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THE RHETORIC HITS THE ROAD: STATE CHALLENGES TO THE AFFORDABLE CARE ACT IMPLEMENTATION

Elizabeth Weeks Leonard *

I. INTRODUCTION

What is it about health reform—about the particular exercise of federal power to compel the purchase of health insurance by individuals[1]—that has sparked such concerted objection from states? Congress has reached deeply into areas of traditional state authority on other occasions in recent memory,[2] without similarly provoking a majority of states to file federal lawsuits or engage in a multi-front attack to dismantle a validly enacted federal statute. How has a federal law, which most clearly infringes on individual rather than states' rights, become the rallying cry for a nationwide Tenth Amendment reinvigoration movement? In keeping with the 2011 Allen Chair Symposium's "Everything But the Merits" theme, this essay considers states' lawsuits not merely beyond the merits but even beyond the litigation itself and places the litigation strategy in the larger context of other forms of state resistance to implementation of the Patient Protection and Affordable Care Act ("ACA" or "Act").[3]

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1. 26 U.S.C. § 5000A (Supp. IV 2010).

2. *See, e.g.*, Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT) Act of 2001, Pub. L. No. 107-56, 115 Stat. 272 (codified in scattered sections of 8, 12, 18, 21, 22, 28, 31, 47, and 50 U.S.C.) (enlisting state law enforcement to carry out federal law); Violence Against Women Act of 1994, Pub. L. No. 103-322, §§ 40001–40703, 108 Stat. 1902, 1902–55 (codified as amended in scattered sections of 8, 16, 18, 28, and 42 U.S.C.), *invalidated in part by* United States v. Morrison, 529 U.S. 598 (2000) (purporting to federalize crime of domestic violence); Clean Air Act, 42 U.S.C. §§ 7409–7410 (2006) (setting national standards with which state standards must comply).

3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119

The following discussion provides an update and reanalysis of my previously published article, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, which made an affirmative case for the widespread trend of state resistance to the then-recently enacted ACA.[4] In the months just before and after the ACA was signed into law, a significant number of states engaged in various forms of objection, including, but not limited to, filing lawsuits challenging the constitutionality of the new federal statute.[5] My earlier article focused on five targets of state resistance: (1) Medicaid expansion, (2) high-risk insurance pools, (3) health insurance exchanges, (4) federal insurance market regulations, and (5) the individual mandate.[6] I identified reasons why state-based dissent to the ACA should not be disregarded simply as partisan sour grapes by "Obamacare" opponents but instead should be considered valuable to the health care decision-making process and federal-state relations.[7]

Scholars have struggled to define an overarching model of federalism[8] and to justify placing primary authority for regulating health care in federal or state hands.[9] The complexity of the health care system and debates over recent federal legislation glaringly reveal the futility of such efforts. We are left instead

(codified in scattered sections of 26 and 42 U.S.C.), *amended by* Health Care and Reconciliation Education Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified at 42 U.S.C. § 1305 (Supp. IV 2010)).

4. Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111, 111 (2010).

5. *Id*. at 113–17.

6. *Id*. at 132–61.

7. *Id*. at 161–68.

8. *See, e.g*., Akhil Reed Amar, *Five Views of Federalism: "Converse-1983" in Context*, 47 VAND. L. REV. 1229, 1229–30 (1994); Jessica Bulman-Pozen & Heather K. Gerken, *Uncooperative Federalism*, 118 YALE L.J. 1256, 1258–60 (2009); Edward S. Corwin, *The Passing of Dual Federalism*, 36 VA. L. REV. 1, 2 (1950); Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and "Dual Sovereignty" Doesn't*, 96 MICH. L. REV. 813, 815–16 (1998); Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 933 (1994); Robert A. Schapiro, *Toward a Theory of Interactive Federalism*, 91 IOWA L. REV. 243, 246–49 (2005); Frank R. Strong, *Cooperative Federalism*, 23 IOWA L. REV. 459, 459 (1938); Philip J. Weiser, *Towards a Constitutional Architecture for Cooperative Federalism*, 79 N.C. L. REV. 663, 665–67 (2001).

9. *See, e.g*., Jonathan H. Adler, *Cooperation, Commandeering, or Crowding Out?: Federal Intervention and State Choices in Health Care Policy*, 20 KAN. J.L. & PUB. POL'Y 199, 205 (2011); Scott L. Greer & Peter D. Jacobson, *Health Care Reform and Federalism*, 35 J. HEALTH POL. POL'Y & L. 203, 204–08 (2010); Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20 KAN. J. L. & PUB. POL'Y 266, 272–73 (2011).

with a theoretically unsatisfying but descriptively accurate "muddled federalism,"[10] which functions, within pragmatic and political limits, to effectuate an array of sweeping health reforms. Like my earlier article, this essay traces the various rhetorical arguments raised by states in opposition to federal health reform, through which states identify different and sometimes conflicting federalism values. At times, states frame objections to the ACA in structural terms regarding the scope of federal power, noting their sovereign interest in retaining control over state legislative and administrative functions. Other arguments highlight the importance of diversity and local tailoring of policies to local tastes and needs. State opponents also emphasize the underlying purpose of the federalist system in protecting individuals from excessive government intrusion. Nevertheless, states also tacitly acknowledge that certain problems are better suited to national regulation. I conclude by echoing my earlier suggestion that this inevitable muddle, as displayed in the health reform context,[11] should be regarded as one of federalism's defining strengths.

II. BACKGROUND

We are less than two years away from the effective date of some of the most dramatic reforms under the ACA,[12] including operation of health insurance exchanges,[13] prohibition on health-status underwriting[14] and exclusions based on pre-existing health conditions,[15] expansion of Medicaid eligibility,[16] imposition of employer penalties,[17] and the requirement that most Americans maintain minimum essential health insurance coverage.[18] I first examined the trend of state resistance to federal health reform during the months of heated congressional and public debate

10. Moncrieff & Lee, *supra* note 9, at 289 (characterizing the ACA's approach as "muddled federalism").

11. *See* Leonard, *supra* note 4, at 168.

12. *See Implementation Timeline*, HENRY J. KAISER FAMILY FOUND., http://healthreform.kff.org/Timeline.aspx (last visited Feb. 24, 2012) [hereinafter *Implementation Timeline*].

13. 42 U.S.C. § 18031 (Supp. IV 2010).

14. *Id.* § 300gg (Supp IV 2010).

15. *Id.* § 300gg-3.

16. *Id.* § 1396a.

17. 26 U.S.C. § 4980(H) (Supp. IV 2010).

18. 42 U.S.C. § 18091 (Supp. IV 2010).

leading up to the ACA's enactment on March 23, 2010.[19] This essay continues that examination at a critical junction, after the public and lawmakers have had two years to digest the massive legislation, with Supreme Court resolution of constitutional challenges pending in July 2012 and near complete implementation of key reforms scheduled for January 2014.

Before the ACA was enacted, it certainly made sense for states to engage in the policy debate over whether comprehensive federal health reform was needed and, if so, what form it should take. States have been active regulators of the health care and health insurance markets for much of the nation's history.[20] Broad federal preemption of one area of insurance regulation—namely, employer health plans—has constrained states' ability to regulate those plans since the 1970s.[21] Until the ACA, however, nothing other than political opposition at the state level prevented states from adopting their own comprehensive health reform laws, such as Massachusetts's 2006 legislation.[22] States were also free to enact statutes or constitutional amendments prohibiting, at least within their own borders, certain types of health reforms, such as a public health insurance plan or a mandate that all citizens purchase health insurