, which HHS granted through two waivers. Beyond applying for a waiver for premium assistance (which applied to individuals earning above 100% of FPL), Iowa proposed enforceable premium payments for individuals earning more than 100% of FPL (coverage could be denied for failure to pay premiums), healthy behavior rewards (which could offset premium payments),

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establishment of adjusted community rating, *id.* (codified at 42 U.S.C. § 300gg (2016)) (amending Public Health Service Act § 2701(a)), opened coverage to previously uninsurable populations.

[248] Arkansas's waiver program had a unique name, a phenomenon we address in Part IV.B.2., the Arkansas Health Care Independence Program, and the newly eligible enrollees are called Private Option Beneficiaries. Tracy Garber & Sarah R. Collins, *The Affordable Care Act's Medicaid Expansion: Alternative State Approaches*, COMMONWEALTH FUND (Mar. 28, 2014), http://www.commonwealthfund.org/publications/blog/2014/mar/medicaid-expansion-alternative-state-approaches. Private Option Beneficiaries have access to additional services that are covered by Medicaid but not included in typical private health plans. *Id.* Cost-sharing for those with incomes above 100% of poverty cannot exceed 5% of family income. *Id.*; *see also* sources cited *supra* note **Error! Bookmark not defined.**.

[249] *See* Robert Pear, *States Urged to Expand Medicaid with Private Insurance*, N.Y. TIMES (Mar. 21, 2013), http://www.nytimes.com/2013/03/22/us/politics/states-urged-to-expand-medicaid-with-private-insurance.html.

[250] Interview with Former Federal Executive Branch Health Care Official 5, *supra* note 204.

[251] Iowa announced its intent to negotiate a waiver on February 26, 2013, *see* Rod Boshart, *Branstad to Seek Federal IowaCare Waiver*, SIOUX CITY J. (Feb. 26, 2013), http://siouxcityjournal.com/news/state-and-regional/iowa/branstad-to-seek-federal-iowacare-waiver/article_a5a6b879-66b8-5850-81b7-f6e1364d1296.html, and presented a proposal on March 4, 2013, *see* Mike Wiser, *Branstad Releases Medicaid Expansion Alternative*, SIOUX CITY J. (Mar. 4, 2013), http://siouxcityjournal.com/news/local/state-and-regional/branstad-releases-medicaid-expansion-alternative/article_c0ab2c08-c443-5f0f-9135-79058fc88bcb.html. Arkansas publicized its intent to seek a waiver on February 26, 2013. *See* David Ramsey, *UPDATE Medicaid Game-Changer*, ARK. TIMES: BLOG (Feb. 26, 2013), https://m.arktimes.com/arkansas/blogs/Post?basename=medicaid-game-changer-feds-approve-putting-entire-expansion-population-on-exchange&day=26&id=ArkansasBlog&month=02&year=2013.

a one year waiver of non-emergency transportation services (no payment for ambulance services used for non-emergency care), and copayments for non-emergency use of the emergency department.[252] HHS approved each of these new features.[253]

Soon thereafter, in September 2013, Michigan initiated expansion waiver negotiations (before Arkansas's waiver was formalized).[254] Michigan did not seek a premium assistance waiver; but, like Iowa, it sought concessions for cost sharing and healthy behavior incentives, which were granted.[255] In addition, Michigan wanted to create health savings accounts for enrollees' cost sharing requirements,[256] which Arkansas later proposed in an amendment to its 1115 waiver.[257] HHS approved Michigan's waiver application a few weeks after Iowa's.[258]

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[252] *See* Henry J. Kaiser Family Found., Medicaid Expansion in Iowa (2015), http://files.kff.org/attachment/fact-sheet-medicaid-expansion-in-iowa/.

[253] In 2014, Iowa required people earning 101-138% of FPL to enroll in a Marketplace Qualified Health Plan (QHP) in its exchange, but low insurer participation led the state to offer an option for premium assistance rather than requiring it. *See id.*

[254] *See* Jonathan Oosting, *Michigan Gov. Rick Snyder Signs Historic Medicaid Plan into Law: This Is about 'Family' Not 'Politics'*, MLIVE.COM (Sept. 16, 2013, 11:31 AM), http://www.mlive.com/politics/index.ssf/2013/09/michigan_gov_rick_snyder_signs_6.html (reporting that Michigan's governor signed legislation allowing him to proceed with negotiating waivers).

[255] Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Stephen Finton, Dir., Mich. Med. Servs. Admin. 1 (Dec. 30, 2013, http://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf (approving waiver request and SPA for Medicaid expansion, including cost sharing for beneficiaries over 100% of FPL and MI Health Accounts for maintaining cost sharing funds).

[256] Ctrs. for Medicare & Medicaid Servs., No. 11-W-00245/5, Healthy Michigan Section 1115 Demonstration 13-17 (2013), http://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf.

[257] *See* Michelle Andrews, *Arkansas Weighs Plan to Make Some Medicaid Enrollees Fund Savings Accounts*, KAISER HEALTH NEWS (July 22, 2014), http://www.kaiserhealthnews.org/Stories/2014/July/22/Michelle-Andrews-on-Arkansas-plan-for-Medicaid-savings-accounts.aspx?; ARK. STATE LEGISLATURE, 2015 CHANGES TO ARKANSAS'S PRIVATE OPTION: INDEPENDENCE ACCOUNTS AND COST SHARING (2014), http://www.arkleg.state.ar.us/assembly/2013/Meeting%20Attachments/830/I12552/Exh%20%20D%20-PrivateOption-2015.pdf

[258] Michigan's waiver was approved on December 30, 2013. *See* Letter from Marilyn Tavenner to Stephen Finton, *supra* note **Error! Bookmark not defined.**, at 1. Iowa's was approved on December 10, 2013. *See* Letter from Marilyn Tavenner, Administrator, Ctrs. for Medicare and Medicaid Servs., to Jennifer Vermeer, Medicaid Dir., State of Iowa 1 (Dec. 30, 2013), http://dhs.iowa.gov/sites/default/files/Iowa_Marketplace_Choice_STCs_12_30_13%20Final

Following Arkansas, Iowa, and Michigan, Pennsylvania's then-Governor Tom Corbett held protracted negotiations with HHS.[259] These were high profile, in part because the waiver application included contentious elements such as enforceable cost sharing and, more controversially, work search requirements, which were not approved by the Obama Administration.[260] Pennsylvania's original proposal called for Arkansas-style premium assistance, but in the end Pennsylvania chose to use Medicaid managed care networks for the newly eligible population—like Iowa.[261] (Under a new governor, Tom Wolf, Pennsylvania reversed course and abandoned its expansion waiver, opting instead for the kind of straightforward expansion envisioned by the ACA.[262])

Additional states soon followed. Tennessee and South Dakota proposed partial expansion through premium assistance waiver applications.[263] The ACA did not allow partial expansion, meaning expansion that does not include everyone earning up to 138% of FPL, so Tennessee and South Dakota's proposals were rejected by the Obama Administration but led to additional, ongoing discussions.[264]

In sum, the third wave introduced not only premium assistance waivers and other red-state features into Medicaid expansion but also showcased HHS's

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.pdf (noting original approval date of December 10, 2013 and supplanting that original approval).

[259] Greg Sargent, *Another Big Boost for Obamacare*, WASH. POST (Aug. 28, 2014), https://www.washingtonpost.com/blogs/plum-line/wp/2014/08/28/another-big-boost-for-obamacare/?utm_term=.6d153b0918dd (noting that "months of jockeying between Corbett and the federal government" occurred before approval of Pennsylvania's plan).

[260] *Id.*

[261] *See* Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Beverly Mackereth, Sec'y, Pa. Dep't of Pub. Welfare 1 (Aug. 28, 2014), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-ca.pdf.

[262] *See* John George, *Wolf begins dismantling Corbett's Healthy PA plan*, Philadelphia Business Journal (Feb. 10, 2015), https://www.bizjournals.com/philadelphia/blog/health-care/2015/02/wolf-begins-dismantling-of-corbett-s-healthy-pa.html.

[263] *Feds Give South Dakota's Partial Medicaid Expansion Plan a Thumbs Down; Utah May Need a Special Session*, KAISER HEALTH NEWS: KHN MORNING BRIEFING (Mar. 14, 2014), https://khn.org/morning-breakout/state-action-on-medicaid-expansion-2/; Andy Sher, *Tennessee GOP Skeptical of Tenncare Expansion*, TIMES FREE PRESS (Dec. 12, 2012), http://www.timesfreepress.com/news/news/story/2012/dec/12/chattanooga-tennessee-gop-skeptical-of-tenncare/94787 (noting interest in expanding only for those up to the federal poverty level).

[264] Ctrs. for Medicare & Medicaid Servs., *supra* note **Error! Bookmark not defined.**, at 12 (rejecting partial expansion); *see also* sources cited *supra* note **Error! Bookmark not defined.**.

highly pragmatic approach to getting as many states to expand Medicaid as possible. Convincing a state to opt-in, even with a waiver that deviated from the ACA as originally envisioned, was a critical step toward achieving the statute's near-universal coverage goal.

HHS also saw it could more effectively get states to adopt ACA policy through *individualized* state-by-state negotiations, rather than viewing the resisting states as a monolithic group. Our interviewees credited HHS Secretary Kathleen Sebelius's background as the former Governor of Kansas for taking this highly effective approach, going state by state, even as it meant that HHS was in a near-constant state of negotiation.[265]

4. Renegotiated Deals, Political Change, and the Fourth Wave

The fourth wave began with the ACA's January 1, 2014 implementation date and has progressed at a more gradual pace than the first three waves. Recall that Medicaid was not implemented by all states directly after its passage in 1965.[266] Although many states embraced Medicaid's promise of generous federal funding, others nearly missed the 1970 deadline for participation; Arizona did not implement Medicaid until 1982.[267] This pattern of gradual—but ultimately widespread—uptake has been replicated to a degree in the ACA's implementation, although the change in presidential administration disrupted implementation momentum and guiderails.

During the late Obama Administration years (2014-2016), New Hampshire, Indiana, Alaska, Montana, and Louisiana expanded Medicaid, each choosing different mechanisms of expansion and pulling different levers of policy and power. For example, New Hampshire began expansion through its existing Medicaid program in the summer of 2014 but submitted a waiver application later that year (approved March 4, 2015[268]) that phased in Arkansas-style premium assistance through 2016 and beyond.[269] In other

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[265] Interview with Former Federal Executive Branch Health Care Official 1, *supra* note **Error! Bookmark not defined.**; Interview with Former Governor, *supra* note **Error! Bookmark not defined.**.

[266] *See supra* Part II.A.

[267] *See* STEVENS & STEVENS, *supra* note 60, at 61; Erik Eckholm, *Late Starter in Medicaid, Arizona Shows the Way*, NY TIMES (Aug. 7, 1991), http://www.nytimes.com/1991/08/07/us/late-starter-in-medicaid-arizona-shows-the-way.html?pagewanted=all."

[268] Letter from Andrew Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to Nicholas A. Toumpas, Comm'r, N.H. Dep't of Health & Human Servs. 1 (Mar. 4, 2015), http://www.dhhs.nh.gov/pap-1115-waiver/documents/pa_approvalletter.pdf.

[269] *See* Letter from Andrew Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs, to Governor Margaret Wood Hasan 1 (Jan. 5, 2016), https://www.medicaid.gov/Medicaid-

words, New Hampshire began with a traditional Medicaid expansion through an SPA and later switched to follow the lead of Arkansas. Alaska and Louisiana both expanded through traditional SPAs, discussed more below.

The thought leader of the fourth wave thus far has been Indiana. Perhaps the most aggressively negotiated expansion, Indiana's 1115 waiver built on its existing "HIP" Medicaid waiver as well as prior expansion states' waivers, yet Indiana sought more concessions than prior states had requested.[270] Approved in January 2015, HIP 2.0 included elements from other states' waivers such as variation in benefit packages (Pennsylvania, Michigan), wellness incentives (Iowa, Michigan), non-emergency transportation non-payment (Pennsylvania, Iowa), and premium assistance for beneficiaries to purchase employer-sponsored insurance (Iowa).[271] HIP 2.0 also contained elements that were new to post-ACA 1115 waivers, such as a complex cost sharing scheme that—for the first time ever—allowed Medicaid enrollees earning more than 100% of FPL to be locked out of coverage for six months if they cannot pay premiums; mandatory use of health savings accounts to pay for cost sharing; non-retroactive enrollment for certain beneficiaries; and graduated cost sharing for non-emergency use of emergency departments.[272] Work requirements were part of the original proposal but were publicly rejected by the Obama Administration.[273]

CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-building-capacity-transformation-orig-1115-appvl-01052016.pdf; *see also* Todd Bookman, *Hassan Holds Medicaid Expansion Kick-Off Event*, N.H. PUB. RADIO (June 30, 2014), http://nhpr.org/post/hassan-holds-medicaid-expansion-kick-event.

[270] Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Joseph Moser, Medicaid Dir., Ind. Family and Soc. Servs. Admin. 1 (Jan. 27, 2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf (approving Indiana's "HIP 2.0" Waiver Application).

[271] *Id*. at 1-3.

[272] Ctrs. for Medicare & Medicaid Servs., No. 11-W-00296/5, Healthy Indiana Plan (HIP) 2.0 1-3 (2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf; Abby Goodnough, *Indiana Will Allow Entry to Medicaid for a Price*, N.Y. TIMES (Jan. 28, 2015), https://www.nytimes.com/2015/01/28/us/politics/indiana-will-allow-entry-to-medicaid-for-a-price.html.

[273] Phil Galewitz, *Kentucky and Feds Near Possible Collision On Altering Medicaid Expansion*, KAISER HEALTH NEWS (July 27, 2016) (summarizing the clash between Kentucky and HHS and prior denials of work requirements requested by other red states, including Indiana), https://khn.org/news/kentucky-and-feds-near-possible-collision-on-altering-medicaid-expansion/. Work requirements were also incorporated into "Repeal and Replace" proposals put forth by Republican legislators during the summer of 2017; we discuss work requirements further below.

Notably, then-Governor Mike Pence (now Vice President of the United States) pursued HIP 2.0 with the aid of then-consultant Seema Verma (now CMS Administrator), who also was paid to design demonstration project waivers for Iowa, Kentucky, Ohio, and Tennessee.[274] (We see multi-state consultants playing the same role in the horizontal dynamics of insurance exchange implementation, as detailed in Part V.) Verma's participation surely facilitated the horizontal learning so prominent in waves three and four of the Medicaid expansion, and HIP 2.0 quickly became a model for other states, including some that had already opted in and that sought modified or new waivers through the end of the Obama Administration and into the Trump Administration.[275] In new waivers, New Hampshire's Arkansas-style premium assistance waiver included some Indiana-style elements such as preventing retroactive coverage for newly eligible enrollees.[276] Montana also mimicked parts of Indiana's successful negotiations, gaining approval for a ninety-day lock-out upon nonpayment of premiums for beneficiaries earning above 100% of FPL.[277]

The fourth wave also added a novel phenomenon: *existing opt-in states* reconsidering already-implemented SPAs or renegotiating *existing* waivers after witnessing new concessions being granted by HHS. Perhaps most notable among the existing opt-in states, Kentucky elected new Republican Governor Matt Bevin in November 2015 after he campaigned to eliminate Kentucky's widely-heralded implementation of the ACA, which included Medicaid expansion through a traditional SPA.[278] Kentucky proposed a new 1115 waiver

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[274] *See* Seema Verma, HHS.GOV, https://www.hhs.gov/about/leadership/seema-verma/index.html (last visited Jan. 27, 2018); *see also* https://www.hmamedicaidmarketsolutions.com/who-we-are/.

[275] Verma's CMS expects states to learn from one another, evidenced by a CMS guidance promoting the streamlining of section 1115 waivers, CMCS Informational Bulletin, Dept. of Health & Human Services (Nov. 2017) ("CMS will develop parameters for expedited approval of certain waiver authorities under demonstrations … that are substantially similar to those approved in other states"), https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf, and by language in the CMS approval letter for Kentucky's demonstration project that includes work requirements, *see* Letter to Adam Meier from Brian Neale, *supra* note **Error! Bookmark not defined.** ("Your substantial work will help inform future state demonstrations seeking to draw on Kentucky's novel approaches to Medicaid reform…").

[276] *See* Letter from Andrew Slavitt to Nicholas A. Toumpas, *supra* note **Error! Bookmark not defined.**, at 1.

[277] Letter from Andrew Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to Mary E. Dalton, State Medicaid Dir., Mont. Dep't of Pub. Health & Human Servs. 1 (Nov. 2, 2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

[278] *See* Nora Kelly, *Can Kentucky's New Governor Undo Obamacare?*, ATLANTIC (Dec. 16, 2015), https://www.theatlantic.com/politics/archive/2015/12/kentucky-bevin-obamacare-kynect-medicaid/420690 (noting that Governor Bevin pledged to dismantle Kentucky's

in the summer of 2016 that contained many of the same elements as the Indiana waiver but sought even more concessions.[279] Like Pennsylvania, Indiana, and other states before it, the Kentucky waiver proposal included work requirements for the population Governor Bevin called the "able-bodied," which the Obama Administration consistently denied.[280]

CMS approved Kentucky's waiver application as this paper was going to press, which signals what the Trump Administration will do with fourth wave renegotiations and new waiver applications.[281] In addition to Kentucky, other states such as Arkansas, Arizona, Indiana, Michigan, and Ohio attempted to renegotiate their expansions,[282] seeking to win the same concessions that other

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insurance exchange and Medicaid expansion); *Proposed Changes to Medicaid Expansion in Kentucky*, HENRY J. KAISER FAM. FOUND. (Aug. 2017), http://files.kff.org/attachment/fact-sheet-Proposed-Changes-to-Medicaid-Expansion-in-Kentucky (noting the move from traditional expansion to waiver expansion).

[279] *See* Ky. Cabinet for Health & Family Servs., KentuckyHEALTH Waiver Application 7-14 (2016) http://chfs.ky.gov/NR/rdonlyres/69D38EB6-602F-4707-933C-80D5AAE907F7/0/KYHEALTHWaiverFINAL.pdf.

[280] *See* Ryland Barton, *Federal Government Starting to Question Bevin's Medicaid Proposal*, WFPL (July 1, 2016), http://wfpl.org/federal-government-starting-question-bevins-medicaid-proposal. Whether such public declarations of opposition to work requirements are the equivalent of an official denial is a difficult question because they are part of a negotiation that occurs both behind closed doors and in the media. The negotiations often lead to a successful demonstration waiver that does not necessitate outright official rejection of a portion of a state's proposal. This leaves the issue open for the next administration to re-interpret, as discussed below.

[281] Victoria Pelham, *States' Waivers Could Lay Groundwork for Big Medicaid Changes*, BLOOMBERG BNA (Aug. 11, 2017), https://www.bna.com/states-waivers-lay-n73014463092/.

[282] Arkansas added cost sharing and limited non-emergency transportation by requiring prior approval but lost on proposed work requirements and asset tests. *See* Henry J. Kaiser Family Found., Medicaid Expansion in Arkansas 1 (2015), http://files.kff.org/attachment/fact-sheet-medicaid-expansion-in-arkansas. Third wave demonstration waivers expire within five years, creating potential for further negotiation and adaptation as those waivers are reapproved, amended, or dropped. Some states have not permanently funded their expansions, and others included sunset clauses in expansion legislation, both of which cause political reevaluation. *See, e.g.*, Letter from Asa Hutchinson, Governor, State of Ark., to Sylvia Matthews Burwell, Sec'y, Dep't of Health & Human Servs. 1 (Dec. 29, 2015), http://posting.arktimes.com/media/pdf/asaletter.pdf; Letter from Sylvia Burwell, Sec'y, Dep't of Health & Human Servs., to Asa Hutchinson, Governor, State of Ark. 2 (Apr. 5, 2016), http://governor.arkansas.gov/images/uploads/Burwell_Letter_to_Governor.pdf. Arizona pursued many of the concessions other states received in their waivers, including wellness incentives, non-emergency medical transportation non-payment, varied benefit packages, and enforceable premiums and copayments with lockout periods. *See generally* Ariz. Health Care Cost Containment Sys., Arizona's Application for a New Section 1115 Demonstration (2015), https://www.azahcccs.gov/shared/Downloads/WaiverApplicationNarrative.pdf. Like Kentucky, Arizona and Arkansas sought work requirements but were denied in negotiations

states received and, in most cases, pushing for even more.[283] Arkansas has even requested partial expansion, which was rejected by the Obama Administration in 2012.[284] This is where the transition to the Trump Administration may make the most difference in the context of Medicaid expansion waivers, given that CMS Administrator Verma crafted state waiver applications that included work requirements in her life as a consultant before she was appointed to run CMS.[285] She and then-HHS Secretary Tom Price issued a letter emphasizing their desire to protect "the most vulnerable populations" and stating that the "best way to improve the long-term health of low-income Americans is to empower them with skills and employment. It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence."[286] Thus, the fourth wave could develop to include additional concessions that will motivate red states to opt in, and it

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with the Obama Administration. Michigan too sought new concessions, and Ohio tried to create premium payments for all income levels in its waiver proposal after expansion by Executive Order, which was denied along with other features such as proposed lockouts for premium nonpayment. *See id.* at 3-4; *see also* Dept. of Health & Human Services, Letter to John McCarthy from Andrew Slavitt (Sept. 9, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/healthy-ohio-program/oh-healthy-oh-program-disapproval-ltr-09092016.pdf; *Medicaid Waiver Tracker: Which States Have Approved and Pending Section 1115 Medicaid Waivers?* HENRY J. KAISER FAM. FOUND. (Jan. 24, 2018), https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/; MaryBeth Musumeci et al., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, HENRY J. KAISER FAM. FOUND. (Feb. 2018), http://files.kff.org/attachment/Issue-Brief-Section-1115-Medicaid-Demonstration-Waivers-The-Current-Landscape-of-Approved-and-Pending-Waivers.

[283] Then-Governor Pence sat on the dais at Governor Bevin's inaugural ceremonies, *see* Joseph Gerth, *Matt Bevin Calls for Unity at Inauguration*, COURIER-JOURNAL (Dec. 8, 2015, 3:46 PM ET), http://www.courier-journal.com/story/news/politics/ky-governor/2015/12/08/matt-bevin-publicly-sworn-governor/76979250 (noting Pence's presence on the gubernatorial stage), so the Indiana-plus direction that Governor Bevin would propose for Kentucky's ACA-based Medicaid expansion was no surprise.

[284] Shannon Firth, *One Little Medicaid Waiver Could Spell Big Changes: Arkansas Proposes 'Partial Expansion' That Would Boot 60,000 from Program*, MEDPAGE TODAY (Sept. 15, 2017), https://www.medpagetoday.com/publichealthpolicy/medicaid/67968. For a summary of states' waiver requests, see MARYBETH MUSUMECI ET AL., HENRY J. KAISER FAMILY FOUND., SECTION 1115 MEDICAID EXPANSION WAIVERS: A LOOK AT KEY THEMES AND STATE SPECIFIC WAIVER PROVISIONS 1 (2017), http://files.kff.org/attachment/Issue-Brief-Section-1115-Medicaid-Expansion-Waivers-A-Look-at-Key-Themes-and-State-Specific-Waiver-Provisions (comparing requests and flagging questionable application features such as work requests and partial expansion).

[285] *See supra* note **Error! Bookmark not defined.** and accompanying text.

[286] Letter from Thomas E. Price, Sec'y, Dep't of Health & Human Servs., and Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Governors 1-2 (Mar. 14, 2017), https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf.

appears that Kentucky's waiver could be the switch that flips other states in the post-Obama realm of ACA implementation,[287] if it survives legal challenges.[288]

Former federal officials told us that in trying to make the ACA work during the end of the Obama Administration, HHS found new ways to compromise.[289] Yet, one place where President Obama's HHS consistently drew the line was work requirements; they were uniformly rejected as inconsistent with the goals of the Medicaid Act and Medicaid expansion.[290] Given the shift in HHS's policy noted above,[291] and Kentucky's work requirement approval,[292] Maine, Wisconsin, and other states are exploring 1115 waivers that would include work requirements, cost sharing, and welfare-style time limits on Medicaid beneficiaries.[293]

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[287] Indiana's waiver application was approved three weeks after Kentucky's; it too included work requirements and other barriers to enrollment for the newly eligible population. *See* Dept. of Health and Human Services, Letter to Allison Taylor from Demetrios Kouzoukas (Feb. 2, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf. *See also* Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, New England Journal of Medicine (Feb. 7, 2018) (predicting more Medicaid expansions will occur with CMS's new policies in place).

[288] Stewart v. Hargan, Case 1:18-cv-00152, filed in Dist. Ct. of D.C. Jan. 24, 2018, http://www.healthlaw.org/issues/medicaid/waivers/stewart-v-hargan-lawsuit-challenging-kentucky-medicaid-waiver-project#.WnoKmKinGbg.

[289] Interview with Former Federal Executive Branch Health Care Official 1, *supra* note **Error! Bookmark not defined.**.

[290] Interview with Former Federal Executive Branch Health Care Official 5, *supra* note 204; Interview with Health Policy Nonprofit Officers 1 (a Former State Official) and 2 (Aug. 1, 2016).

[291] Letter from Thomas E. Price and Seema Verma to Governors, *supra* note 292, at 2 (focusing on work as a way out of poverty, and thus out of Medicaid benefits, and expressing openness to states' proposals to limit Medicaid to the "truly vulnerable").

[292] Kentucky amended its application seeking work requirements by making them quite stringent for people who re-enroll in Medicaid within a certain period of time, effectively shortening the clock for work requirements to kick in when enrollees churn out of and back into the program. *See* Ky. Cabinet for Health & Family Servs., Proposed Operational Modification to Waiver Application 3-6 (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf (requesting amendments to Kentucky's waiver application); *see also* Deborah Yetter, *Bevin Revises Medicaid Plan, Seeks to Reduce Kentucky's Rolls by Another 9,000 People*, COURIER-JOURNAL (July 7, 2017 10:06 AM ET), http://www.courier-journal.com/story/news/2017/07/07/bevin-proposes-more-changes-limit-states-medicaid-health-plan/450982001 (explaining the amended waiver application in plain English). This amendment was part of the approved waiver. *See* note **Error! Bookmark not defined.** *supra*.

[293] *See* MaryBeth Musumeci et al., Henry J. Kaiser Family Found., Proposed Medicaid Section 1115 Waivers in Maine and Wisconsin, (May 10, 2017), http://files.kff.org/attachment/Issue-Brief-Proposed-Medicaid-Section-1115-Waivers-in-Maine-and-Wisconsin.

In a mirror image to Kentucky's 2015 election, Democrat John Bel Edwards rejected prior Republican Governor Bobby Jindal's non-expansion politics and expanded Medicaid eligibility in Louisiana.[294] His desire to enroll uninsured individuals as quickly as possible with a lean administrative staff led Louisiana to be first to take advantage of a rapid enrollment mechanism that allows states to use Supplemental Nutrition Assistance Program (SNAP) eligibility (commonly known as food stamps) to reach out to Medicaid-eligible individuals for enrollment.[295] This expedited enrollment tool had been approved as a special type of waiver before the ACA, but a 2015 CMS guidance letter presented the option (without a waiver) for SNAP enrollees who were "certain" to be financially eligible for Medicaid under the ACA's accounting methods.[296] By exercising this option, Louisiana swiftly added more than 300,000 new beneficiaries.[297] Louisiana thus offered a model for states that may experience political switches that lead to opting in with a desire to onboard newly eligible beneficiaries quickly, even in a post-Obama Administration environment.

One former Governor told us that a common conversation topic among governors behind closed doors, especially at National Governors' Association meetings, is precisely the topic of successful strategies for expansion.[298] This is horizontal interaction to be sure, but it is not states acting in concert or using combined leverage to move HHS. Rather, states have experienced horizontal learning, leading to a sort of sibling rivalry, seeking what others acquired plus a little more.

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[294] Elizabeth Crisp, *Louisiana Road to Medicaid Expansion Long, Winding but Finally Here*, ADVOCATE (July 5, 2016, 4:17 PM), http://www.theadvocate.com/baton_rouge/news/politics/article_e8196910-42f5-11e6-91cf-87926f6a6eac.html?sr_source=lift_amplify.

[295] *See* Kevin Litten, *Louisiana to Use Food Stamp Data for Medicaid Expansion*, NEW ORLEANS TIMES-PICAYUNE (May 6, 2016), http://www.nola.com/politics/index.ssf/2016/05/medicaid_expansion_food_stamps.html. HHS encouraged this approach to Medicaid expansion. *See* Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., to State Health Officials & State Medicaid Dirs. 2, 4-5 (May 17, 2013), https://www.medicaid.gov/federal-policy-guidance/downloads/sho-13-003.pdf (encouraging use of SNAP to speed enrollment in CHIP and Medicaid).

[296] Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., to State Health Officials & State Medicaid Dirs. 3 (Aug. 31, 2015), https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-15-001.pdf (describing use of targeted enrollment through SNAP as a SPA option rather than a waiver option after the ACA).

[297] Elizabeth Crisp, *Medicaid Expansion Enrollment Tops 300K in Louisiana*, ADVOCATE (Sept. 19, 2016, 11:55 AM), http://www.theadvocate.com/baton_rouge/news/politics/article_d42ae198-7e89-11e6-a7cf-6f685013d5fc.html.

[298] Interview with Former Governor, *supra* note **Error! Bookmark not defined.**.

The Medicaid implementation story illustrates our point that this is not a zero-sum game. Some states "won" concessions through individualized demonstration waivers. The Obama Administration arguably "lost" by conceding on the principle of universality in negotiations, allowing states to reintroduce exclusionary measures like lock-out for failure to pay premiums. But HHS "won" by bringing state after state into the ACA. States that have not yet negotiated their way to expansion have arguably "lost," because their citizenry have the highest uninsurance rates in the nation.[299] A state like Kentucky originally adopted an ACA-based Medicaid expansion but then sought an exclusionary demonstration waiver.[300] Is Kentucky cooperative? Is it more sovereign to implement Medicaid expansion through an SPA or through a negotiated waiver? Each reserves power and allows choices for the state, and each involves federal standards that the state must observe. Who has won?

Even if we could answer such questions, "wins and losses" do not necessarily teach anything about "health care federalism." It is uncertain whether these negotiations have been beneficial for health outcomes, or more beneficial than total nationalization would have been. It seems clearer, however, that these negotiations increased state power and control within the ACA's framework, and that these dynamics are continuing into the Trump Administration's implementation of the ACA.

B. Federalism Attributes: States as Individual Republics; Local Variation and Control

It is ironic that federalism scholars often discuss "the states" as if they were a monolithic bloc, since one of the underpinnings of classic federalism theory is to recognize each state as a sovereign government—and thus distinguishable from the next state. The Medicaid expansion highlights these differences and reinforces the important influence that intrastate politics - and the expression of state sovereignty that comes with it - has on state interaction with federal law. Medicaid expansion involved fifty-two different negotiating sovereigns—each state (plus D.C.) individually and the federal government. It also involved politically fraught intrastate decisionmaking that underscores the important differences among governors, legislatures, and state administrative agencies in state policymaking and undermines accounts of modern federalism as dominated by partisanship.

1. Intrastate Differences as a Countervailing Force to Partisanship

[299] *See* Henry J. Kaiser Family Found., *supra* note 174, at 1, 3.

[300] See *supra* notes **Error! Bookmark not defined.**, **Error! Bookmark not defined.**-**Error! Bookmark not defined.** and accompanying text.

Not all states have the same legal or constitutional structure. These acknowledged differences affect how a state might go about implementing, or even deciding to implement, a federal program.[301]

One of our interviewees emphasized that "Congress has no idea how states work and does not take that question, including how state budgets work, into account when drafting."[302] States had different laws regulating insurance and Medicaid going into the ACA and that affected the choices they made.[303]

Internal state actors also diverge from one another in significant ways. In the Medicaid context, budget considerations, influential health care stakeholders—especially hospitals—as well as low-income and rural citizenry's needs, turned some red state governors into Medicaid supporters, even when they faced resistance from legislators in their own party. For example, Republican Governor Jan Brewer announced Arizona would expand, then faced opposition from legislators; she then called a surprise legislative session and refused to end it until expansion legislation passed.[304] Similar (though less extreme) circumstances arose in North Dakota and Ohio, each of which also had a Republican governor supporting expansion over vociferous Republican legislative protests, but expansion ultimately occurred.[305]

Some governors tried working around legislatures altogether. For instance, Kentucky Governor Steve Beshear implemented Medicaid expansion using a longstanding Kentucky law that commanded Medicaid funds to be maximized.[306] He commissioned reports supporting his position, which then

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[301] *See, e.g.*, SHELLY TEN NAPEL ET AL., STATE HEALTH REFORM ASSISTANCE NETWORK, MANAGING STATE-LEVEL ACA IMPLEMENTATION THROUGH INTERAGENCY COLLABORATION 4-10 (2012), http://www.statenetwork.org/wp-content/uploads/2014/11/State-Network-Managing-State-Level-ACA-Implementation-Through-Interagency-Collaboration-FINAL.pdf (encouraging state actors that have historically had different goals in state policy making to work together to implement the ACA).

[302] Interview with Former Governor, *supra* note **Error! Bookmark not defined.**.

[303] Interview with Health Policy Nonprofit Officers 1 (a Former State Official) and 2, *supra* note **Error! Bookmark not defined.**.

[304] Governor Brewer signed legislation expanding Arizona's Medicaid program on June 17, 2013. *See* Mary K. Reinhart, *supra* note **Error! Bookmark not defined.**.

[305] *See* Smith, *supra* note **Error! Bookmark not defined.**; Young, *supra* note **Error! Bookmark not defined.**; Dan Zak, *Spurning the Party Line*, WASH. POST (Jan. 5, 2016), http://www.washingtonpost.com/sf/national/2016/01/05/decliderskasich/?utm_term=.a01dc5f22912.

[306] *See* KY. REV. STAT. ANN. § 205.520(3) (West 2017); Sheila Lynch-Afryl, *Kentucky Court Rejects Constitutional Challenges to Medicaid Expansion, Insurance Exchanges*, WOLTERS KLUWER: HEALTH L. DAILY (Sept. 5, 2013), http://www.dailyreportingsuite.com/health/news/kentucky_court_rejects_constitutional_chal

enabled him to instruct the Kentucky Cabinet for Health and Family Services (CHFS) to expand Medicaid pursuant to state law.[307] The legislature argued he could not expand in this manner (administratively and without specific legislative action), but state courts sided with the governor, allowing expansion to proceed.[308] Similarly, Ohio Governor John Kasich asked the state Controlling Board (a commission that facilitates use of federal funds outside the legislative budgeting process) to approve use of available federal funds for Medicaid expansion.[309] The Ohio legislature had refused to pass a budget that included expansion but was bypassed by the Controlling Board working with the Governor.[310] In 2017, the legislature proposed legislation that would require re-approval of Medicaid expansion every six months so as to limit this kind of workaround.[311]

In Alaska, Governor Bill Walker (an Independent) rejected the anti-expansion policy of Governor Sean Parnell (a Republican) and expanded through an existing state Medicaid law that automatically accepts federal eligibility categories labeled as "mandatory."[312] The Alaska Legislative Council challenged Governor Walker's action to expand Medicaid, claiming that *NFIB* had converted the expansion into a Medicaid option that could only

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lenges_to_medicaid_expansion_insurance_exchanges (providing background on Beshear's Medicaid expansion approach).

[307] Press Release, Kerri Richardson & Terry Sebastian, Ky. Governor's Office, Gov. Beshear Expands Health Coverage to Over 300,000 Kentuckians (May 9, 2013), http://kentucky.gov/Pages/Activity-Stream.aspx?viewMode=ViewDetailInNewPage&eventID=%7b611A39A2-740F-45C2-B715-2F36F3C6AC96%7d&activityType=PressRelease.

[308] *See, e.g.*, Henry J. Kaiser Family Found., An Overview of Actions Taken by State Lawmakers Regarding Medicaid Expansion 4-5 (Feb. 2015), http://files.kff.org/attachment/fact-sheet-an-overview-of-actions-taken-by-state-lawmakers-regarding-the-medicaid-expansion; Lynch-Afryl, *supra* note **Error! Bookmark not defined.**.

[309] Minutes of the October 21, 2013 Meeting, Controlling Bd. of the Ohio Office of Budget & Mgmt. 7 (Oct. 21, 2013), https://ecb.ohio.gov/public/MeetingsandAgendas.aspx (search for October 21, 2013 minutes, and download as pdf).

[310] *See* David Schleicher, *Federalism and State Democracy*, 95 Tex. L. Rev. 763, 796-97 (2017) (detailing the history of Medicaid expansion in Ohio).

[311] Andy Chow, *House Budget Proposes a Tighter Grip on Medicaid Expansion Funds*, WKSU (May 1, 2017), http://wksu.org/post/house-budget-proposes-tighter-grip-medicaid-expansion-funds.

[312] *See* Edited Transcript of Decision on Record at 17-21, Alaska Legislative Council v. Walker, No. 3AN-15-09208 CI, 2016 WL 4073651 (Alaska Super. Ct. Mar. 1, 2016), https://premiumtaxcredits.wikispaces.com/file/view/EX%2018.pdf/571389417/EX%2018.pdf (discussing Alaska Statute § 47.07.020 (2016)) Craig Tuten, *Legislature's Medicaid Expansion Lawsuit Against State Dismissed*, ALASKA COMMONS (Mar. 2, 2016), http://www.alaskacommons.com/2016/03/02/legislatures-medicaid-expansion-lawsuit-against-state-dismissed.

be implemented through affirmative legislative changes.[313] The state court held that Alaska could sign on to the expansion through an SPA over legislative objection;[314] in early 2016, the legislature lost steam and did not appeal the decision.[315]

In other states, governors commissioned studies of expansion, which have supported ongoing intrastate negotiations regarding Medicaid expansion,[316] even after the Trump Administration took office.[317] On the other hand, some governors that have fought expansion have been deeply opposed by their legislatures, such as in Maine, where Governor LePage vetoed Medicaid expansion five times, leading to a ballot initiative in the 2017 election that rendered Maine the first state to expand by referendum,[318] allowing the state to work around him.[319] And some governors have supported expansion but have been unable to work around their legislatures, such as North Carolina Governor Roy Cooper, a Democrat who attempted to reverse his Republican predecessor's decision to opt out of Medicaid expansion,[320] or Missouri Governor Jay

[313] *See* Tuten, *supra* note **Error! Bookmark not defined.**.

[314] *See* Edited Transcript of Decision on Record, *supra* note **Error! Bookmark not defined.**, at 19, 24. Thanks to Mark Regan for assistance in making the points in this paragraph.

[315] Tegan Hanlon, *Legislative Council Drops Medicaid Lawsuit Against Gov. Walker*, ALASKA DISPATCH NEWS (June 29, 2016), https://www.adn.com/politics/2016/06/29/legislative-council-drops-medicaid-lawsuit-against-gov-walker.

[316] *See, e.g.*, *Medicaid Expansion Options Community Workgroup to Hold First Meeting*, UTAH DEP'T HEALTH (Apr. 22, 2013), http://udohnews.blogspot.com/2013/04/medicaid-expansion-options-community.html (recognizing that Utah's governor supported expansion during the 2015 legislative session).

[317] *See, e.g.*, Bruce Japsen, *More States to Expand Medicaid Now that Obamacare Remains Law*, FORBES (Mar. 26, 2017, 9:19 AM), https://www.forbes.com/sites/brucejapsen/2017/03/26/more-states-to-expand-medicaid-now-that-obamacare-remains-law/#457fa50c19a6 (reporting on Kansas and North Carolina's continued efforts to expand, the latter at the legislature's behest); Rose Hoban, *In First Budget, Cooper Pushes for Medicaid Expansion*, N.C. HEALTH NEWS (Mar. 2, 2017), https://www.northcarolinahealthnews.org/2017/03/02/first-budget-cooper-pushes-medicaid-expansion (noting North Carolina Governor Roy Cooper's efforts to expand Medicaid).

[318] Patrick Whittle, *Maine OKs Medicaid Expansion in First-of-Its-Kind Referendum*, AP NEWS (Nov. 8, 2017), https://www.apnews.com/cf007502a8dc421990c4d8dfcde19235/Maine-OKs-Medicaid-expansion-in-first-of-its-kind-referendum.

[319] Christopher Cousins, *Medicaid Expansion Referendum Headed to Maine Ballot*, BANGOR DAILY NEWS (Nov. 1, 2017, 2:08 PM), http://bangordailynews.com/2017/02/21/news/state/medicaid-expansion-referendum-headed-to-maine-ballot/ (reporting on a state ballot initiative to expand Medicaid given the governor's stonewalling).

[320] *See* Chris Cioffi, *Gov. Roy Cooper's Medicaid Expansion Plan Temporarily Blocked*, NEWS & OBSERVER (Jan. 14, 2017, 10:29 PM), http://www.newsobserver.com/news/politics-government/state-politics/article126678654.html; David Ranii, *Gov. Roy Cooper Wants to*

Nixon, a Democrat who was thwarted by a Republican-dominated legislature.[321]

Of course, some governors and their legislatures have aligned. For example, Governor Perry submitted a letter to Secretary Sebelius just days after *NFIB*, publicly proclaiming that Texas opted out of both the Medicaid expansion and the exchanges,[322] and the Texas legislature supported that letter with legislation preventing compliance.[323]

We surmise the reason that governors have diverged so much from legislatures of their own party has to do with governors' traditional accountability for state budgets and their longer time horizons.[324] Governors are also likely to feel the heat from industry—such as the ire of the hospitals in non-expansion states—in more focused fashion than any single legislator.[325] It may be easier for legislators to take stands purely for political reasons.[326]

Expand Medicaid; Republicans Vow to Fight, NEWS & OBSERVER (Jan. 4, 2017, 12:34 PM), http://www.newsobserver.com/news/business/article124491039.html (describing tension between the new governor and the legislature).

[321] *See* Kyle Cheney, *Missouri Nixes Medicaid Expansion*, POLITICO (May 8, 2013, 5:19 AM EDT), http://www.politico.com/story/2013/05/missouri-lawmakers-torpedo-medicaid-expansion-091040 ("A symbolic vote in 2010 deemed that Missouri wouldn't participate in the law and a more substantive ballot measure in 2012 blocked Nixon's administration from unilaterally establishing a state-run insurance exchange."). The newly elected Republican governor opposed expansion in early 2017. *See* Austin Huguelet, *Despite Failure of GOP Health Care Bill, Greitens Remains Opposed to Medicaid Expansion*, ST. LOUIS POST-DISPATCH (Mar. 28, 2017), http://www.stltoday.com/news/local/govt-and-politics/despite-failure-of-gop-health-care-bill-greitens-remains-opposed/article_a7c15c13-b314-5384-bf3a-a78f32aa348d.html.

[322] *See* Letter from Rick Perry, Governor, State of Tex., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health and Human Servs. (July 9, 2012), https://www.scribd.com/document/99590002/Rick-Perry-s-Letter-to-HHS-Secretary-Kathleen-Sebelius?doc_id=99590002&download=true&order=440429142.

[323] *See* James Jeffrey, *Texas Bill Thwarts Medicaid Expansion Here*, AUSTIN BUS. J. (May 28, 2013, 7:32 AM CDT), http://www.bizjournals.com/austin/blog/abj-at-the-capitol/2013/05/texas-bill-thwarts-medicaid-expansion.html; *see also* H.B. 3791, 83d Leg., Reg. Sess. (Tex. 2013).

[324] Interview with Former Governor, *supra* note **Error! Bookmark not defined.**.

[325] *See, e.g.*, Alexander Hertel-Fernandez et al., *Business Associations, Conservative Networks, and the Ongoing Republican War Over Medicaid Expansion*, 41 J. HEALTH POL., POL'Y & L. 239, 244 (2016) (describing hospitals applying pressure to expand Medicaid); Bruce Japsen, *Pressure on Governors to Expand Medicaid Under ObamaCare*, FORBES (Mar. 8, 2014, 10:01 AM), https://www.forbes.com/sites/brucejapsen/2014/03/08/pressure-on-gop-governors-to-expand-medicaid-under-obamacare/#b68f3fd5bcf3 (describing pressure on governors).

[326] *See, e.g.*, Hertel-Ferndandez et al., *supra* note **Error! Bookmark not defined.**, at 259-61 (offering example of Missouri legislators' rejection of expansion).

Governors, on the other hand, must work with Medicaid commissioners and (sometimes elected) state insurance commissioners, get blamed for budget crises, answer to industry, and see benefits in shifting healthcare costs to the federal government while simultaneously creating more in-state medical sector jobs.[327]

One former governor who we interviewed put it this way: "The governor represents the entire state and has a statewide vision, whereas the legislature is drawn from small districts and tends to be more reactive."[328] Indeed, as the most recent Republican efforts to repeal the ACA drew to a close, we saw this dynamic in play once again. Bipartisan groups of governors allied to protest the substance of the repeal legislation.[329]

Some recent federalism scholarship puts a heavy emphasis on partisan politics as the primary domain in which modern federalism issues play out. That narrative is a nationalist narrative to some extent, as interstate differences and individual state differences matter less to it than national party affiliation. But as Rick Hills has observed, the ACA implementation calls this assumption into question.[330] For instance, Jessica Bulman-Pozen argues that states are a proving ground in which national parties test their policies and claims that the split over ACA implementation was "perfectly partisan."[331] David Schleicher likewise predicts, as Hills puts it, that state politicians will "march[] in lockstep with their national counterparts."[332] Schleicher also notes, however, that federalism theory that emphasizes partisanship may be less relevant when it

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[327] *Cf. id.* at 250 ("Governors are pivotal state officials and have long played a central role in Medicaid policy making.").

[328] Interview with Former Governor, *supra* note **Error! Bookmark not defined.**.

[329] *See* Letter from John Hickenlooper, Governor, State of Colo., et alto Mitch McConnell, Majority Leader, U.S. Senate, and Charles E. Schumer, Minority Leader, U.S. Senate (Sept. 19, 2017), https://www.colorado.gov/governor/sites/default/files/bipartisan_governors_letter_re_graham-cassidy_9-19-17.pdf.

[330] Rick Hills, *Governors and the Failure of ACA Repeal: Federalism as Safeguard Against National Partisan Politics*, PRAWFSBLAWG (July 28, 2017, 11:46 AM), http://prawfsblawg.blogs.com/prawfsblawg/2017/07/governors-and-the-failure-of-aca-repeal-federalism-as-safeguard-for-national-partisan-politics.html.

[331] Jessica Bulman-Pozen, *Partisan Federalism*, 127 HARV. L. REV. 1077, 1081, 1098 (2014).

[332] *See* Hills, *supra* note **Error! Bookmark not defined.** (discussing Jessica Bulman-Pozen's theory of "Partisan Federalism" and David Schleicher's article on "Federalism and State Democracy"); *see also* Schleicher, *supra* note **Error! Bookmark not defined.**, at 765 ("Elections where voters rely on party preferences developed in relation to another level of government are common enough worldwide that political scientists have developed a term for them: 'second-order elections.'" (footnote omitted)).

comes to governors.[333] Our study substantiates that claim. Schleicher further suggests that state democracy itself—a key federalism attribute—is strengthened by these acts of differentiation from the national party.[334]

The ACA story, to be sure, illustrates a key role for partisanship, but in many ways the partisanship was superficial. Our account uncovers an intrastate dynamic that undermines the lockstep partisan account of state-federal interaction as the only, or even dominant, game in town.

2. Autonomy and Local Variation

Furthering the point about individual states acting as their own differentiated sovereigns, every state and federal official we interviewed told us that each state acted *alone* in negotiations with HHS.[335] The Medicaid expansion did not play out as a battle between the national government and "the states" as a collective. Instead, the Obama Administration was a serial negotiator, inking distinct deals with individual states, all of which watched the others then negotiated in their own interests.[336]

One influential critique of modern federalism theory—Edward Rubin and Malcolm Feeley's argument that schemes like the ACA's are mere decentralization not federalism—argues that two key criteria for federalism, even within a cooperative program, are at least "partial autonomy" and identity with the state.[337] The leverage the states exerted in ACA implementation and the extent to which they were able to shape their programs so individually seems to fit within the Rubin-Feeley model. To us, it is notable in this vein that state Medicaid programs typically adopt a state-centered identity. They have

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[333] *See* Schleicher, *supra* note **Error! Bookmark not defined.**, at 797-98

[334] *See* Schleicher, *supra* note **Error! Bookmark not defined.**, at 771.

[335] Interview with Former Federal Executive Branch Health Care Official 1, *supra* note **Error! Bookmark not defined.**; Interview with Former Federal Executive Branch Health Care Officials 2, 3, and 4, *supra* note 31; Interview with Former Federal Executive Branch Health Care Official 5, *supra* note 204; Interview with Former Governor, *supra* note **Error! Bookmark not defined.**; Interview with State Policy Organization Officers 1, 2, 3, and 4, *supra* note **Error! Bookmark not defined.**.

[336] One scholar of Canadian federalism wrote: "[F]ederal-provincial relations resemble international diplomacy, and often Ottawa's only option is to negotiate separate bilateral deals with individual provinces." JONATHAN A. RODDEN, HAMILTON'S PARADOX: THE PROMISE AND PERIL OF FISCAL FEDERALISM 263 (2006) (citation omitted).

[337] *See* FEELEY & RUBIN, *supra* note **Error! Bookmark not defined.**, at 16.

names like "HIP 2.0," "TennCare," and "Husky Health," rather than Indiana Medicaid, Tennessee Medicaid, or Connecticut Medicaid.[338]

With respect to the kind of variety that federalist regimes are expected to demonstrate, these individual state negotiations produced enormous policy and legal diversity. Table 1 offers a snapshot of the wide range of possible state decisions regarding Medicaid expansion. These decisions include not just whether to expand Medicaid but how to do so as a matter of law, when, and with which negotiated modifications to the ACA's structure.[339] The breadth of variations illustrates a classic federalism value in action—local decision making—but with the modern twist of occurring *within* a national baseline established by federal law. At the same time, variability across states in Medicaid access conflicts with a common health policy goal of equality[340]—the very goal the ACA's universal Medicaid expansion was designed to address.[341] A preference for variety and state choices tends to undermine moral aims like this one in a federalist regime; but of course, this point is not unique to health care.

Table 1 shows that states have explored a variety of legal structures for implementing federalist policies. As was discussed above, many first and second wave states used an SPA to comply with the terms of the ACA, the traditional mechanism for a state to indicate to HHS its strategy for complying with federal Medicaid law.[342] But, as was also discussed, states have sought section 1115 demonstration waivers too, both to offer more than the ACA requires and to pursue variables that push on the baseline enacted in the ACA.[343] In states that have not yet expanded, negotiations are ongoing both intrastate and inter-governmentally with HHS, and another snapshot one year in the future would offer further variations.

Table 1

To build on this narrative, Table 2 offers a different snapshot, illustrating the variety of state policy choices exercised after states have made the choice to expand Medicaid eligibility, such as: which states have opted in; states that

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[338] *See* Interview with Former Federal Executive Branch Health Care Officials 2, 3, and 4, *supra* note 31; *Medicaid Program Names*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Feb. 5, 2009), https://aspe.hhs.gov/dataset/medicaid-program-names.

[339] *See supra* Part ___.

[340] Nicole Huberfeld & Jessica L. Roberts, *An Empirical Perspective on Medicaid as Social Insurance*, 46 U. of Toledo L. Rev. 545, 557 (2015) (exploring Medicaid expansion as social justice).

[341] *See supra* Part III.A.

[342] *See supra* Part IV. ___.-___.

[343] *See supra* Part IV.A.

accepted the ACA's policy choice of universal expansion but sought waivers to expand eligibility above the ACA's baseline; and some influential variations in section 1115 waivers such as method of implementation (e.g., premium assistance), cost sharing and premiums, health behavior (or wellness) incentives, work requirements, and other policy choices. The states that have slowly opted in by negotiating their way to expansion have enjoyed the most policy discretion, seen in the chart by the numerous policy variables adopted by third and fourth wave expansion states. As discussed above,[344] each new 1115 waiver involves more variation from the federal baseline, and fourth wave states are leveraging the option to expand eligibility that *NFIB* created and that HHS might not have been eager to grant if not for the Court's interference. Table 2 accounts for expansion waivers and submitted waiver applications but not informal negotiations.

Table 2

V. Insurance Exchange Implementation

Occurring alongside and revealing similar themes to those we have introduced in the context of the Medicaid expansion, the ACA's exchange implementation produced its own surprising array of implementation options and federalism-related features. We describe in this Part the ways in which exchange implementation was likewise dynamic, adaptive, and marked by horizontal relationships and intrastate politics. We focus on these themes rather than on chronological progression, because there were less visible waves of implementation in this context, creating instead a more fluid environment in which structures changed and evolved.

The exchange implementation story also turns many traditional federalism assumptions on their head—or at least sideways. Traditional federalism characteristics like cooperation, sovereignty, autonomy, and variation show up in odd ways in the context of the state-federal interchange over the exchanges. For instance, it is difficult to predict, merely from a state's choice whether or not to implement an exchange, if that state has been cooperative, disobedient, autonomous, or producing policy variation.

We also saw a recurrent desire in this context for some *middle ground* between traditional federalist and nationalist stances. Congress tends to draft statutes as nationalist or federalist in terms of architecture—with one or fifty options. But under the ACA, states worked with HHS to devise "hybrid" state-federal exchange structures that were not envisioned by the ACA's drafters, but that allowed states to retain control with significant federal support. Some

[344] *See supra* Part IV.A.

states preferred instead to model their exchanges on other states', with a general consensus emerging that while some variation of exchange structure may be useful, fifty different exchanges were too many—but one might have been too few. Some of these state moves were under the radar for political reasons and raise transparency concerns; hybrid structures obfuscated state cooperation with the national government while still allowing states to be in de facto control.

To that end, as in the Medicaid context, the exchange implementation also undermines the account, popular in both the media and among some federalism scholars, that partisanship drove intergovernmental relations under the ACA above all else. Simultaneous with the public political resistance and in direct tension with it, many red states actually worked quietly with the federal government to devise the best policies for their states. In many cases, these moves were precipitated by the same kinds of divergences among intrastate actors that we highlighted in the Medicaid account, for example, with state insurance commissioners bucking governors of their own party to cooperate.

A. Cooperation, Resistance, and Autonomy in Dynamic Exchange Implementation

Like the Medicaid expansion, the exchange implementation also rolled out with a first wave, but the states' exchange stances since then have been much more fluid and unpredictable. *All* of the states except Alaska applied for and received the initial, no-strings attached exchange planning grants made available to states in the fall of 2010,[345] shortly after the ACA was enacted, and approximately three-fifths of the states jumped in within months of the statute's enactment to exercise their option to operate their own transitional high risk pools for those with preexisting conditions.[346] In February 2011, HHS also awarded "early innovator" grants to six states—Kansas, Maryland, New York, Oklahoma, Oregon, and Wisconsin—and to a consortium of New England states—Connecticut, Maine, Massachusetts, Rhode Island, and Vermont—all of which declared interest in developing exchange information technology that could be adapted and implemented by other states.[347] These states emerged early out of an apparent desire to position themselves as "thought leader

[345] ANNIE L. MACH & C. STEPHEN REDHEAD, CONG. RESEARCH SERV., R43066, FEDERAL FUNDING FOR HEALTH INSURANCE EXCHANGES 2 & n.6 (2014). South Carolina, North Dakota, Texas, and Louisiana eventually returned most of their planning grant funds. *See Establishing Health Insurance Marketplaces: An Overview of State Efforts*, HENRY J. KAISER FAM. FOUND. fig.2 (May 2, 2017), https://www.kff.org/health-reform/issue-brief/establishing-health-insurance-exchanges-an-overview-of.

[346] *See* Timothy Jost, *Implementing Health Reform: The Web Portal and Early Retiree Reinsurance*, HEALTH AFF. BLOG (May 6, 2010), https://www.healthaffairs.org/do/10.1377/hblog20100506.005013/full.

[347] MACH & REDHEAD, *supra* note 345, at 2-3, 4-5 tbl.1.

states." By mid-2013, forty-six states had received 3.6 billion dollars in planning, implementation, and early innovator grants.[348]

But politics quickly turned the tide firmly against working with HHS after the initial grant phase. The *NFIB* litigation both sowed uncertainty about the ACA's future—which made states more reluctant to jump out in front and establish exchanges that might ultimately be struck down—and turned opposition to the statute into a Republican loyalty litmus test. Soon, Kansas, Oklahoma, and Wisconsin returned their early innovator grants,[349] and most red states declined to establish their own exchanges at all.[350]

This resistance was unexpected. The most federalism-oriented states were expected to exercise their federally offered "right of first refusal" to implement the federal program at the state level, as we see in other similarly structured schemes. It was expected that states would want the ability to vary their own programs—be able to tailor the program to the needs of the particular state—but also that states would view the federal statute as encroaching less on state domains when states control implementation.[351] This was a key point in the original Medicaid Act's implementation and in predecessor programs.[352] It was also emphasized by Republicans early in the ACA implementation. One Republican official said letting the federal government operate a state's insurance exchange was a "Trojan horse" that would pave the way to a full-scale federal takeover.[353] But the hot politics of the ACA trumped traditional federalism perspectives and reversed the usual course. Notably, states would have had the same policy autonomy even without *NFIB*—that holding had nothing to do with insurance exchanges. *NFIB*'s effect with respect to the exchanges was on the choices states made rather than on the existence of the choices in the first place.

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[348] *Establishing Health Insurance Marketplaces: An Overview of State Efforts*, *supra* note 345.

[349] MACH & REDHEAD, *supra* note 345, at 3. Nevertheless, thirty-seven states and D.C. applied for and received Level 1 exchange establishment grants, which provided funds for states to take steps toward establishing a state-based exchange without needing to meet the specific exchange structure and governance requirements needed for a Level 2 grant. *Id.* at 2.

[350] *See* Sarah Kliff, *It's Official: The Feds Will Run Most Obamacare Exchanges*, WASH. POST: WONKBLOG (Feb. 18, 2013), https://www.washingtonpost.com/news/wonk/wp/2013/02/18/its-official-the-feds-will-run-most-obamacare-exchanges.

[351] *See generally* Gluck, *supra* note 1, at 572-74 (describing how allowing states to implement federal programs may be more "politically palatable" in areas of traditional state control).

[352] *See* Huberfeld, *Federalizing Medicaid*, *supra* note 61, at 441-45.

[353] *See* Douglas Holtz-Eakin, *Yes to State Exchanges*, NAT'L REV. (Dec. 6, 2012, 12:00 PM), http://www.nationalreview.com/article/334956/yes-state-exchanges-douglas-holtz-eakin.

The paradoxical outcome was that the most anti-ACA states were the same states inviting the federal government to take over their insurance markets. The intention was to be seen as doing nothing to cooperate with, or to help, "Obamacare."[354] The result has been a much more robust role for the federal government in running state insurance markets than Congress, and many states, ever expected.[355]

There were surprises too, even within the (typically blue) states that rushed to implement their own exchanges. As in our Medicaid account—indeed more so—extensive back-and-forth movement between state and federal structures emerged in the exchanges. Some states have moved back and forth between running their own exchanges and seeking the federal government to run them. A state like Oregon, which created its own exchange, defaulted to the federal exchange platform because intractable technical issues stymied its efforts.[356] Texas relied on the federal exchange out of protest rather than administrative failure.[357] In the reverse direction, as further detailed below, some Republican states like Kansas worked out deals behind-the-scenes that effectively put their exchanges under state control, moving from red to blue in practice, even though they are still formally labeled "federal exchanges" for purposes of political cover (and reporting/paperwork simplicity).[358] Kentucky rhetorically opposed the ACA at the national political level but still adopted a highly successful state exchange under Governor Beshear—with the state, not federal,

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[354] Interview with Former Executive Branch Health Care Officials 2, 3, and 4, *supra* note 31 ("Obamacare is a bad word."); Interview with State Policy Organization Officers 1, 2, 3, and 4, *supra* note **Error! Bookmark not defined.**.

[355] *See supra* Part III.

[356] *See* Jeff Manning, *Cover Oregon: $248 Million State Exchange to Be Jettisoned in Favor of Federal System*, OREGONIAN (Apr. 25, 2014, 11:30 PM), http://www.oregonlive.com/health/index.ssf/2014/04/cover_oregon_after_spending_24.html.

[357] *See, e.g.*, S.B. 1795, 83d Leg., Reg. Sess. (Tex. 2013), http://www.capitol.state.tx.us/tlodocs/83R/billtext/pdf/SB01795F.pdf (establishing requirements for navigators in Texas to "ensure that Texans are able to find and apply for affordable health coverage under any federally run health benefit exchange"). *Cf.* Letter from Rick Perry to Kathleen Sebelius, *supra* note **Error! Bookmark not defined.** (documenting Governor Perry's protest against the ACA's exchange structure).

[358] Christine H. Monahan, *Safeguarding State Interests in Health Insurance Exchange Establishment*, 21 CONN. INS. L.J. 375, 424 (2015) ("In February 2013, the Kansas Insurance Commissioner sent a letter to the director of CCIIO explaining that while there was 'no political support for a partnership arrangement,' the state would like approval to perform plan management functions (such as certifying that health plans met state and federal statutory and regulatory requirements) on behalf of the federally run exchange." (quoting Letter from Sandy Praeger, Comm'r of Ins., Kan. Ins. Dep't, to Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight (Feb. 15, 2013), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ks-exchange-letter-2-15-2013.pdf.)).

identified name "Kynect."[359] The new governor, Matt Bevin, dismantled the exchange in opposition to the ACA—not because it was failing; it was a "model" exchange by all accounts.[360]

These data bring to the surface questions about how useful it is, as federalism scholars are wont to do, to focus on "cooperation," and even sovereignty, in complex state-national schemes. In the examples above, is Oregon more "cooperative" and is Texas more "sovereign" merely because one resisted, one didn't, but both wound up with the same structure? Or is Kentucky or Arkansas more "autonomous"? Both have been calling their own shots, but only one (Kentucky) ever had its own exchange.

The data also raise the very difficult question about how we could have a theory of federalism that turns on mere *motivation*. Taking the example above, Texas is only more federalist because of its attitude. Constitutionalists would shudder at the thought that federalism could so malleable or subjective. Consider, for example, two states—New Mexico and Texas—both of which have exchanges operated by the federal government and so as a formal matter look identical from a structural federalism perspective. But the state's control is very different across the two exchanges. As Figure 3 illustrates, New Mexico relies on the federal exchange platform, but otherwise operates its own exchange, including conducting plan management and consumer assistance; setting its own geographic rating areas, reinsurance, and risk adjustment formulas; and running rate reviews and Medical Loss Ratio (MLR) compliance. Texas has declined to operate an exchange, enforce any reform provisions like MLR compliance, or set its own geographic rating areas. Now who looks more federalist and autonomous? Is it sufficient to put all these categories aside and say that states got to make their own choices and that is enough for federalism?

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[359] *See, e.g.*, Glenn Kessler, *What Did Mitch McConnell Mean When He Suggested the Kentucky State Exchange Was 'Unconnected' to Obamacare?*, WASH. POST (May 29, 2014), https://www.washingtonpost.com/news/fact-checker/wp/2014/05/29/what-did-mitch-mcconnell-mean-when-he-suggested-the-kentucky-state-exchange-was-unconnected-to-obamacare/?utm_term=.53dde6e658cd; Editorial, *Say Again, Senator, ACA Unkynected?*, LEXINGTON HERALD-LEADER (May 28, 2014, 12:00 AM), http://www.kentucky.com/opinion/editorials/article44490792.html. Under Beshear's successor, Governor Matt Bevin, Kentucky still operates a state exchange but relies on the federal government to provide significant plan management support. *See infra* note 394 and accompanying text (discussing this kind of "state based marketplace federal plan management" exchange).

[360] *See* Amber Phillips, *Kentucky, Once an Obamacare Exchange Success Story, Now Moves to Shut It Down*, WASH. POST (Jan. 14, 2016), https://www.washingtonpost.com/news/the-fix/wp/2016/01/14/a-republican-governors-move-to-shutter-kentuckys-obamacare-exchange-explained/?utm_term=.5f58ad647031.

Fig. 3[361]

We return to the subjects of autonomy and sovereignty in Part VI. But the state and federal officials we interviewed consistently emphasized that states had "enormous autonomy" in developing their exchanges if they wished to participate—*regardless* of whether the exchange structure was state or federal.[362] Indeed, the data confirm that states that engaged with implementation have retained much more control over their insurance markets' policy design than those that have resisted any role.

As the figure illustrates, the structure has been less important than the state's own involvement. States that ran their own exchanges did not necessarily exert more control over exchange policy than did states defaulting to the federal model. The key to policy control was *participation and engagement* within the federal statutory scheme, regardless of whether it was formally structured as state or federally implemented. For example, Maine and Kansas defaulted to federal exchanges, but opted to maintain significant control over their health insurance markets. Both states conduct plan management, enforce compliance with reform provisions, sought adjustments to medical loss ratios, and conduct rate reviews.

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Post-Election Update on the Relevance of Structure. The change of administration has added an important wrinkle to our account. Until recently, the experience of the exchanges was mostly interchangeable regardless of

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[361] Data in Table 1 were drawn from the following sources: Ctr. for Consumer Info. & Ins. Oversight, *Compliance and Enforcement*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html (last visited Nov. 5, 2017); Ctr. for Consumer Info. & Ins. Oversight, *Market Rating Reforms*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html (last updated Mar. 3, 2017); *State Health Insurance Marketplace Types, 2018*, HENRY J. KAISER FAM. FOUND., https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Jan. 2, 2018); Ctr. for Consumer Info. & Ins. Oversight, *State Requests for MLR Adjustment*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state_mlr_adj_requests.html (last visited Nov. 5, 2017); Ctr. for Consumer Info. & Ins. Oversight, *State Effective Rate Review Programs*, CTR. MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html (last updated Mar. 17, 2017).

[362] Interview with Health Policy Nonprofit Officers 1 (a Former State Official) and 2, *supra* note **Error! Bookmark not defined.**; *see also* Interview with Former Federal Executive Branch Health Care Official 1, *supra* note **Error! Bookmark not defined.**.

structural platform. But in 2017, some noticeable differences emerged between state and federally operated exchanges.

Whereas under the Obama Administration, states with federal exchanges received as much, if not more, federal support as states with their own exchanges, the Trump Administration has moved to strangle the exchanges as part of its larger effort to destabilize the ACA.[363] Federally operated exchanges are more susceptible to these hostile efforts simply because the federal government has more control over them.

One salient example occurred in the context of open enrollment, the key period in which individuals must sign up for insurance. Whereas states with their own exchanges retain control over enrollment periods and advertising efforts, the administration slashed funding, canceled outreach events, and cut the 2017 enrollment period in half for those states on the federal exchange.[364] The irony of course is that it is the red states that are suffering most—they have lost the most autonomy—because they refused to implement the statute in the first place.

In a further irony, this dynamic has made state Republican officials some of the most important advocates for sustaining the ACA. A letter from ten governors, five from each party, was a pivotal turning point in one of the failed attempts to repeal the ACA in the summer of 2017.[365] Republican governors

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[363] *See* Exec. Order No. 13,813, 82 Fed. Reg. 48,385 (Oct. 17, 2017) (directing agencies to explore options to pull healthy individuals off of the exchanges); Patient Protection and Affordable Care Act: Market Stabilization, 45 C.F.R. § 155.410 (2017) (ending the open enrollment period on December 15, 2017, rather than January 31, 2018); Abbe Gluck, *President Trump Admits He's Trying to Kill Obamacare. That's Illegal.*, VOX (Oct. 17, 2017, 1:40 PM EDT), https://www.vox.com/the-big-idea/2017/10/17/16489526/take-care-clause-obamacare-trump-sabotage-aca-illegal (detailing the administration's efforts to stifle open enrollment, cut advertising and navigator funding, and cut off payments to the insurance industry); Shelby Gonzales, *Trump Administration Slashing Funding for Marketplace Enrollment Assistance and Outreach*, CTR. ON BUDGET & POLICY PRIORITIES (Sept. 1, 2017, 1:30 PM), https://www.cbpp.org/blog/trump-administration-slashing-funding-for-marketplace-enrollment-assistance-and-outreach (discussing the Trump administration's decision to cut funding for outreach to consumers and navigator programs).

[364] *See* 45 C.F.R. § 155.410 **(**ending the open enrollment period on December 15, 2017, rather than January 31, 2018); Timothy Jost, *CMS Cuts ACA Advertising by 90 Percent Amid Other Cuts to Enrollment Outreach*, HEALTH AFF. BLOG (Sept. 1, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170901.061790/full (describing 90% cuts in advertising and 40% cuts in funding to insurance navigator programs).

[365] Jonathan Martin & Alexander Burns, *Governors from Both Parties Denounce Senate Obamacare Repeal Bill*, N.Y. TIMES (July 14, 2017), https://www.nytimes.com/2017/07/14/us/politics/governors-oppose-senate-affordable-care-act-repeal.html; Letter from John Hickenlooper et. al to Mitch McConnell and Charles E. Schumer, *supra* note **Error! Bookmark not defined.**.

took to the media in the fall of 2017 to protest the Administration's moves to cut funding to insurers and destabilize the exchanges.[366]

On the other side, however, another twist was occurring in Idaho at the time this Article went to press. Idaho chose to run its own exchange in 2013—one of the few red states to do so, even as it did not expand Medicaid.[367] In 2017, the Governor decided to create a parallel marketplace to the exchanges to allow for lower cost, less regulated plans.[368] Critics argued this move was illegal under the ACA and would destabilize the state's ACA marketplace.[369] But part of what enabled Idaho to even try this ACA-undermining strategy is that it runs its own exchange.

From this we can conclude that in the long term, the choice between a state-led and federal structure may be more significant than it initially appeared in our study. With an administration pitted against the statute, states that do not go out on their own suddenly are more unstable—and indeed less sovereign and less autonomous—than they were just months before, simply because a hostile caretaker is now in control. And at least in the case of the ACA, states that run their own federal programs may have more control when it comes to under enforcing or weakening them.

To some federalism scholars, the rapidity with which the context of state autonomy has shifted may further the point that federalism was never there in the first place. They may argue it is too contingent to be truly federalist—a criticism they might level at all forms of intrastatutory federalism. But a statute drafted differently could have given more protection from interference to national-exchange states. We can draw from constitutional law for the sovereignty values we may wish to further, but then recognize that those are being effectuated through Congress's policy choices in statutory design. That may make them more or less stable depending on how the statute defines the parameters of the state-federal relationship.

B. Under the Radar Adaptation and Engagement: Hybrid Federalism and the "Secret Boyfriend" Model

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[366] *See, e.g.*, Jeff Stein, "*It's Going to Hurt Everybody": Nevada's GOP Governor Rips Trump Over ACA Sabotage*, VOX (Oct. 13, 2017, 2:40 PM EDT), https://www.vox.com/policy-and-politics/2017/10/13/16472686/brian-sandoval-aca-trump.

[367] Idaho Insurance Marketplace, "About," http://www.idahomarketplace.org/about.

[368] Idaho Governor News Release, "Governor Directs Development of Guidelines for more Affordable Health Coverage," (Jan 5., 2018), https://gov.idaho.gov/mediacenter/press/pr2018/1_Jan/pr_01.html

[369] Paul Demco & Rachana Pradhan, *How One Conservative State is Flouting Obamacare*, POLITICO (Feb. 14, 2018), https://www.politico.com/story/2018/02/14/idaho-obamacare-trump-administration-insurance-347961.

Extraordinary adaptivity also emerged in exchange implementation. Creative solutions developed in large part from the tension between the political pressure on state officials to publicly "resist" the ACA[370] and the practical view many of those same officials held that the long-term interest of the states—their sovereign interests—were not to cede full control of their insurance markets to the federal government.

Congress's initial structural allocation turned out to be more of a starting point than the end point. New structures developed in part because Congress's initial allocation was far too simplistic: Congress assumes state choices would be of the "either/or" variety--state or federal. They turned to be far more complex.

1. Split Exchanges

Some states adapted through a kind of compromise—a "purple state" solution of sorts—choosing to run their own state exchanges in part, but relying on the federal government for another part. For instance, Mississippi and Utah ran their own state-based exchanges for small businesses but carved out the individual insurance exchanges for the federal government to run.[371] This move was mostly political. The ACA's highly controversial individual mandate was the focal point of the political resistance and was closely associated with the individual market and its exchange. As a result, states like Utah refused to take any action that could be seen as supportive of the mandate, even as those states implemented other parts of the ACA and ceded power to the federal government in politically resisting the law.[372]

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[370] *See generally* Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111, 113-18, 161-68 (2010) (describing the political pressures to resist implementation of the ACA and the value in state officials' publicly opposing the law).

[371] *See* AVENUE H: UTAH'S SMALL BUSINESS MARKETPLACE, https://www.avenueh.com; Jeff Amy, *Mississippi to Create Small Business Health Insurance Exchange*, INS. J. (Sept. 9, 2013), https://www.insurancejournal.com/news/southeast/2013/09/09/304514.htm.

[372] Ironically Utah was the state most often invoked as a "model" for the ACA state-based exchanges during the statute's drafting process (along with Massachusetts) before politics drove its compromise solution. Utah was held up as an example of a state that had conducted a different kind of exchange experiment than Massachusetts (Utah had an "open" exchange, essentially letting all insurers in without screening), in discussions of how capacious the states' options were in exchange design. *See* GREGG GIRVAN, HERITAGE FOUND., NO. 2453, CONSUMER POWER: FIVE LESSONS FROM UTAH'S HEALTH CARE REFORM 2 (2010), http://www.heritage.org/health-care-reform/report/consumer-power-5-lessons-utahs-heath-care-reform ("State lawmakers who want to maintain the independence of their states' health care system and fiscal future in the wake of the new federal law should consider Utah's recent experience with health care reform."); Robert Pear, *Health Care Overhaul Depends on States' Exchanges*, N.Y. TIMES (Oct. 23, 2010), http://www.nytimes.com/2010/10/24/health/policy/24exchange.html.

2. Hybrid Exchanges: Federalism Borne of Necessity, Federalism in Secret

A more complex category of exchanges—and a salient example of pragmatic administration—comes in the context of the so-called hybrid exchanges, which blend state and federal management functions and come in many different forms. The hybrid exchange was a model developed by HHS in a guidance document early in the implementation, with the goal of attracting more states to engage.[373] One high-level federal interviewee told us that it had become clear that many states did not want the binary choice Congress laid out; they wanted to be able to rely on the federal government for as much as they individually needed, whether it was technical, political, or practical, but still wanted policy control.[374] Another official told us that some states wanted more control but needed political cover—a way to keep up appearances that the federal government was still in charge so as not to appear in betrayal of the red-state resistance.[375]

The hybrids were thus a type of blended entity borne of necessity. Reacting to the changed landscape after *NFIB*[376] and concerned that fewer states than expected were running their own exchanges, HHS helped redesign federally-run exchanges that were heavily supported by the federal government but still directed on the policy front by states.[377] Seven states took up this hybrid possibility.[378] Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia were given a choice under the hybrid model of whether to conduct their own plan management activities, consumer assistance, outreach, and education functions.[379] The federal government took on any remaining supportive and administrative responsibilities.[380]

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[373] CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., AFFORDABLE INSURANCE EXCHANGES GUIDANCE 1 (2013), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf.

[374] Interview with Former Federal Executive Branch Health Care Officials 2, 3, and 4, *supra* note 31.

[375] *Id.*

[376] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588-89 (2012).

[377] Interview with Former Federal Executive Branch Health Care Officials 2, 3, and 4, *supra* note 31.

[378] *See Letters*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/cciio/Resources/Letters/index.html#Health Insurance Marketplaces (last visited Dec. 16, 2017) (compiling approval letters for states' exchanges, including seven who applied to adopt a partnership model).

[379] Ctr. for Consumer Info. & Ins. Oversight, *supra* note 373, at 1.

[380] *See id.*

To our view, these hybrid exchanges may be the ultimate instantiation of cooperative federalism: a regime in which the federal government does what it does best, offering administrative support and maximizing the advantages of centralization and economies of scale while giving states a platform to design and run their own programs. Arkansas switched to a state-based exchange for 2017, and the hybrid model provided the means for that transition to more state control.[381]

But the idea of "cooperating" with the federal government in this way was still politically taboo for many state actors. One puerile problem was that the hybrid exchanges were called "partnership" exchanges, and some states did not want to appear to be in "partnership" with the Obama Administration.[382]

Another problem was the intrastate political arena. Some insurance commissioners and other lower-level state officials wanted to retain control over state insurance markets, even as governors and legislatures insisted on public resistance.[383] For example, another seven states—Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia—did not opt into the hybrid model for these political reasons, but they did not want a full-scale federal exchange either.[384] As result, they actually took on significant exchange management functions, but they needed to keep these decisions *relatively secret*.

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[381] Louise Norris, *Arkansas Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (May 30, 2017), https://www.healthinsurance.org/arkansas-state-health-insurance-exchange ("For the first three years of exchange implementation, Arkansas had a partnership exchange for individuals, but for 2017 . . . they have a state-based exchange using the federal enrollment platform . . . .").

[382] Interview with Former Federal Executive Branch Health Care Officials 2, 3, and 4, *supra* note 31; Interview with State Policy Organization Officers 1, 2, 3, and 4, *supra* note **Error! Bookmark not defined.**; *see also* SARAH DASH ET AL., COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: KEY DESIGN DECISIONS FOR STATE-BASED EXCHANGES 10 (2013), http://www.commonwealthfund.org/~/media/files/publications/fund-report/2013/jul/1696_dash_key_design_decisions_state_based_exchanges.pdf; Monahan, *supra* note 358, at 423-24; Sarah Dash, Research Fellow, Georgetown Univ. Health Policy Insts. Ctr. on Health, Health Care Exchange Panel Discussion at the 2014 Yale Health Law & Policy Society Conference: Health Insurance Exchange Implementation; Early Challenges and Opportunities (Feb. 8, 2014); *cf.* Weeks Leonard, *supra* note 370, at 162 ("[R]hetorical federalism acknowledges that federalism arguments have political salience aside from earnest concerns about the federal structure.").

[383] David K. Jones et al., *Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. HEALTH POL., POL'Y & L. 97, 114, 121, 125 (2014) (detailing conflicts between three state insurance commissioners and governors).

[384] *See* Monahan, *supra* note 358, at 415-16.

Sometimes state moves were so discreet that it appeared that one arm of the government was trying to hide its actions from another. Take Kansas as an example.[385] Its state insurance department designed a plan for a hybrid exchange, desiring to retain control over its insurance markets rather than cede that power to the federal government.[386] However, under HHS's hybrid exchange guidance, the governor was required to sign off on a state's hybrid exchange "blueprint."[387] Kansas's governor refused to "partner" with the Obama Administration, even as the insurance commissioner pressured for that result.[388]

In response, HHS adapted again. Less than one week later, HHS announced a new hybrid option, called state "plan management" (not "partnership").[389] Plan management exchanges do not require formal gubernatorial approval but rather require only informal communications between the federal government and state insurance commissioners, thereby allowing state insurers to get around resistant state capitols.

Thus, in these seven states, the state commissioners, sometimes at odds with the political interests of their own governors, were making decisions, quietly running important aspects of their exchanges even as governors continued to publicly pledge their steadfast resistance to cooperating with the ACA. While a few states exist in which the insurance department has refused to implement the ACA, most state insurance departments are actively engaged, even in states with a federally-facilitated exchange.[390]

These models raise transparency and accountability concerns that we discuss further in Part VI. One of our federal official interviewees colorfully dubbed these interactions the "*secret boyfriend" model*: states that wanted the assistance the federal government offered but were afraid to admit it to the public or even to other parts of state government.[391] HHS even helped these

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[385] This narrative largely is drawn from *id.* at 415-16, 423-24.

[386] *See id.*

[387] *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges: Frequently Asked Questions; Blueprint*, CTRS. FOR MEDICARE & MEDICAID SERVS. (May 16, 2012), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html (noting that a state pursuing a partnership exchange must submit an Exchange Blueprint which contains an "Exchange Model Declaration Letter" from the governor).

[388] *See* Monahan, *supra* note 358, at 423-24.

[389] *Id.*

[390] Only four states have refused to enforce compliance with insurance reform provisions. *See supra* Figure 3.

[391] Interview with Former Federal Executive Branch Health Care Officials 2, 3 ad, *supra* note 31.

states to market their supposedly uncooperative exchange efforts to provide political cover.

Another type of hybrid emerged to help (often blue) states that tried to establish their own marketplaces but failed. Known as "State-based Marketplace-Federal Platform" or "Federally-supported State Based Marketplace" exchanges, these are exchanges in which the states make all of the policy decisions but rely on the federal government's IT platform on Healthcare.gov.[392] Five states currently have this kind of exchange, including Oregon and New Mexico, which both had previously tried to operate a fully state-based exchange but failed for technical reasons.[393] In 2015, this option allowed Arkansas to transition from a federal exchange to assuming full policy control of its marketplace while not having to assume the risk of setting up a new technical platform.[394] Hawaii, in contrast, transitioned last year from this model to a full federal exchange.[395] In short, HHS developed a wide continuum of structural options along the spectrum from state to federal to engage as many states as possible in implementation. In most cases the key to state autonomy was the level of engagement, not the formal structure.

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[392] *State Health Insurance Marketplace Types, 2018*, *supra* note 361; Ctr. for Consumer Info. & Ins. Oversight, *State-Based Exchanges*, CTRS. FOR MEDICARE & MEDICAID SERVS. (last updated Sept. 15, 2017), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html.

[393] *See State Health Insurance Marketplace Types, 2018*, *supra* note 361 (to locate, select the map icon, and filter for those states using a "State-based Marketplace-Federal Platform"); Rosalie Rayburn, *Plans for State-Run Health Exchange Dropped*, ALBUQUERQUE J. (Apr. 8, 2015, 2:26 PM), https://www.abqjournal.com/566536/plans-for-state-run-health-exchange-dropped.html?utm_content=buffer4a725&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer; Gosia Wozniacka, *Oregon Dropping Online Health Exchange for U.S. Site*, BELLINGHAM HERALD (Apr. 25, 2014, 12:09 PM), http://www.bellinghamherald.com/news/politics-government/article22226607.html.

[394] *See State Marketplace Profiles: Arkansas*, HENRY J. KAISER FAM. FOUND. (Oct. 8, 2013), https://www.kff.org/health-reform/state-profile/state-exchange-profiles-arkansas/#footnote-87649-15 ("On April 23, 2013, Governor Beebe signed HB 1508 which authorizes the transition of the Marketplace from a state-federal Partnership Marketplace to a State-based Marketplace to take effect on July 1, 2015."); Christopher Koller, *Supported State-Based Marketplaces: The Point of Convergence?*, HEALTH AFF. BLOG (Jun. 11, 2015), http://healthaffairs.org/blog/2015/06/11/supported-state-based-market-places-the-point-of-convergence (discussing the substantial state responsibilities in federally-supported SBM states and benefits of using the federal platform).

[395] Louise Norris, *Hawaii Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (Nov. 11, 2017), https://www.healthinsurance.org/Hawaii-state-health-insurance-exchange/ ("[S]tarting in November 2016, to facilitate enrollment in plans for 2017, Hawaii switched to a fully-federally-run exchange, although that state still oversees the plans that are sold in the exchange.").

C. Horizontal Federalism in Exchange Implementation: More Cooperation than Competition

The ACA included in its insurance reforms a formal mechanism for state-to-state cooperation: States could establish "regional" exchanges, combining insurance pools and regulations into a single market.[396] As it turns out, the ACA's stated vision of "horizontal federalism" did not materialize—no states established regional exchanges.[397] But other forms of horizontal federalism developed on the ground, including robust state networks and an important role for quasi-official state organizations in coordinating implementation. Several "thought leader states" also emerged and played important roles in disseminating information and experience to later-moving states.

1. Inter-State Cooperation

Inter-state cooperation has been a dominant feature of exchange implementation—and this is different from the Medicaid story, which is more competitive across states.[398] Some of this cooperation was facilitated by formal networks that states used to exchange information and coordinate efforts. These include the networks of "Early Innovator" states—states that took the lead in implementation and so served as a model for others.[399] Other inter-state networks were supported by federal entities as well as quasi-governmental organizations, including the Center for Consumer Information and Insurance Oversight (CCIIO),[400] the Health Care Reform Regulatory Alternatives Working Group of the National Association of Insurance Commissioners

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[396] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(f), 124 Stat. 119, 179 (2010) (codified at 42 U.S.C. § 18031).

[397] Sarah Dash et al., Healthy Policy Brief: Health Insurance Exchanges and State Decisions (2013), https://www.healthaffairs.org/do/10.1377/hpb20130718.132696/full/healthpolicybrief_96.pdf.

[398] *See supra* Part IV.

[399] *See* Ctr. for Consumer Info. & Ins. Oversight, *States Leading the Way on Implementation: HHS Awards "Early Innovator" Grants to Seven States*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2011), http://www.cms.gov/CCIIO/Resources/Grants/states-leading-the-way.html.

[400] *Id.* (describing a CCIIO grant to a "a multi-state consortium led by the University of Massachusetts Medical School"); Linda J. Blumberg, Urban Inst., Multi-State Health Insurance Exchanges 1 (Apr. 2011), https://www.urban.org/sites/default/files/publication/27251/412325-Multi-state-Health-Insurance-Exchanges.PDF (describing the federal policy of allowing states to form multi-state exchange networks rather than single state exchanges).

(NAIC),[401] the State Health Exchange Leadership Network of the National Academy for State Health Policy,[402] and the National Governors' Association (NGA) and the National Conference of State Legislatures (NCSL).[403] The ACA empowered and formalized some of these horizontal networks. The most salient example is that the ACA explicitly directed HHS to involve the NAIC in implementation.[404]

Informal networks also emerged to trade information and coordinate efforts. These included technical assistance networks facilitated by the Robert Wood Johnson Foundation,[405] the network of states that cooperated in the UX 2014 project to design user interfaces,[406] informal networks of exchange officials who hired the same consultants and contractors, the informal network of states working in opposition to the ACA supported by the American Legislative Exchange Council,[407] and unofficial relationships that emerged out of formal networks, conferences, and workshops. One former federal official we interviewed noted that they helped organize regular meetings between state officials, so-called "learning collaboratives" facilitated by HHS, to enable state success in implementing exchanges and to share information between states for troubleshooting.[408]

Unlike in the Medicaid context, in creating exchanges, states did band together to exert leverage on the federal government for collective goals. For example, Christine Monahan describes how an informal group of states defaulting to federal exchanges cooperated to retain plan management

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[401] *See Health Care Reform Regulatory Alternatives (B) Working Group*, NAT'L ASS'N OF INS. COMM'RS, http://www.naic.org/cmte_b_exchanges_hcr_reg_alt_wg.htm (last visited Jan. 27, 2018).

[402] *See State Health Exchange Leadership Network*, NAT'L ACAD. FOR STATE HEALTH POLICY, http://www.nashp.org/state-health-exchange-leadership-network (last visited Jan. 27, 2018).

[403] Interview with Health Policy Nonprofit Officers 1 (a Former State Official) and 2, *supra* note **Error! Bookmark not defined.** (detailing the support for state coordination from federal and other entities).

[404] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1311(c)(1)(F), 1321(a)(2), 1333(a)(1), 1341(b)(1), 123 Stat. 119, 174, 186, 206, 209 (codified in scattered sections of 42 U.S.C.); *see also* Monahan, *supra* note 358, at 409-14 (describing some of the NAIC's efforts).

[405] *See, e.g.*, *About*, STATE HEALTH REFORM ASSISTANCE NETWORK, http://statenetwork.org/about (last visited Dec. 21, 2017).

[406] *See Who's Involved*, ENROLL UX, http://www.ux2014.org/whos-involved (last visited Dec. 21, 2017).

[407] *See, e.g.*, Christie Herrera, *Health Care Freedom Makes a Big Impact in 2012*, AM. LEGIS. EXCHANGE COUNCIL (Mar. 26, 2012) (describing state efforts growing out of the ALEC initiative).

[408] Interview with Former Federal Executive Branch Health Care Official 5, *supra* note 204.

functions: "Their collective advocacy ultimately resulted in the creation of the 'marketplace plan management option' by which states could conduct plan management on behalf of the federally run exchange . . . ."[409] Similarly, a group of partnership exchange states coordinated efforts to persuade CCIIO not to require them to enter into formal memoranda of understanding, thereby avoiding a potential political problem for state officials.[410] While our sense from the interviews is that the advocacy also came from the other direction—from HHS and the White House—this is nevertheless a good example of how informal horizontal networks can be an effective method of federalism negotiation.

State networking efforts like these have received some recent attention in the new federalism literature. For example, political scientist John Nugent has argued that these organizations are critical players in "safeguarding federalism"—in the form of helping states leverage and interact with the federal government—in the context of a national scheme with key potential state roles.[411] Our study lends support to that account.

2. "Thought Leader" States

Another dimension of horizontal federalism in the exchange context was visible in the emergence of "thought leader" states. These states served as policy entrepreneurs and increased efficiency for states that were further behind in implementation.[412] As in the Medicaid context, thought-leader states in exchange implementation emerged organically.[413] (By contrast, a handful of federal statutes exist in which Congress designates a leader state that others are free to follow; a classic example is California in environmental law.[414])

Connecticut, as noted, provides an example in its efforts to market its successful exchange platform to other states. Connecticut's entrepreneurial exchange officials told us that they "realized they had invented a better mousetrap," and that they could "package their services and expertise and make them available to other states."[415] The Connecticut exchange director, Kevin

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[409] Monahan, *supra* note 358, at 416.

[410] *Id*. at 415.

[411] *See* JOHN D. NUGENT, SAFEGUARDING FEDERALISM: HOW STATES PROTECT THEIR INTERESTS IN NATIONAL POLICYMAKING 31 (2009).

[412] *See infra* notes 415-423 and accompanying text.

[413] *See supra* Part IV.

[414] In the Clean Air Act, Congress designated California as the leader state and offered states the option to adopt federal pollution standards or the higher standards California had developed. *See* Gluck, *supra* note **Error! Bookmark not defined.**, at 1756.

[415] Kevin Counihan, CEO, Access Health CT, Panel Discussion at Yale Law School Insurance Exchange Conference (Feb. 2014); Email from Sarah Dash, President & CEO, Alliance for Health Policy, to authors (Jan. 11, 2018) (on file with authors) (confirming notes from conference); Email from Gabriel Scheffler, Regulation Fellow, Univ. of Pa. Law

Counihan, even sought to create a separate company to market the successful Connecticut exchange platform to other states.[416] He promoted Connecticut's system as giving other states "the benefits of a state-based marketplace without the headaches of building or staffing it. . . . ."[417] Members of the board of the Connecticut exchange argued that they could "package [their] services and expertise and make them available to other states, promoting collaboration and avoiding a duplication of effort."[418]

At least four other states, including Maryland, Massachusetts, Minnesota and Nevada, used other states' exchange platforms as their own.[419] Maryland did adopt Connecticut's technology. (Connecticut, however, did not make the money it had hoped to make off its leadership: The federal government had funded Connecticut's exchange and that proved an obstacle to Connecticut charging others to copy that platform.[420]) In most cases the sister-state-model option was an alternative to inviting the federal government to operate a federal exchange in the wake of technical failures in those states' efforts to operate their own. Even states that maintained their own exchanges following initial difficulties leveraged other states' experiences through consulting firms, as illustrated in the following figure.

Sch., to authors (Jan. 11, 2018) (same); Email from Christine Monahan, (Jan. 11, 2018) (on file with authors) (same).

[416] Jeff Cohen, *Connecticut Looks to Sell Its Obamacare Exchange to Other States*, NPR: SHOTS (Feb. 28, 2014, 3:31 AM), http://www.npr.org/sections/health-shots/2014/02/27/283526215/connecticut-looks-to-sell-its-obamacare-exchange-to-other-states.

[417] Robert Pear, *Connecticut Plans to Market Health Exchange Expertise*, N.Y. TIMES (Feb. 24, 2014), http://www.nytimes.com/2014/02/25/us/connecticut-plans-to-market-health-exchange-expertise.html (quoting Kevin Counihan).

[418] *Id.* (quoting Dr. Robert E. Scalettar, member of the Connecticut exchange board).

[419] Jenna Johnson, *Maryland Looks to Connecticut for Health Exchange Answers*, WASH. POST (May 31, 2014), https://www.washingtonpost.com/local/md-politics/maryland-looks-to-connecticut-for-health-exchange-answers/2014/05/31/481a7b9c-db83-11e3-8009-71de85b9c527_story.html; *MNsure Chooses Deloitte as Lead Vendor*, CBS MINN. (Apr. 16, 2014, 12:50 PM), http://minnesota.cbslocal.com/2014/04/16/mnsure-chooses-deloitte-as-lead-vendor ("Minnesota's online health insurance marketplace announced Deloitte Consulting on Wednesday as the lead manager to overhaul its troubled website and computer systems, citing the company's record of success in other states."); Kyle Roerink, *Nevada's $16 Million No-Bid Project with Deloitte Reveals Firm's Growing Influence in Health Care*, LAS VEGAS SUN (Jul. 17, 2014, 2:00 AM), https://lasvegassun.com/news/2014/jul/17/deloitte-silver-state-exchange-brian-sandoval (describing Nevada's decision to hire Deloitte based on its success designing other state insurance exchanges).

[420] Jenna Johnson & Mary Pat Flaherty, *As Md. Rebuilds Its Insurance Health Exchange, Lots of Room for Pressure and Little Room for Missteps*, WASH. POST (May 3, 2014), https://www.washingtonpost.com/local/md-politics/as-md-rebuilds-its-health-insurance-exchange-lots-of-pressure-and-little-room-for-missteps/2014/05/03/4ba5c12c-d214-11e3-937f-d3026234b51c_story.html?utm_term=.4a5743f6d207,

Fig. 4[421]

Private Company	Exchange Involvement
hCentive (3 States)	• hCentive currently operates exchanges in Massachusetts, New York, and Colorado. • Massachusetts hired hCentive after failed rollout by CGI (original contractor for Healthcare.gov), explicitly citing hCentive's record of success in other states.
Deloitte (6 States)	• Deloitte oversaw exchange rollout in Connecticut, Rhode Island, Kentucky, and Washington. • Minnesota and Maryland later hired Deloitte as a result of its successes in those four states.
Optum (1 State Currently, 2 Overall)	• Following difficulties with CGI (the contractor initially used for Healthcare.gov), Vermont hired Optum, citing the fact that Optum oversaw the smooth transition for Massachusetts from CGI to hCentive. • Optum additionally owns a 24% stake in

[421] Data related to hCentive are drawn from the following sources: Felice J. Freyer, *Mass. Sticking with Its Health Insurance Website*, BOS. GLOBE (Aug. 8, 2014), http://www.bostonglobe.com/metro/2014/08/08/connector/9OEeH60TkGLoh3SM4DzU6O/story.html; Dan Mangan, *The 'Policy Geek' Picked to Save Massachusetts' Obamacare Exchange*, CNBC (May 8, 2014, 4:14 PM), http://www.cnbc.com/2014/05/08/the-policy-geek-picked-to-save-massachusetts-obamacare-exchange.html; *Solutions for Integrated Eligibility Services and State Exchanges*, HCENTIVE (last accessed Jan. 2, 2017), https://www.hcentive.com/government. Data for Deloitte are drawn from the following sources: *Johnson*, *supra* note 419; *MNsure Chooses Deloitte as Lead Vendor*, *supra* note 419; Christine Vestal & Michael Ollove, *Why Some State Health Exchanges Worked*, KAISER HEALTH NEWS (Dec. 11, 2013), http://khn.org/news/why-some-state-run-health-exchanges-worked. Optum data are drawn from the following source: Lynnley Browning, *Thanks for Nothing: Obamacare Website Bunglers Fired*, NEWSWEEK (Aug. 6, 2014, 10:09 AM), http://www.newsweek.com/thanks-nothing-obamacare-website-bunglers-fired-263205. GetInsured data are drawn from the following source: C*onsumer-Friendly, Low-Risk, Financially Sustainable Solutions for States*, GETINSURED (last accessed July 25, 2016), https://solutions.getinsured.com/states. According to GetInsured's website, "20% of Americans enrolled in ACA coverage used a GetInsured platform." *Id.* Idaho officials chose to contract with GetInsured to build the exchange and Accenture to oversee the project. *Idaho's Health Insurance Exchange Awards $40.8 Million in Contracts*, BOISE ST. PUB. RADIO (Feb. 21, 2014), http://boisestatepublicradio.org/post/idahos-health-insurance-exchange-awards-408-million-contracts. Those two companies were also responsible for the California exchange rollout. *Id.* GetInsured also runs Mississippi and New Mexico's small business exchanges. *See* GetInsured, Corporate Fact Sheet (2014), https://blog.getinsured.com/wp-content/uploads/2014/02/GI-Corporate-Fact-Sheet.pdf.

	hCentive.
GetInsured (2 States)	• California hired GetInsured initially to oversee exchange rollout. • Idaho sought to transition from a federally-facilitated Marketplace (FFM) model and hired GetInsured due to success in California.

3. A Middle Ground Between One and Fifty Options

In this story of states modeling on and borrowing from one another, we see a parallel to our account of the hybrid exchanges. In both instances, there is recognition that a middle ground between fifty separate models and a single national model might be ideal as a matter of structural allocation. We note that the ACA is not the first example of this. For instance, in the corporate law context, a few states' corporate-law statutes have emerged as the basis for most states' choices; that is, there are not 50 different options and each state does not reinvent the wheel.[422] Our point here is that, likewise, this middle ground in the ACA emerged *organically*, rather than as a result of the ACA's intentional design by Congress. States themselves may be adapting but Congress still appears to be operating with outmoded design options. It continues to use the old-school "either-or," "one-or-fifty," model of structural allocation in drafting

In contrast, a middle ground may capture efficiencies, economies of scale and advance some uniformity in ways inferior to a full national exchange but superior to fifty different ones. So understood, this horizontal movement, like the story of the hybrids, might point toward a federalism "sweet spot." As Access CT's CEO commented about the various exchange models: "We do not need 50 of these things, but we might need eight."[423]

D. Intrastate Differences, Redux

As we emphasized in the Medicaid discussion, one cannot understand the ACA implementation without discarding the fiction that states are monolithic blocs. Divergences in state law and divergences among the internal state actors—in other words attributes of the state *sovereign* apparatuses—are critical to how federal-law implementation occurs on the ground. This is another response to those who would argue that what we saw was mere management or decentralization.[424]

[422] *See* Roberta Romano, *The States as a Laboratory: Legal Innovation and State Competition for Corporate Charters*, 23 J. ON REG. 209, 215 (2006) (cataloguing states' adoption of statutory innovations in corporate law).

[423] Counihan, *supra* note 415.

[424] Cf. RUBIN & FEELEY, supra note 10.

Beginning with the law, states went into the ACA with different pre-existing insurance laws on the books.[425] Some states already had generous insurance mandates—requirements that insurers cover specified services.[426] A few states already had community-rating requirements—meaning insurers could not price according to health risk by especially wide margins.[427] New York had a particularly stringent community rating requirement that it continued even after the ACA was passed, to the apparent detriment of the health of its own insurance market.[428] Other states' insurance laws gave their insurance commissioners power, under state law, to buck federal requirements.[429] President Obama's famous "if you like your health plan you can keep it" statement destabilized many exchanges by allowing healthy customers, expected to join the new insurance pools, to remain outside of them.[430] States that bucked the President and decided not to allow individuals to keep their old

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[425] KATHERINE SWARTZ ET AL., COMMONWEALTH FUND, HOW INSURERS COMPETED IN THE AFFORDABLE CARE ACT'S FIRST YEAR 7-8 (2015), http://admin.issuelab.org/permalink/download/25038.

[426] *See, e.g.*, *Pre-ACA State Mandated Benefits in the Individual Health Insurance Market: Mandated Coverage in Mental Health*, HENRY J. KAISER FAM. FOUND. (2010), https://www.kff.org/other/state-indicator/pre-aca-state-mandated-benefits-in-the-individual-health-insurance-market-mandated-coverage-in-mental-health; *Pre-ACA State Maternity Coverage Mandates: Individual and Small Group Markets*, HENRY J. KAISER FAM. FOUND. (2010), https://www.kff.org/other/state-indicator/pre-aca-state-maternity-coverage-mandates-individual-and-small-group-markets.

[427] *See* Anthony T. Lo Sasso, *Community Rating and Guaranteed Issue in the Individual Health Insurance Market*, EXPERT VOICES (Nat'l Inst. Health Care Mgmt., Washington, D.C.), Jan. 2011, https://www.nihcm.org/pdf/EV-LoSassoFINAL.pdf (describing community rating and state policies before the ACA). One study shows some correlation between states with these generous requirements and the type of exchange they chose, which were mostly state-run exchanges. *Compare Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)*, HENRY J. KAISER FOUND. (2012), https://www.kff.org/other/state-indicator/individual-market-rate-restrictions-not-applicable-to-hipaa-eligible-individuals (showing limits on rating by state), *with State Health Insurance Marketplace Types, 2018*, *supra* note 361 (showing marketplace type by state). A simpler explanation might be that these states were largely Democratic and so were sympathetic with the ACA from the start.

[428] *See* N.Y. INS. LAW § 3231 (McKinney 2017) (mandating one-to-one community rating); *Obama's New York Model: How the State Destroyed Its Insurance Market Using Obamacare Rules*, WALL ST. J. (July 23, 2013, 7:28 P.M.), https://www.wsj.com/articles/SB10001424127887323993804578615760275211052.

[429] *See* Richard Cauchi, *State Laws and Actions Challenging Certain Health Reforms*, NATIONAL CONF. STATE LEGISLATURES (Mar. 25, 2017), http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx.

[430] *See* Robb Mandelbaum, *How Holdover Health Plans Help Some Businesses but Hurt Obamacare*, FORBES (Feb. 28, 2017, 9:30 AM), https://www.forbes.com/sites/robbmandelbaum/2017/02/28/liked-your-insurance-and-kept-it-how-holdover-plans-hurt-obamacare.

plans had healthier exchange markets in the end according to at least one study.[431]

Looking next to differences among internal state actors, as with Medicaid, we see governors' interests diverging from those of their legislatures. Some states, including New Jersey, Michigan, and Illinois, were unable to create their own exchanges because of the objections of one of the elected branches necessary to pass the required implementing legislation.[432] Three states' executives—Kentucky, New York, and Rhode Island—worked an end-run around recalcitrant legislatures and created state-based exchanges through purely executive authority.[433] Four of the seven states that adopted the hybrid "partnership" exchange model also used purely executive authority to adopt their exchanges.[434] In at least one state, the fact that a partnership exchange could be launched by the executive, rather than by legislative action, was the very reason it was used.[435]

We also saw conflicts between insurance commissioners eager to retain control of state insurance policy and governors of the state states resistant to engage with the exchanges and appear cooperative with the ACA. These intrastate struggles played out different in each state--because each state has its own unique local democracy. Not all of these efforts were successful. Mississippi's elected insurance commissioner, for instance, applied to HHS—unsuccessfully—for approval to create a state-based exchange in Mississippi, without the approval of either the governor or the legislature.[436] But many workarounds that did emerge succeeded largely because of cooperation between state and federal insurance officials.

E. "Picket Fence" Federalism

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[431] *See* Kevin Lucia et al., *The Extended "Fix" for Canceled Health Insurance Policies: Latest State Action*, COMMONWEALTH FUND: TO THE POINT (Nov. 21, 2014), http://www.commonwealthfund.org/publications/blog/2014/jun/adoption-of-the-presidents-extended-fix; *Cf.*, W. Virginia *ex rel.* Morrisey v. United States Dep't of Health & Human Servs., 827 F.3d 81, 84 (D.C. Cir. 2016), *cert. denied*, 137 S. Ct. 1614 (2017) (rejecting a state challenge to the transitional policy based on lack of standing).

[432] *See* Nat'l Conference of State Legislatures, *supra* note 220.

[433] *Id*.

[434] *Id.*

[435] *Id*.

[436] *See* Jeffrey Hess, *HHS Denies Mississippi's Bid to Run Its Own Exchange*, KAISER HEALTH NEWS, (Feb. 8, 2013, 10:15 AM), http://kaiserhealthnews.org/news/hhs-denies-mississippis-bid-to-run-its-own-exchange (reporting an HHS spokesman said that "[w]ith the Governor's refusal to work with us or the insurance commissioner, there is no way to coordinate strategy with other agencies that he's in charge of").

Federalism scholars will undoubtedly see in some these stories—especially in the case of the hybrid exchanges—the concept of "picket fence federalism." That term is used to describe when administrators across governments may more closely identify with one another in furtherance of shared policy goals than they do with more senior members of their own government.[437]

The formal and informal networks that we have already described among implementers facilitated these picket-fence relationships between state insurance experts and their federal counterparts. Another contributing factor was that many key Administration officials were former state insurance commissioners or held similar roles. These included: HHS Secretary Kathleen Sebelius (Kansas)[438]; the first Director of the Exchange Office of the CCIIO Joel Ario (Oregon and Pennsylvania)[439]; acting director of the State Exchanges Group, the Oversight Group, and the Insurance Programs Group Teresa Miller (Oregon, then Pennsylvania)[440]; CCIIO director Steve Larsen (Maryland)[441]; director of the Office of Consumer Information and Insurance Oversight at HHS Jay Angoff (Missouri)[442]; and the first CEO of healthcare.gov Kevin Counihan (Connecticut).[443] States also engaged directly with the federal

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[437] *See* Roderick M. Hills, Jr., *The Eleventh Amendment as Curb on Bureaucratic Power*, 53 STAN. L. REV. 1225, 1227 (2001).

[438] *See* Peter Baker & Robert Pear, *Kansas Governor Seen as Top Choice in Health Post*, N.Y. TIMES (Feb. 18, 2009), http://www.nytimes.com/2009/02/19/us/politics/19health.html.

[439] *See Our Experts: Joel Ario*, COMMONWEALTH FUND, http://www.commonwealthfund.org/about-us/experts/ario-joel.

[440] Miller was administrator of the Oregon Insurance Division before working in the Obama Administration. Afterward, she was the Pennsylvania Insurance Commissioner and now is head of the Pennsylvania Department of Health and Human Services. *See Pennsylvania Selects Commissioner Miller to Lead Department of Human Services*, Ins. J. (Aug. 18, 2017), https://www.insurancejournal.com/news/east/2017/08/18/461692.htm; Press Release, Commonwealth of Pa., Governor Wolf to Nominate Insurance Commissioner Teresa Miller to be Inaugural Secretary of Health and Human Services (May 23, 2017), https://www.governor.pa.gov/governor-wolf-to-nominate-insurance-commissioner-teresa-miller-to-be-inaugural-secretary-of-health-and-human-services.

[441] Sara Hansard, *CCIIO Director Steve Larsen Leaving for UnitedHealth Unit Optum in Mid-July*, BLOOMBERG BNA (June 20, 2012), https://www.bna.com/cciio-director-steve-n12884910135.

[442] *Executive Profile: Jay Angoff*, BLOOMBERG, https://www.bloomberg.com/research/stocks/private/person.asp?personId=401886&privcapId=7986335

[443] Connecticut's Counihan was the first CEO of the federal exchange. *See* Dan Diamond, *Kevin Counihan, the New "Obamacare CEO," Faces Four Key Challenges*, FORBES (Aug. 26, 2014, 12:25 PM) *https://www.forbes.com/sites/dandiamond/2014/08/26/meet-kevin-counihan-the-new-obamacare-ceo/#443414ed218e.* In addition, Gary Cohen, the former Director of the CCIIO, was previously the Deputy Commissioner and General Counsel of the California Department of Insurance. *See* Sarah Hansard, *Gary Cohen Selected as New*

government in the ACA implementation process. States actively participated in the notice and comment rulemaking process and, even more frequently, weighed in through informal channels.[444] Every state that received any kind of exchange grant—all forty-nine of them[445] had a designated state officer who served as the state's point person at HHS and was available to interact "on a daily or weekly basis."[446] State insurance departments were in regular contact with the CCIIO regarding technical implementation issues.[447] Consistent with their historical roles as the "intergovernmental lobby,"[448] the National Governors Association (NGA) and the National Conference of State Legislators (NCSL) also actively engaged with federal officials regarding exchange implementation.[449] The State Health Exchange Leadership Network also engaged vertically, albeit on a less formal basis than the others.[450]

F. Deconstructing "Federalism" Attributes

The traditional federalism account contends that certain attributes—autonomy, sovereignty, checks against the federal government, local policy variation, experimentation, accountability—are most attainable for states when states are separate from federal law. Modern federalism scholars diminish the importance of some attributes, like sovereignty, and find others in centralization rather than separation. Our account pushes against both perspectives.

We already have discussed how autonomy and sovereignty in the ACA did indeed emerge. But they emerged without any separation—and indeed in many instances independent of the formal state-or-federal exchange design. This does not mean that these attributes will necessarily emerge from all federal statutes that include states as implementers; but rather, that they can if Congress designs them as such.

Director of HHS Insurance Oversight Office, BLOOMBERG BNA (Aug. 22, 2012), http://www.bna.com/gary-cohen-selected-n12884911327/.

[444] Monahan, *supra* note 358, at 398-409 & tbl. 3 (listing frequency with which each state submitted a comment).

[445] *See id.* at 403-04.

[446] *Id.*

[447] *See* Email from Brian Webb, Manager of Health Policy, Nat'l Assoc. of Ins. Comm'rs, to authors (Feb. 5, 2015) (on file with the authors) ("[S]tate DOIs (other than those who have law forbidding implementation of the ACA—see Missouri) have regular contact directly with CCIIO/CMS on technical implementation issues.").

[448] NUGENT, *supra* note 411, at 31.

[449] *See* Monahan, *supra* note 358, at 409-14 (describing HHS communications with NGA and NCSL, NGA conferences attended by state and federal exchange officials, and NCSL resources on state action on exchanges).

[450] *Id.* at 414-15. State legislatures did not have formal institutional connections to HHS, thus direct vertical connections with legislatures are harder to document and assess, but the potential exists given how state officials move from one branch to another somewhat fluidly.

Local accountability is another federalism attribute that is muddled by the exchange story. State involvement—especially when it comes to hybrids and "secret boyfriends"—obfuscates that democracy value. We return to this point in the next Part. Here, we pause to discuss policy variation and experimentation.

Variation and experimentation are two of the commonly touted federalism attributes, and yet they seem much less linked to federalism structures than most accounts assume. The variation-in-exchange-implementation story has two intersecting vectors. On the one hand, the ACA homogenized insurance law and policy to an important extent. Before the statute was passed, wide inequities and variation existed across states in the number of uninsured and the generosity of insurance plans.[451] After the ACA, inequities decreased across virtually all states, although some interstate differences remained.[452] The ACA also established national network adequacy standards for the first time.[453] Prior to the ACA, almost all states had at least some measures in place to ensure network adequacy, but states varied widely in their approaches.[454] The ACA enabled the Secretary of HHS to ensure that plans offered on marketplaces had "a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide[d] information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers."[455]

On the other hand, we still see significant variation across exchange models—but those differences do not stem from the choice between state and federal exchange structures. The ACA explicitly leaves to state discretion many of the important details regarding the structure and operation of the exchanges,

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[451] *See* Henry J. Kaiser Family Found., *supra* note 174, at 8; CATHY SCHOEN ET AL., COMMONWEALTH FUND, AMERICA'S UNDERINSURED: A STATE-BY-STATE LOOK AT HEALTH INSURANCE AFFORDABILITY PRIOR TO THE NEW COVERAGE EXPANSIONS, at ix–x, 3-4 (2014), http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/mar/1736_schoen_americas_underinsured.pdf (reporting wide variations between states in the number of individuals with access to adequate insurance).

[452] *See* Henry J. Kaiser Family Found., *supra* note 174, at 8.

[453] JANE B. WISHNER & JEREMY MARKS, URBAN INST., ENSURING COMPLIANCE WITH NETWORK ADEQUACY STANDARDS: LESSONS FROM FOUR STATES 4 (2017), http://www.urban.org/sites/default/files/publication/88946/2001184-ensuring-compliance-with-network-adequacy-standards-lessons-from-four-states_0.pdf.

[454] *See* Justin Giovannelli et al., Health Affairs, Health Policy Brief: Regulation of Health Plan Provider Networks 3 (2016), https://www.healthaffairs.org/do/10.1377/hpb20160728.898461/full/healthpolicybrief_160.pdf.

[455] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1311(c)(1)(B), 124 Stat. 119, 174 (2010) (codified at 42 U.S.C. § 18031).

and regulations promulgated under the ACA expand that discretion.[456] As Figure 3 illustrates, state discretion under the ACA created the possibility of vast differences in insurance markets even within exchange types. For example, some states used their authority to conduct rate review to vary significantly from the federal rating standards, limiting insurers' ability to impose surcharges for tobacco use or increase premiums based on age.[457] Other states prohibited insurers on their marketplaces from providing coverage for abortions.[458]

As is evident, the data reveals enormous variety, even *within a particular category of exchange model*, in how the exchanges look depending on states' level of involvement. Critically, although the federal government is nominally operating exchanges in about three dozen states, this does not mean all states' federally-run exchanges look the same—precisely because the federal

[456] Most importantly, the regulations gave states a choice of the health insurance policy that would serve as the benchmark plan to determine the essential health benefits that must be offered by plans in the individual and small group markets. *See, e.g.*, *Essential Health Benefit (EHB) Benchmark Plans, 2017*, HENRY J. KAISER FAM. FOUND. (2017), http://www.kff.org/health-reform/state-indicator/essential-health-benefit-ehb-benchmark-plans-2017/ ("States must choose an EHB benchmark plan from among the following ten plans operating in the state . . . ."). For federal-exchange states, CMS did impose quantitative standards, but the standards varied further by county composition. *See* Ctr. for Consumer Info. & Oversight, Ctrs. For Medicare & Medicaid Servs, 2017 Letter to Issuers in the Federally-Facilitated Marketplaces 23-24 & tbl. 2.1 (2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf (setting time/distance maximums for different types of providers like primary care physicians, hospitals, and endocrinologists). Federal-exchange states conducting plan management were allowed to accept to the federal standard or implement their own. For example, in a "large" county, a network would have to cover a primary care physician at most 10 minutes or 5 miles away from 90% of enrollees. *Id.* at 24 tbl.2.1. In a rural county, a network would have to include a primary care physician at most 30 minutes or 40 miles away for 90% of enrollees. *Id.* CMS proposed, but ultimately declined to adopt, quantitative standards for plans in all states regardless of exchange type. CMS particularly noted that establishing national quantitative standards was less necessary because states were working to implement a model statute devised by the National Association of Insurance Commissioners on network access and adequacy. *See* Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017, 81 FED. REG. 12,204, 12,205 (Mar. 8, 2016) (codified at 45 C.F.R. pts. 144, 147, 153, 154, 155, 156, 158).

[457] *See* Figure 3; Justin Giovanelli, et al., *Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market*, Commonwealth Fund 2–7 (Dec. 2014), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/dec/1795_giovannelli_implementing_aca_state_premium_rate_reforms_rb_v2.pdf.

[458] Alina Salganicoff et al., *Coverage for Abortion Services and the ACA*, Kaiser Fam. Found. 4 (Sept. 2014), https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-and-the-aca.

government was eager to give states input even within the federal model, whether through a hybrid structure or just through a federal exchange in which states had a voice in directing policy.

In total, twenty-nine states and D.C. are making plan management decisions, including eighteen states using the federal IT platform (the six partnership states, seven plan-management states, and five state based exchange states using Healthcare.gov).[459] In forty-seven states and D.C., the state insurance departments are managing health plan rate reviews.[460] Seventeen states and Guam sought adjustments to the federal medical loss ratio.[461] Forty-six states oversee compliance with ACA market reform standards.[462] The majority of states have chosen to set their own geographic rating areas, including fifteen states with federally-run exchanges, seven plan management states, six partnership states, four states with state-based exchanges on the federal IT platform, and all twelve states with fully state-run exchanges.[463]

For those federalism theorists who embrace federalism for policy variety, this data should give pause. It offers examples of locally-driven experimentation that comes through a *national* program with a flexible, state-centered component. Pure separation of state and federal is not necessary—indeed, perhaps not even ideal—for the states to fulfill their role as policy "laboratories." [464] States may not even be necessary! At the same time, the nationalism in the exchange design did have something of a smoothing effect at least on the equity front, in the sense that it set a floor that lessened some of the basic differences in coverage in the individual insurance markets across states.[465] In

[459] *See State Health Insurance Marketplace Types, 2018*, *supra* note 361.

[460] Ctr. for Consumer Info. & Ins. Oversight, *supra* note 361. Only Texas, Wyoming, and Oklahoma do not have effective state-run rate review programs. *Id.*

[461] Ctr. for Consumer Info. & Ins. Oversight, *State Requests for MLR Adjustment*, *supra* note 361. Nine of the states seeking adjustment had federally-run exchanges, two had federally-facilitated marketplaces but ran plan management, four were partnership model states, and two ran federally supported state based marketplaces. *See State Health Insurance Marketplace Types, 2018*, *supra* note 361 (select location and filter for relevant states).

[462] Ctr. for Consumer Info. & Ins. Oversight, *Compliance and Enforcement*, *supra* note 361. Only Missouri, Oklahoma, Texas, and Wyoming "notified CMS that they do not have the authority to enforce or are not otherwise enforcing the Affordable Care Act market reform provisions." *Id.*

[463] Ctr. for Consumer Info. & Ins. Oversight, *Market Rating Reforms: State Specific Geographic Rating Areas*, *supra* note 361; *State Health Insurance Marketplace Types, 2018*, *supra* note 361 (filter for relevant states).

[464] *See* sources cited *supra* note **Error! Bookmark not defined.**

[465] *Health Insurance Coverage of the Total Population*, HENRY J. KAISER FAM. FOUND. (2016), https://www.kff.org/other/state-indicator/total-population (to locate, select "trend

other words, even where there has been policy autonomy, it has not been complete.

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Postscript on ACA Waivers. Another form of market variation could come in the form of waivers. The ACA includes a provision—section 1332—that allows states to seek waivers from the statute's insurance requirements if the state can propose a program that would provide essentially the same coverage at the same cost.[466] Waivers were not permitted until 2017 under the statute, and so data about them were not included in our five-year study. We might expect to see aggressive use of this provision under the Trump Administration.

Early data is mixed. In 2017, the new Administration did approve waivers for Alaska, Minnesota, Oregon, and Hawaii,[467] which allowed the states to take on the health care costs of certain higher-cost individuals, taking them out of the market's risk pools and thereby lowering premiums overall[468]; in Hawaii's case, it waived provisions related to the ACA requirement to operate a small business insurance marketplace.[469] At the same time, more recently, the Administration did not act on waiver proposals from two other red-states—Iowa and Oklahoma—which included many conservative reforms.[470] Some media reports suggested that the Administration, hostile to the law, did not want to approve of any programs that would *strengthen* health care markets in those states.[471] In other words, this may mark a 180-degree turn from the

graph" and filter by insurance type) (showing a trend toward less variation in uninsured levels and sources of insurance across states).

[466] *See generally* Heather Howard & Galen Benshoof, *Health Affairs Blog Post: 1332 Waivers and the Future of Health Reform*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 237 (2015) (explaining the waiver program and its potential).

[467] *See State Roles Using 1332 Health Waivers*, NAT'L CONF. STATE LEGISLATURES (Dec. 30, 2017), http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx (summarizing all state requests for 1332 waivers and their goals).

[468] *See, e.g.*, *id*.

[469] *Id*.

[470] *See id.*; Timothy Jost, *ACA Round-Up: 1332 Waiver News From Iowa and Minnesota; Big Blow to Graham Cassidy*, HEALTH AFF. BLOG (Sept. 22, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170922.062146/full; Leslie Small, *Waiver Weirdness: What the Oklahoma and Iowa Cases Could Mean for Other States Seeking ACA Exemptions*, FIERCEHEALTHCARE (Oct. 10, 2017, 12:52 PM), http://www.fiercehealthcare.com/aca/oklahoma-iowa-waiver-joel-ario-trump.

[471] *See, e.g.*, Small, *supra* note 470; Eric Levitz, *Trump Personally Tried to Sabotage Obamacare in Iowa*, N.Y. MAG. (Oct. 6, 2017, 10:59 AM), http://nymag.com/daily/intelligencer/2017/10/trump-personally-tried-to-sabotage-obamacare-in-iowa.html; *see also* Letter from Terry Cline, Sec'y of Health & Human Servs. & Comm'r of Health, Okla. State Dep't of Health, to Steven Mnuchin, Sec'y, U.S. Dep't of the Treasury, and Thomas E. Price, Sec'y, U.S. Dep't of Health & Human Servs. (Sept. 29, 2017),

Medicaid strategy of the Obama administration, which was generous in granting waivers they perceived as suboptimal from a policy perspective, in the interests of the long-term goal of entrenching the law in as many states as possible.

VI. Federalism Values, Old and New

Detailing the ACA's federalism features in implementation is easier than evaluating the umbrella concept of "federalism" as whole in the statute or devising legal doctrine to effectuate the kind of federalism we describe. Indeed, one takeaway from the study is that approaching "federalism" as a single package may be an impossible task, not only because many of the attributes we associate with federalism may not be unique to federalist structural arrangements, but also because, even when it comes to what we expect *from* federalism, the concept stands in for so much.

Federalism at times seems advanced as an end it itself—aimed at generating the structural and democracy benefits believed to derive from the multiple layers of government. But federalism also is a tool used by Congress for improving *policy*—a means to an end. In the context of the ACA, that end is good health policy, a concept that is itself ill-defined. If federalist structural arrangements only deliver on some of the things we expect—whether autonomy, good health care outcomes, experimentation, etc.—is it really federalism? Do courts have a role in protecting it? What, again, is health care federalism for?

A. Federalism and Democracy Goals

If one views federalism as concerned only with keeping the federal government out of the picture, this study has little to offer. So does health care in general. As our historical account in Part II details, the federal government has *never* been an outsider to health care law. The ACA is just a more extreme version of what came before.

The big question concerns how to think about sovereignty and autonomy when are we not talking about separate spheres of power. We might say the ACA enhanced state sovereignty because the alternative—exclusion of states from any role in the federal scheme—would have dramatically reduced state control over health care. But couching an absolute concept like sovereignty in terms of relativity is conceptually challenging. It is easier, and maybe more apt, to talk about *control.* The ACA did offer states policy control—power that

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https://www.ok.gov/health2/documents/Oklahoma%201332%20Waiver%20Withdrawal%209.29.17.pdf (documenting Oklahoma's withdrawal of its 1332 waiver request citing the Administration's delay).

was enhanced by the leverage to opt-out and to extract concessions from the federal government.

Another way to think about questions of sovereignty and autonomy is to ask whether the ACA's implementation helped to strengthen or to diminish state local democracy. State governments are their own democracies and make their own state law—and that is indeed a hallmark of being sovereign. Perhaps counterintuitively, the ACA did not necessarily diminish this aspect of state sovereignty. The ACA preempts some areas of health law traditionally considered reserved for states, so by that measure, state sovereignty is lost. But the statute itself also has generated an enormous amount of new state law. Our data count hundreds of state laws and state administrative acts issued in Medicaid and exchange implementation alone.[472] Like any major federal law that relies on state implementation, the ACA depends on the healthy functioning of *the state sovereign lawmaking apparatus*.[473] As one of us has argued, this very fact—the fact that major national schemes rely on functioning state legal and legislative regimes—also gives these aspects of state sovereign governance enduring relevance, even in an era dominated by national law.[474] Had Congress designed the ACA with no role for the states, we would not have any of these intrastate government debates or this volume of state lawmaking on health policy. Health policy would be mostly federal all the way down, as in Medicare.

Government accountability is another central democracy value and one often mentioned in the context of federalism. Conservative members of the Court, including the dissenters in *NFIB*[475] and going back at least to Justice O'Connor's opinion in *New York v. United States*, have expressed concern that cooperative federalism schemes obfuscate accountability, leading voters to blame states for what are actually federal policies.[476]

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[472] *See* Medicaid Research Chart (on file with authors). *See generally* KATIE KEITH & KEVIN W. LUCIA, COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: THE STATE OF THE STATES (2014), http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2014/Jan/1727_Keith_implementing_ACA_state_of_states.pdf (cataloging vast amounts of state legislative and regulatory action taken by the end of 2013).

[473] For elaboration of this point, see Gluck, *supra* note 40, at 1999.

[474] *See id.* at 2000, 2007.

[475] Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2660 (2012) (Scalia, J., dissenting) ("When Congress compels the States to do its bidding, it blurs the lines of political accountability.").

[476] *See* New York v. United States, 505 U.S. 144, 168-69 (1992) (expressing concern that if the federal government commandeered states to perform federal regulatory schemes, then state politicians would bear the brunt of unpopular policies because voters would be ignorant as to whether policy choices were made by the state or the federal government.)

On the one hand, the ACA's story substantiates this concern. The federal government certainly tried to "punt" some decisions to the states. One example comes in the form of the ACA's "essential health benefits" (EHBs)—the baseline benefit package that the statute's insurance reforms guarantee for all exchange plans. Although the ACA itself directs the federal agencies to determine which benefits should be counted as EHBs, this decision proved so controversial that HHS outsourced it to the states.[477] A similar example comes from the more recent Republican repeal proposals. Those bills nominally would have left the ACA's EHBs and other generous insurance reforms in place—because they are politically popular—while at the same time inserting waiver provisions allowing the states to remove them.[478]

But our findings also flip some of these accountability concerns on their head. The kind of hybrid federalism structures that HHS pursued to facilitate implementation of the ACA—including the "secret boyfriend" model—helped *state* politicians blur responsibility. These structures gave the state actors *cover* to participate in a scheme that they viewed as valuable but politically risky. When the ACA was later successful, some state electorates were largely unaware that their state was benefitting from cooperating with the federal administrative scheme.[479] Since the 2016 presidential election, we have seen evidence that the citizenry is deeply confused about the implications of repealing the law, what it accomplished, whether it even exists, and who is accountable for what.[480]

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[477] *See* SABRINA CORLETTE ET AL., URBAN INST., CROSS-CUTTING ISSUES: MOVING TO HIGH QUALITY, ADEQUATE COVERAGE; STATE IMPLEMENTATION OF NEW ESSENTIAL HEALTH BENEFITS REQUIREMENTS 3-5 (2013), http://aucd.org/docs/rwjf407484.pdf ("[T]he ACA calls for the Secretary of [HHS] . . . to define a set of essential health benefits to be offered by all new fully insured individual and small-group health plans, beginning January 1, 2014. . . . Rather than define a uniform, national set of essential health benefits, HHS provided that each state could choose a benchmark plan on which to base their EHB package.").

[478] *See, e.g.*, S. Amend. 1030 to H.R. 1628, 115th Cong., 163 CONG. REC. S5682-95 (as proposed, Sept. 13, 2017).

[479] *See, e.g.*, Sarah Kliff, *Why Obamacare Enrollees Voted for Trump*, VOX (Dec. 13, 2016, 8:10 AM), https://www.vox.com/science-and-health/2016/12/13/13848794/kentucky-obamacare-trump ("I kept hearing the same theory over and over again: Kentuckians just did not understand that what they signed up for was part of Obamacare. If they had, certainly they would have voted to save the law.").

[480] Kyle Dropp & Brendan Nyhan, *One-Third Don't Know Obamacare and Affordable Care Act Are the Same*, N.Y. TIMES: THE UPSHOT (Feb. 7, 2017), https://www.nytimes.com/2017/02/07/upshot/one-third-dont-know-obamacare-and-affordable-care-act-are-the-same.html?_r=0 ("35 percent of respondents said either they thought Obamacare and the Affordable Care Act were different policies (17 percent) or didn't know if they were the same or different (18 percent) . . . . When respondents were asked what would happen if Obamacare were repealed, even more people were stumped."); Ilya Somin, *Public Ignorance About Obamacare*, VOLOKH CONSPIRACY (May 1, 2013, 1:27

The democracy value of accountability in this context was traded off for policy ends—entrenchment and expansion of the statute. That story itself instantiates the multitude of values that we tend to group under the single federalism umbrella. The states' under-the-radar moves allowed the ACA to be implemented in states where resistance might have otherwise prevented it. The number of remaining uninsured would be higher but for this adaptive federalism. Maybe that makes this aspect of the story a more nationalist one, but federalism enabled it.

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B. Federalism and Policy Goals

The political and judicial arenas tend to give more attention to federalism for federalism's own sake—for the political and constitutional values it advances—than to federalism for policy goals. That theme has certainly been dominant in the ACA's implementation. But this has not always been the case. The Federalist Papers themselves contain a well-known statement in the other direction, putting the "public good" above the "sovereignty of the States" in the event the two were to conflict.[481] So understood, federalism is a means to an end, not the end in and of itself.[482]

But even this narrower slice of federalism as "means" still stands in for many things. One way to think about federalism as a tool for policy is that it generates a particular *kind* of policy solution. As we already have discussed, local variation and experimentation are the kinds of policy values typically associated with federalism. But a different way to think about federalism as a tool for policy is that federalism may generate the best specific policy outcomes on a particular substantive question. In the context of the ACA's

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PM), http://volokh.com/2013/05/01/public-ignorance-about-obamacare ("42% of Americans are unaware that the Affordable Care Act is still the law of the land.").

[481] *See* THE FEDERALIST NO. 45, at 289 (James Madison) (Clinton Rossiter ed., 1961) ("It is too early for politicians to presume on our forgetting that the public good, the real welfare of the great body of the people, is the supreme object to be pursued; and that no form of government whatever has any other value than as it may be fitted for the attainment of this object. Were the plan of the convention adverse to the public happiness, my voice would be, Reject the plan. Were the Union itself inconsistent with the public happiness, it would be, Abolish the Union. In like manner, as far as the sovereignty of the States cannot be reconciled to the happiness of the people, the voice of every good citizen must be, Let the former be sacrificed to the latter.")

[482] *Compare e.g.*, Gerken, *supra* note **Error! Bookmark not defined.**, at 1039 ("Gluck sees state power as an 'end worth achieving itself.' . . . I understand both decentralization and centralization to be means to an end." (quoting Gluck, *supra* note 2, at 1050)), *with* Gluck, *supra* note 2, at 1046-47 (critiquing Gerken's view of federalism as means to ends unrelated to federalism).

drafting, there were indeed numerous suggestions that health policy is made better closer to the people as justifications for the statute's state-led structure.

Both of these categories of "federalism as means" are more complicated than may initially appear. With respect to state-centered administration to generate variation and experimentation, we already have illustrated in detail how these features emerged almost independently of the structural arrangements in the ACA (for example, state vs. federal exchange). In other words, these core federalism attributes do not actually seem unique to it.

With respect to federalism as a tool for specific health policy outcomes, that too remains unclear, in large part because, on the health policy side, clear outcome goals have not been specifically defined. Access, cost, and quality are just of many potential outcome metrics commonly used—and fought over—in health policy circles. We pause here to offer here a brief and oversimplified snapshot of the kinds of policy analyses that could be undertaken if one had a clearly articulated system goal.

1. ACA Federalism and Medicaid Outcomes

It is almost certain that the ACA's Medicaid expansion as drafted—which would have mandated a nationwide expansion—would have increased access to care simply by covering 2.5 million more lives than would have been covered had the Supreme Court in *NFIB* not given states a choice. But that figure is not the only salient outcome measure for whether the state-led model that *NFIB* created delivered, as it does not take into account other factors that are constants in any health policy conversation, such as cost or quality of care.

Empirical studies of ACA implementation have begun to document that, especially in Medicaid expansion states, those who have become insured through the ACA have better access to care.[483] Studies also show that access does not occur at the expense of individuals who were already insured—they are not being crowded out as some feared would occur.[484] Medicaid beneficiaries experience better access to care and better health,[485] better ability

[483] *See, e.g.*, Stacey McMorrow et al., *Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-Income Parents*, 36 HEALTH AFF. 808, 812 (2017) (finding "significant increases in access and use among low-income parents in expansion states," as well as "strong improvements in almost every affordability measure examined for parents in expansion states").

[484] *See* Salam Abdus & Steven C. Hill, *Growing Insurance Coverage Did Not Reduce Access to Care for the Continuously Insured*, 36 HEALTH AFF. 791, 797 (2017) ("We found no consistent evidence that increases in insurance coverage rates . . . were associated with worsened access to care . . . .").

[485] *See, e.g.*, Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA

to take medications consistently,[486] and less trouble paying medical bills.[487] Medicaid coverage is better than uninsurance[488] (which sounds like a low baseline but was a tenacious trope around the time that the ACA was being drafted), for example by increasing the probability that a patient will present earlier with an illness or injury, which contributes to better management of a medical issue.[489] Research indicates that the newly eligible may experience longer wait times for appointments with specialists than with primary care providers.[490]

INTERNAL MED. 1501, 1507-08 (2016) ("After 2 years of coverage expansion in Kentucky and Arkansas, compared with Texas's nonexpansion, there were major improvements in access to primary care and medications, affordability of care, utilization of preventative services, care for chronic conditions, and self-reported quality of care and health.").

[486] *See* Benjamin D. Sommers et al., *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586, 588 (2017), http://www.nejm.org/doi/pdf/10.1056/NEJMsb1706645.

[487] *See* DELOITTE, MEDICAID EXPANSION REPORT: 2014, at 35-36 (2015), http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf; Kaiser Comm'n on Medicaid & the Uninsured, Henry J. Kaiser Family Found., What's at Stake in the Future of the Kentucky Medicaid Expansion? 2 (2016), http://files.kff.org/attachment/fact-sheet-Whats-At-Stake-in-the-Future-of-the-Kentucky-Medicaid-Expansion; *see also* ANTONISSE ET AL., *supra* note **Error! Bookmark not defined.**, at 1.

[488] Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year* 29 (Nat'l Bureau of Econ. Research, Working Paper No. 17190, 2011), http://www.nber.org/papers/w17190 ("Using a randomized controlled experiment design, we examined the approximately one-year impact of extending access to Medicaid among a low-income, uninsured adult population. We found evidence of increases in hospital, outpatient, and drug utilization, increases in compliance with recommended preventive care, and declines in exposure to substantial out-of-pocket medical expenses and medical debts. There is also evidence of improvement of self-reported mental and physical health measures, perceived access to and quality of care, and overall wellbeing"). The authors found no statistical difference in emergency room usage. *Id*. at 3. *See also, e.g.*, Benjamin D. Sommers, et al., *Three-Year Impacts of The Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults*, 36:6 HEALTH AFF. 1119, 1124-25 (June 2017) ("Our four years of data indicate that the ACA's coverage expansion to low-income adults was associated with significant improvements in access to primary care and medications, affordability of care, preventive visits, screening tests, and self-reported health."), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0293.

[489] Andrew P. Loehrer et al., *Association of the Affordable Care Act Medical Expansion with Access to and Quality of Care for Surgical Conditions*, JAMA Surgery E5 (Jan. 24, 2018), https://jamanetwork.com/journals/jamasurgery/fullarticle/2670459 ("In this study of surgical patients in 42 states (including Washington, DC), the ACA's Medicaid expansion was associated with higher coverage rates, earlier presentation, and improved probability of optimal care for common and serious surgical conditions. Our data reinforce that insurance coverage is an important contributor to earlier presentation with less severe disease at the time of diagnosis.").

[490] *See* Sommers, *supra* note 488, at 1126.

With respect to the cost of health care, Medicaid expansion costs both states and the federal government more than pre-ACA Medicaid.[491] Yet, studies show that those states that expanded Medicaid eligibility are better off economically than states that have not.[492] The costs of expansion largely are borne by the federal government, even when the supermatch phases down to 90%, and states are able to offset costs (such as for uncompensated care) that were the state's responsibility before Medicaid expansion.[493] Insurance marketplace premiums are lower in states that expanded Medicaid.[494] Hospitals have had fewer uninsured patients requiring treatment in emergency departments,[495] and one study reported that hospitals—especially rural hospitals—were less likely to close in expansion states.[496] Evidence indicates that people do not leave employment due to Medicaid expansion, countering

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[491] *See* MACPAC, *State and Federal Spending Under the ACA*, https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca/ (last visited Feb. 16, 2018).

[492] *See, e.g.*, DEBORAH BACHRACH ET AL., STATE HEALTH REFORM ASSISTANCE NETWORK, STATES EXPANDING MEDICAID SEE SIGNIFICANT BUDGET SAVINGS AND REVENUE GAINS 1 (2016), http://www.statenetwork.org/wp-content/uploads/2016/03/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-March-2016.pdf ("Data regarding Medicaid expansion in 11 states—Arkansas, California, Colorado, Kentucky, Michigan, New Mexico, Oregon, Maryland, Pennsylvania, Washington state, and West Virginia— and the District of Columbia confirm that states continue to realize savings and revenue gains as a result of expanding Medicaid."); STAN DORN ET AL., URBAN INST., WHAT IS THE RESULT OF STATES NOT EXPANDING MEDICAID? 1 (2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946 ("A review of state-level fiscal studies found comprehensive analyses from 16 diverse states. Each analysis concluded that expansion helps state budgets.").

[493] *See* Benjamin D. Sommers & Jonathan Gruber, *Federal Funding Insulated State Budgets from Increased Spending Related to Medicaid Expansion*, 36 HEALTH AFF. 938, 941-43 (2017) (studying the federal/state budgetary balance in Medicaid expansion states and concluding that costs were borne primarily by the federal government not states); *see also* MACPAC, *supra* note 491.

[494] ADITI P. SEN & THOMAS DELEIRE, DEP'T HEALTH & HUMAN SERVS., THE EFFECT OF MEDICAID EXPANSION ON MARKETPLACE PREMIUMS 2 (2016), https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf ("We estimate that Marketplace premiums are about 7 percent lower in expansion states, controlling for differences across states . . . .").

[495] ANTONISSE ET AL., *supra* note **Error! Bookmark not defined.**, at 1, 4 (updating a June 2016 literature review, which also found that states and hospitals netted economic benefits from Medicaid expansion).

[496] Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37:1 HEALTH. AFF. 111, 117 (Jan. 2018) (finding hospitals in states that expanded Medicaid were less likely to close, especially rural hospitals).

fears that Medicaid somehow causes joblessness (a different kind of economic effect).[497]

Not much data is available yet to assess the economic impact of demonstration waivers in ACA implementation.[498] Section 1115 demonstration waivers are supposed to be budget neutral to the federal government, but HHS gauges budget neutrality in a number of ways that facilitate rather than impede waiver approvals.[499] In the Medicaid expansion context, negotiating a waiver takes time, and HHS's evaluation and approval of a waiver usually take anywhere from several months to more than a year.[500] This extended negotiation and approval process is not cost-free; people who are uninsured have no consistent means of care and thus are more costly when they arrive in hospitals, which provide expensive and inefficient emergency care under federal law.[501] (This expensive point of rescue was part of the calculus in drafting the ACA to ensure coverage of low-income populations.)[502] In addition, demonstration waivers have specific timing and reporting that make immediate, quantifiable evaluation tricky; they were typically approved for five

[497] *See id.* at 7; *see also* LARISA ANTONISSE ET AL., HENRY J. KAISER FAMILY FOUND., THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: FINDINGS FROM A LITERATURE REVIEW 9 (2016), http://files.kff.org/attachment/Issue-brief-The-Effects-of-Medicaid-Expansion-under-the-ACA-Findings-from-a-Literature-Review ("[S]tudies examining other measures of employment and employee behavior (such as transitions from employment to nonemployment, the rate of job switches, transitions from full- to part-time employment, labor force participation, and usual hours worked per week) have not found significant effects of Medicaid expansion.").

[498] To fill the gap, Kaiser Family Foundation conducted interviews and focus groups in Michigan and Indiana to learn about implementation of their waivers. *See* MARYBETH MUSUMECI ET AL., HENRY J. KAISER FAMILY FOUND., AN EARLY LOOK AT MEDICAID EXPANSION WAIVER IMPLEMENTATION IN MICHIGAN AND INDIANA 3 (2017), http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Medicaid-Expansion-Waiver-Implementation-in-Michigan-and-Indiana (noting, among five key findings, some indication that administration is costly and complex as well as confusing for beneficiaries).

[499] *Waivers*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/subtopic/waivers (last visited Oct. 6, 2017) (detailing each type of waiver and how states obtain waivers).

[500] *Id.*

[501] This is due to EMTALA, 42 U.S.C. § 1395dd(b) (2016), discussed briefly in Part II.A, which requires hospitals that have emergency departments to treat or stabilize and transfer all individuals who present with an emergency condition regardless of their ability to pay.

[502] *See* Elisabeth Rosenthal, *Paying Till It Hurts* (pt. 5)*: E.R. Visit; As Hospital Prices Soar, a Stitch Tops $500*, N.Y. TIMES (Dec. 2, 2013), http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?hpw&rref=us&_r=1 (revealing high cost of emergency care in hospitals, which "charge paying or well-insured patients more to compensate for others they treat at a loss").

years and renewed for three, though some provisions had a one-year timeline.[503]

Historically, waivers' successes or failures were not evaluated until a state applied to renew or amend a waiver, and 1115 waivers have a long history of implementation without supervision or reflection.[504] The ACA modified the 1115 waiver process so that states report annually, regardless of the duration of the initial waiver approval.[505] Indiana's HIP 2.0 waiver has been criticized based on its first annual report, which indicated that enrollment was low due to the exclusionary measures in the state's waiver.[506] Although the waiver was in effect for only about one year, the commissioned study of its implementation showed that the state has trouble managing enrollee compliance with rules for premium payments, wellness programs, and other measures designed to decrease enrollment in Medicaid.[507] Another example exists in Iowa, which

[503] *See About Section 1115 Demonstrations*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Jan. 2, 2018). For examples of one-year Section 1115 waivers and extensions, *see Florida Section 1115 Demonstration Fact Sheet*, MEDICAID.GOV, 5, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf (last visited Jan. 6, 2018) (stating that CMS authorized a one-year extension for the Low Income Pool component of their Section 1115 demonstration); *Iowa Wellness Plan Section 1115 Demonstration Fact Sheet*, MEDICAID.GOV, 1, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-fs.pdf (last visited Jan. 6, 2018). CMS announced late in 2017 it would adjust some waiver approval and renewal features, allowing for "fast track" approval of waiver provisions already approved in other states and allowing waiver approvals to last longer (ten years, in some instances). *See* Brian Neale, Ctr. for Medicaid & CHIP Servs., CMCS Informational Bulletin (2017), https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf.

[504] Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y, L., & ETHICS 213, 214-15 (2015) (discussing "opaque" 1115 waiver and renewal processes). ACA § 10201 created a more robust 1115 waiver by adding notice and comment as well as reporting requirements to Section 1115 waiver applications and renewals. *Id.* at 215; Pub. L. No. 111-148, § 10201, 124 Stat. 119, 922 (2010) (codified at 42 U.S.C. § 1315(d) (2016)).

[505] *See* 42 C.F.R. § 431.428 (2017).

[506] *See, e.g.*, Letter from Am. Cong. of Obstetricians and Gynecologists et al., to Thomas Price, Sec'y, U.S. Dep't of Health & Human Servs. 2 (Mar. 17, 2017), http://ccf.georgetown.edu/wp-content/uploads/2012/03/HIP-2.0-Comments-March-17.pdf ("Findings in the HIP 2.0 interim evaluation report show [that Indiana's] policies are affecting participation in the program and making it harder for people to obtain care . . . .").

[507] *See generally* LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0: INTERIM EVALUATION REPORT, 3, 20-21 (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf (revealing that one-third of "conditionally enrolled" members—individuals who have applied and are eligible for Medicaid but have not yet started coverage—never complete enrollment because they fail to

applied for an extension of a one-year waiver that allowed charging for non-emergency transportation. The little evidence collected indicated that Medicaid beneficiaries' access to care was *decreased* by this "experiment" (especially for individuals earning less than 100% of FPL) even though the state's hypothesis for the demonstration project was that access to care would not decrease.[508] Overall, many elements common in Medicaid expansion waivers (described in Part IV, above) are likely to be costlier for states to administer than traditional Medicaid.[509]

As a different example, waiver provisions that are designed to prevent continuous enrollment will decrease costs to the state, and therefore also the federal government under Medicaid's matching funding; but, they will curtail the extent of coverage. In part to reduce costs, states now are seeking to implement waivers that will drive the newly eligible population *out* of Medicaid; for example, Kentucky had an 1115 waiver approved early in 2018 that is designed to decrease state Medicaid costs through work requirements, cost sharing, and other features, and according to the state's own evaluation, enrollment will drop by nearly 100,000.[510]

As we discussed in Part IV, some states have gone farther than the ACA's Medicaid expansion, offering more generous coverage. Those efforts have the

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make the required premium payments and contributions to their Personal Wellness and Responsibility ("POWER") Account, and noting that only 66 percent of enrollees required to make contributions to their POWER Accounts reported ever hearing of the POWER Account). HHS required this interim evaluation as well as a final evaluation at the end of the three-year waiver.

[508] *See* Letter from Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to Julie Lovelady, Interim Medicaid Dir., State of Iowa (Dec. 30, 2014), http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf.

[509] *See* Melissa Burroughs, *The High Administrative Costs of Common Medicaid Expansion Waiver Elements*, FAMILIES USA (Oct. 20, 2015, 9:51 AM), http://familiesusa.org/blog/2015/10/high-administrative-costs-common-medicaid-expansion-waiver-elements.

[510] Deborah Yetter, *Bevin Unveils Plan to Reshape Medicaid in Ky.*, COURIER-JOURNAL (June 22, 2016), http://www.courier-journal.com/story/news/politics/2016/06/22/bevin-unveils-plan-reshape-medicaid-ky/86211202 (discussing the waiver application's indication that Medicaid enrollment will decline by nearly 86,000 people by 2021); Jason Bailey, *What's In the Governor's Proposed Medicaid Changes*, KY. CTR. FOR ECON. POL'Y (June 22, 2016), http://kypolicy.org/summary-governors-proposed-medicaid-changes. The waiver proposes a number of mechanisms that are likely to block, discourage, or cause sporadic enrollment; for example, beneficiaries who cannot pay premiums or who do not meet work requirements would be "locked out" for months. Yetter, *supra* note 510; see also *See* Letter from Matthew G. Bevin, Governor, Commonwealth of Ky., to Brian Neale, Dir., Ctr. for Medicaid & CHIP Servs. (July 3, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf.

predictable effect of costing the federal government more money in matching payments.

In sum, *NFIB*'s enhancement of state policy control over Medicaid expansion unquestionably served both structural ends sometimes advanced by federalists, including state leverage and policy autonomy, as well as serving policy ends like variation and experimentation—although we note that 1115 waivers were possible even within a full nation-wide Medicaid expansion. It far less clear that as a tool to improve health policy outcomes—along the most common metrics of cost, access, and quality—*NFIB*'s state-led structure of the Medicaid expansion was successful. But then, Congress never assumed it would; that is why Congress did not draft the Medicaid expansion that way in the first place.

2. ACA Federalism and Exchange Outcomes

In contrast, Congress did assume that exchanges would benefit from a state-led structure. The data thus far is equivocal and no firm conclusion can be drawn on whether the structure of the exchanges, in terms of being state or federally run, made a difference.[511] Most states lost insurers between 2014 and 2017 regardless of exchange type,[512] but some of these losses were due to other acts of political resistance[513]—including the shutting off of critical insurance stabilization funding by the Republican-controlled Congress—and some states still had a net gain.[514]

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[511] *See, e.g.*, Sabrina Guilbeault et al., *Making the Grade: Evaluating the Performance of State Health Insurance Marketplaces*, COLLABORATIVE (May 26, 2016), http://collaborativeri.org/research/making-the-grade-evaluating-the-performance-of-state-health-insurance-marketplaces (finding marketplaces with federally-run exchanges performed as well or better than state-based exchanges and hybrids); *Marketplace Enrollment as a Share of Potential Marketplace Participation*, HENRY J. KAISER FAM. FOUND. (Mar. 31, 2016), http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015 (compiling data on marketplace enrollment as a percentage of total eligible individuals, with federally-facilitated marketplaces performing worse than state-based or hybrid exchanges).

[512] Partnership model states fared the best, increasing the average number of issuers slightly from 2014 to 2017 (from 3.67 to 4.33). *See Number of Issuers Participating in the Individual Health Insurance Marketplaces*, HENRY J. KAISER FAM. FOUND. (2018), https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace (listing the number of issuers by state, from these which averages were calculated). Other exchange types lost roughly one or fewer issuers over the three-year period on average. *Id.* Federally supported state-based marketplaces fared the worst, losing 1.2 insurers on average. *Id.*

[513] Gluck, *supra* note 363 (detailing acts of political resistance).

[514] *See Number of Issuers Participating in the Individual Health Insurance Marketplaces*, *supra* note 512.

Average premiums have increased in forty-six states and the District of Columbia, more than doubling in some states, though premium tax credits have largely insulated consumers from the increases.[515] On the other hand, approximately 16.9 million more Americans received health care coverage in the first two years of the ACA,[516] and 12.2 million Americans received insurance through the exchanges in the most recent open enrollment period.[517]Data from a few years before the ACA's passage also revealed wide variation among the number of uninsured across states.[518] The ACA has closed that gap in each state, but differences across states remain.[519]

The data are more equivocal on whether state based exchanges performed better across the typical variables of market penetration, premium levels and number of insurers. States with federally-run exchanges had lower enrollment in 2014 than states with state-based marketplaces.[520] This trend reversed in 2015, and federally-facilitated marketplaces had higher enrollment growth than state-based marketplaces.[521] The federal government has doled out billions of dollars in marketplace development grants, but those states that received the

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[515] Cynthia Cox et al., *2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces*, HENRY J. KAISER FAM. FOUND. (Nov. 1, 2016), http://www.kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces. For example, the second most expensive silver plan in Phoenix, Arizona cost $300 more per month in 2017 than 2016 for a 40-year-old non-smoker earning $30,000. *Id.* After tax subsidies, though, the price remained steady at $207 per month. *Id.* Preliminary data from the 2018 open enrollment period suggests this trend will continue to hold true. *See* Rabah Kamal et al., *An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges*, HENRY J. KAISER FAM. FOUND. (Aug. 10, 2017), https://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges. Some analysts view the rate increases in 2017 as a necessary market correction as the health profile of the pool of insured individuals became clear. *See* Ashley Semanskee & Larry Levitt, *Individual Insurance Market Performance in Mid 2017*, at 5 HENRY J. KAISER FAMILY FOUND. (2017), http://files.kff.org/attachment/Issue-Brief-Individual-Insurance-Market-Performance-in-Mid-2017.

[516] Katherine G. Carman et al., *Trends in Health Insurance Enrollment, 2013-15*, 34 HEALTH AFF. 1044, 1044 (2015).

[517] *Total Marketplace Enrollment*, HENRY J. KAISER FAM. FOUND., http://www.kff.org/health-reform/state-indicator/total-marketplace-enrollment (last visited Dec. 21, 2017).

[518] *See generally* John Holahan, *Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?*, *in* FEDERALISM AND HEALTH POLICY, *supra* note 17, at 111, 111-142 (2003).

[519] *See Health Insurance Coverage of the Total Population*, *supra* note 465; HENRY J. KAISER FAMILY FOUND., *supra* note 174, at 2, 4.

[520] *Marketplaces Make Significant Progress in 2015*, URB. INST. (Apr. 8, 2015), http://apps.urban.org/features/marketplace-enrollment.

[521] *Id.*

most grants have not necessarily been the most successful.[522] In terms of both enrollment and cost, at least some data reveal that state-based exchanges did not outperform either federal or hybrid marketplaces, as it was expected they would.[523]

C. Federalism, Regulation and Law[524]

Our study also has implications for federalism's doctrinal landscape. First and foremost, we need to know what we are talking about to know what law is protecting or whether law even can protect it. Courts are generally ill-suited to address one important segment of federalism questions: questions about policy, such as whether federalist structures produce better health outcomes. We doubt courts are even the appropriate place to address other federalism attributes, like cooperation, variation, and experimentation because they are so context-specific and dynamic. Frankly, based on our study, we would eliminate those factors entirely as irrelevant to any deep analysis of "federalism."

Courts are far better at policing clear boundaries, which we do not have here, and at focusing on process, which we do. We can envision, for instance, courts intervening in cases to be sure that the policy control a statute gives to states remains with the states.[525] Our data corroborate the focus of much of the new federalism literature on the central role of vertical and inter-agency bargaining as the central feature of modern, intrastatutory federalism relationships.[526] The former federal officials we interviewed told us that their

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[522] *See* Robert B. Hackey & Erika L. May, *Measuring the Performance of Health Insurance Marketplaces*, 314 JAMA 667, 667 (2015) ("Hawaii's SBM, the nation's most expensive marketplace in terms of per enrollee costs, received more than $205 million in federal funding, but as of February 2015 had only enrolled 12,625 individuals. . . . In contrast, Florida accepted no federal funding for ACA planning and implementation, but its FFM enrolled more subscribers than any other state in 2015 (1,596,296 individuals).").

[523] *Id.* at 668 ("This is a counter-intuitive outcome because SBMs retained a larger role in regulating insurance premiums. In such states, insurance commissioners were expected to use their rate review powers to exert downward pressure on insurers' premium requests."). Evidence suggests that insurers in SBMs performed better financially than insurers in FFMs. *See* Mark A. Hall et al., *Financial Performance of Health Insurers: State-Run Versus Federal-Run Exchanges*, MED. CARE RES. & REV., Mar. 6, 2017, at 1, 7 However, this effect may be attributable to the state's decision on Medicaid expansion. *Id.*

[524] The arguments in this section benefited tremendously from the thoughts of one of our initial colleagues in this study, Dean Ted Ruger at the University of Pennsylvania Law School.

[525] *See* Ernest A. Young, *Two Cheers for Process Federalism*, 46 VILL. L. REV. 1349, 1351 (2001) ("[W]hat judicial review we have should be directed toward maintaining a vital system of political and institutional checks on federal power, not on policing some absolute sphere of state autonomy.").

[526] *See, e.g.*, ERIN RYAN, FEDERALISM AND THE TUG OF WAR WITHIN 350 (2011) (recognizing "the important interpretive roles by political actors in vertical federalism bargaining"); Gerken, *supra* note **Error! Bookmark not defined.**, at 1010 (discussing states' powers as

daily interactions with each state individually were all-consuming and complex.[527] These vertical negotiations were the core dynamic of ACA implementation.

We also saw that the federal government exerts power—but not hegemonically. The dance between the federal government and each state is not a zero-sum negotiation over policy optimization between a federal executive and state actors who might disagree on a single dimension. The federal government has at least two negotiating levers, regulatory policy and budget generosity, and it can switch between them (or use both) to implement its policy goals. Extending this two-lever bargaining dynamic is a temporal and vision mismatch between national and state policy ends. If the Obama Administration was typical, the federal executive operates on a longer time horizon than most state officials, a point confirmed by several of our interviewees.[528] States likely care more about Medicaid implementation specifics given their primary role in delivering health care and the budgetary consequences they face every year. The federal executive tends to aim at a higher level of generality.

These factors combine to give states a lot more leverage than most newer federalism scholars assume, and we doubt this observation is unique to the ACA. Much of the new scholarship has portrayed the states as *victims* in these negotiations, calling for new legal doctrines as a way to level the bargaining playing field between states and the federal government.[529] Our study casts doubt on whether the states need more protection or power at all. At least in the context of the ACA, states have proven themselves quite adept at leveraging available options to their benefit.[530] We suspect this leverage was due not only to *NFIB*, although it undoubtedly helped. States still had the lever of refusing to establish their own exchanges and, as we have seen, that was a powerful tool to bring HHS to the table to adapt. And, the Medicaid waiver provisions were available before *NFIB*.

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that "of the servant"); Gluck, *supra* note 1, at 570 (discussing "important vertical and horizontal implementation networks" that arise in the context of the ACA); Ruger, *supra* note 52, at 224-26 (emphasizing state leverage under the ACA).

[527] Interview with Former Federal Executive Branch Health Care Official 5, *supra* note 204; Interview with Former Federal Executive Branch Health Care Official 1, *supra* note **Error! Bookmark not defined.**.

[528] Interview with State Policy Organization Officers 1, 2, 3 and 4, *supra* note **Error! Bookmark not defined.**; Interview with Former Federal Executive Branch Health Care Official 1, supra note **Error! Bookmark not defined.**; Interview with Former Federal Executive Branch Health Care Official 5, *supra* note 204.

[529] *See generally* Erin Ryan, *Negotiating Federalism*, 52 B.C. L. REV. 1, 24-73 (2011) *Cf.*, *e.g.*, Ilya Somin, *Federalism and the Roberts Court*, 46 PUBLIUS: J. FEDERALISM 441, 442 (2016) (praising the Roberts Court's "strengthen[ing of] judicial enforcement of limits on federal power . . . for the purpose of leaving greater scope for state and local authority").

[530] *See supra* Parts IV & V.

Central to the negotiating power that we observed are several features that appear not to be limited to the ACA: state choice to implement; a context in which the federal government does not wish to or lacks capacity to implement a program nationwide itself; and the executive branch's commitment to program's success. Of course other kinds of statutes exist too—including ones with less political salience—in which an administering agency might be able to step in more easily or be more willing to stake out firmer negotiating positions at the expense of entrenching the law.

It also is notable that Congress and federal courts remain largely on the sidelines when it comes to these intergovernmental negotiations.[531] We saw little of those institutions in our study after Congress set the ACA in motion and the Court effectively amended it in *NFIB*. Part of the reason is that almost no legal doctrine applies to these new vertical interactions, and so courts have had little role to play.[532] As noted, we can imagine doctrines that would recognize the federalism features within national statutory implementation and seek to effectuate them. As another example of such doctrine, we might recognize rights for state implementers to challenge executive action that undermines a law's effectiveness—at the moment those kinds of challenges are exceedingly difficult to bring.[533] One important legal move already has occurred, perhaps in recognition of the growing importance of bargaining relationships: the ACA amended the Medicaid 1115 waiver process to bring more transparency to waiver negotiations.[534] Waivers were notorious legal black boxes across all areas of law, and this new transparency has facilitated state copying in Medicaid.

Another problem is that current legal doctrine does not recognize and so cannot capture the blended entities that modern federalism statutes like the ACA produce.[535] These institutions are neither "state" nor "national." Ask any health law scholar if an insurance exchange—whether it is state-run, federally-

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[531] *Cf.* Jessica Bulman-Pozen, *Executive Federalism Comes to America*, 102 U. VA. L. REV. 953, 954 (2016) (arguing that Congress is sidelined because of polarization, not legal doctrine, and seeing an enchanced role for executive negotiations as a result).

[532] Gluck, *supra* note 40, at 1997 ("This push-pull of nation and state—both from *inside* the landscape of federal statutes—is more than just an interesting theoretical observation. It is a 'law' problem. When it comes to legal doctrines to deal with this new world of statutory federalism, ours is a sorry state of affairs.").

[533] The Take Care clause provides a means of suing the executive but is an extraordinarily high hurdle. Abbe R. Gluck, *President Trump Admits He's Trying to Kill Obamacare. That's Illegal,"* https://www.vox.com/the-big-idea/2017/10/17/16489526/take-care-clause-obamacare-trump-sabotage-aca-illegal (Oct. 17, 2017).

[534] *See* Watson, *supra* note 548.

[535] *See generally* Gluck, *supra* note 40 (detailing the lack of doctrine).

run, or hybrid—is a state or federal entity, and a variety of conflicting answers will follow. They are mixed entities of the sort that—because they retain some features of state sovereignty—have puzzled constitutional and federal courts scholars when it comes to categorizing them as state or federal.[536]

In years to come, courts will certainly be asked whether challenges to aspects of insurance-exchange operation are federal- or state-law questions for purposes of jurisdiction and applicable law, just as courts have been asked—and unevenly answered—such questions regarding state implementation of the Clean Air Act.[537] Questions are also likely to arise concerning to what extent Congress can direct state officials in federal-law implementation. For instance, the ACA required state insurance commissioners to engage in rate review that some states did not already allow those officials to perform.[538] Courts have not answered if federal law may authorize this otherwise ultra-vires state-official behavior, or whether state law first must authorize state officials to act as federal law requires. The Court narrowly skirted this question a few terms ago—the same term that it also skirted the difficult question of when individuals can challenge states for lax implementation of federal law when that implementation is overseen also by state officials.[539]

This blurring of state and national contributes to the conceptual difficulties for federalism we already have outlined. It also undermines the assumptions made by federalism legal doctrines, which still rest on a separate-spheres conception.

D. Federalism and Health Care

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[536] *Cf.* Gluck, *supra* note 40, at 2007, 2027, 2033 (illustrating confusion about similar entities, such as the implementation tools of the state-led federal statute, the Clean Air Act (CAA)).

[537] Ernest A. Young, *Stalking the Yeti: Protective Jurisdiction, Foreign Affairs Removal, and Complete Preemption*, 95 CALIF. L. REV. 1775, 1787-88 (2007) (discussing cases evincing confusion under the CAA).

[538] *See States Implement Health Reform: Premium Rate Reviews*, NAT'L CONF. STATE LEGISLATURES (Dec. 2010), http://www.ncsl.org/research/health/states-implement-health-reform-premium-rate.aspx ("Under federal law, states (usually insurance departments) will review rates and determine whether they are unreasonable. . . . [Only t]wenty-four states give the state insurance department or commissioner legal power of prior approval or disapproval of certain rate changes.").

[539] *See* Douglas v. Indep. Living Ctr., 565 U.S. 606, 616 (2012) (declining to decide "whether the Ninth Circuit properly recognized a Supremacy Clause action to enforce this federal statute before the agency took final action"); Va. Office for Prot. & Advocacy v. Stewart, 563 U.S. 247, 255, 257-58 (2011). The Court returned to a similar question in Armstrong v. Exceptional Child Ctr., 135 S. Ct. 1378 (2015). In *Armstrong*, the Court held that doctors could not sue state officials for under-enforcing the Medicaid Act, despite the federal government's lack of opposition to such a suit. *See id.* at 1382, 1387-88.

Federalism as a tool of health policy in particular remains theoretically muddy. On the one hand, an attachment to retaining localism in health care persists that clearly relates to federalism. Wholesale nationalization of health care has been something that Americans have only strongly supported when circumstances are dire to all, such as when Medicare was enacted in 1965,[540] or when populations that Congress views as especially vulnerable—mothers, children, the elderly—need help.[541] The tradition instead has been to place trust in state-run programs to control quality, bring down healthcare costs, enhance competition, and promote innovation—in other words, federalism has been assumed the means to improve policy outcomes.[542]

It is well established that health care varies across geographic markets.[543] Some of differences are driven by the kinds of differences typically discussed in federalism literature. Medicine historically has a very local culture, and provider practices may vary substantially even across communities within the same state.[544] Even Medicare, the national health insurance program for the elderly and disabled, still relies on local coverage determinations.[545]

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[540] *See* STARR, *supra* note 62, at 368-69.

[541] *See, e.g.*, Robert J. Blendon & John M. Benson, *Americans' Views on Health Policy: A Fifty-Year Historical Perspective*, HEALTH AFF., Mar./Apr. 2001, at 33, 34 ("Shortly before Medicare was enacted, 75 percent of the public said that the federal government should pass a law to provide medical care for seniors."); Lisa Shapiro, *First Focus, The Children's Health Insurance Program: Why CHIP is Still the Best Deal for Kids* 1 (2016), https://firstfocus.org/wp-content/uploads/2016/09/Why-CHIP-Still-Best-Deal-041817.pdf ("The American people overwhelmingly support CHIP's continuation. In a May 2014 poll conducted by American Viewpoint, voters favored extending funding for CHIP by a 74-14% margin, including 66-19% among Republicans.").

[542] *See* FEDERALISM AND HEALTH POLICY, *supra* note 17, at 6-7.

[543] *See* John Wennberg & Alan Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCIENCE 1102, 1107 (1973).

[544] *See, e.g.*, Hall v. Hilbun, 466 So. 2d 856, 872 (Miss. 1985) ("Because of . . . differences in facilities, equipment, etc., what a physician may reasonably be expected to do in the treatment of a patient in rural Humphreys County or Greene County may vary from what a physician in Jackson may be able to do. A physician practicing in Noxubee County, for example, may hardly be faulted for failure to perform a CAT scan when the necessary facilities and equipment are not reasonably available."); James N. Weinstein et al., *Trends and Geographic Variations in Major Surgery for Degenerative Diseases of the Hip, Knee, and Spine*, HEALTH AFF., 7 Oct. 2004, at 81, 82 ("In a given region, local physicians tend to apply their rules of practice consistently, which results in the 'surgical signature' phenomenon: rates for specific surgical procedures that are idiosyncratic to a region, sometimes differing dramatically among neighboring regions.").

[545] *See* 42 U.S.C. § 1395ff(f)(2)(B) (2016) ("For purposes of this section, the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1395y(a)(1)(A) of this title.").

Geographic variations in diseases[546] and local health behaviors also drive differences.[547]

Other differences are driven by inequality, including disparities when it comes to local resources[548] and social determinants of health.[549] Moral considerations may outweigh a preference for localism in these circumstances, depending on whether the policy goal of health care federalism is outcomes or structure. Those moral considerations were part of Congress's motivation to nationalize the Medicaid expansion in drafting the ACA.[550]

In this vein, a particularly fascinating outgrowth of the ACA from a health care federalism perspective is that the threat of its repeal has done more to make possible a *nationalized* vision of health care than ever before. Calls for a fully national, "single payer," system were politically impossible before the Trump administration. But the threat to the ACA's efforts to expand health care access have led many to raise moral concerns above structural ones and has brought single-payer arguments into the mainstream.[551]

But whichever side of the line one is on, our key point for present purposes is that little evidence supports any of the structural options as being best. Little data exists showing states acting alone, as opposed to states working within

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[546] Curtis W. Noonan et al., *Temporal and Geographic Variation in United States Motor Neuron Disease Mortality, 1969-1998*, 64 NEUROLOGY 1215, 1219 (2005) (finding a "northwest gradient" in the incidence of motor neuron disease); Richard S. Ostfeld et al., *Climate, Deer, Rodents, and Acorns as Determinants of Variation in Lyme-Disease Risk*, 4 PLOS BIOLOGY 1058, 1058 (2006) (noting that "Lyme disease is most prevalent in northeastern and north-central regions").

[547] *See, e.g.*, Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States, 2001-2014*, 315 JAMA 1750, 1756 (2016) (describing the importance of local trends in health behaviors in creating geographic differences in health care).

[548] *See* Paul Campbell Erwin et al., *The Association of Changes in Local Health Department Resources with Changes in State-Level Health Outcomes*, 101 AM. J. PUB. HEALTH 609, 614 (2011).

[549] Harry J. Heiman & Samantha Artiga, Henry J. Kaiser Family Found., Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity 2 (2015), http://files.kff.org/attachment/issue-brief-beyond-health-care; Jennifer Weisent et al., *Socioeconomic Determinants of Geographic Disparities in Campylobacteriosis Risk: A Comparison of Global and Local Modeling Approaches*, 11 INT'L J. HEALTH GEOGRAPHICS, no. 45, 2012, at 1, 2 (describing the socioeconomic factors influencing rates of campylobacteriosis, a common cause of gastroenteritis).

[550] "And we have now just enshrined . . . the core principle that everybody should have some basic security when it comes to their health care." Remarks on Signing the Patient Protection and Affordable Care Act, March 23, 2010, at http://www.presidency.ucsb.edu/ws/?pid=87660.

[551] See Abbe R. Gluck, *Obamacare as Superstatute*, https://balkin.blogspot.com/2017/07/obamacare-as-superstatute.html (July 29, 2017).

federal guidelines, actually achieve better health outcomes. Even less evidence exists that measures the difference between outcomes when states work alone, versus inside federal guidelines, versus when the federal government simply acts alone, implementing federal law without the states.

The ACA is the ultimate compromise. It retains and strengthens the pre-existing landscape of fragmented and structurally diverse health care programs. It straddles the systemic philosophical options, incorporating components of both individual responsibility and solidarity/universality into one statute. And when it comes to federalist structures, the statute embraces a federalist model with a nationalized baseline, even as the health care goals it aims to accomplish may be better suited to a fully nationalized structure, at least when it comes to Medicaid. But that is why we can say with more certainty that the ACA's implementation structure serves state power than we can say that the implementation proves that federalism results in the best health policies.

Some newer federalists might take a third way. Gerken, for instance, might focus less on state power and more one how the ACA creates a structure that accommodates policy difference or leads to beneficial policy churn.[552] Even so, to say that health care federalism is merely a vehicle to allow for a variety of policy solutions does not ring completely true to us, in large part because we have shown that we can have that policy churn without state-led programs at all. Moreover, even if health care federalism is mostly understood as a vehicle for policy diversity, that does not amount to a normative defense of it. Either that variety produces benefits in itself—such as in the form of health outcomes—or it should be justified on different terms, whether on grounds of democracy benefits from federalist structures or on the moral terms of the benefits of such diversity that would result in the denial of health care in a varied system.

None of this is to suggest that federalism is not "real" in health care. Our story makes the salience of the state role, including the importance of state sovereignty, clear. But federalism's normative justifications require more serious clarification and evaluation. More empirical examination of benefits and drawbacks of different federalist structures-across classic health policy metrics such as coverage, quality, and cost are needed. That data would provide information about whether federalism *should be* a key *policy* move. If it turns out federalist structures do not make for better policy outcomes in a particular area, then we need to ask whether there is instead a normative justification for suboptimal policy choices in exchange for other structural/political/constitutional benefits that we think health care federalism as an end unto itself would offer.

[552] *See* Gerken *supra* note 6, at 1026.

Conclusion

The ACA's implementation offers a window on modern American federalism—and modern American nationalism—in action. The implementation process baked into the statute's structure, despite being flipped by *NFIB* and the ensuing political resistance, invites participation from a wide range of state and federal actors and extends that iterative process forward through time. The process is both vertical and horizontal, and exceedingly adaptive, as state and federal actors respond not just to federal regulators but also to internal state dynamics, other states' experiences, and to complex policy goals. States move back and forth between different structural arrangements vis-à-vis the federal government, and negotiation with federal counterparts is a near-constant.

The story is not one of separate-spheres federalism, but it is not one of states as subservient entities lacking sovereignty either.[553] Rather, the ACA's structure has given the states a great deal of policy autonomy and leverage. It has relied on the gears of state sovereign democracy to work and so strengthens those democracies in the process. At the same time, the state/national blur ACA produces has sometimes obfuscated accountability—notably sometimes masking state cooperation with the federal program when it would be politically unpopular to engage. The features we detail have endured, including after the election and the arrival of an Administration hostile to the law.

In work documenting this study at an earlier stage, we labeled our findings "The New Health Care Federalism."[554] We have moved away from this label here, in part because we suspect our story is not unique to health care. The ACA's scale simply makes the features we describe particularly salient. We also are not certain whether the features we identify mark differences in kind or degree from what came before. States have negotiated with the federal government for decades; internal state politics have always mattered; Congress has used states as lead implementers of federal law for many years. But the ACA showcases these features in extreme fashion, and it deconstructs "federalism" in ways we not seen before. This does not mean that no other statute does it; just that the ACA makes it impossible to ignore.

Federalism scholars spend most of their time arguing for a particular structural arrangement based on prior goals and values.[555] The ACA's architecture challenges whether any of these goals and values are unique to federalism or any particular expression of it. It illustrates how federalism is a proxy for many ideas and challenges us to ask what we are really fighting over, or seeking, when we invoke the concept. Underneath it all is a modern system

[553] *Cf.* RUBIN & FEELEY, supra note 10.

[554] *See* Gluck & Huberfeld, *supra* note 224.

[555] *See* Gerken, *supra* note 6.

of governance that blends state and federal in ways that legal doctrine has not recognized.

And when it comes to health care, conceptual difficulties multiply, largely because first principles are wanting. Without settling on the overarching goals of a health care system in the first place, no one can determine if the kind of state/federal arrangements built into the ACA serve those goals. And without deciding whether structural separation of state and federal is an end in itself or whether that separation is a means to a policy end—or both—we cannot say much that is meaningful about it in this context. As a result, we cannot determine whether federalism is serving its ostensible purposes, how strongly it is entrenched, or how vigorously it is worth defending.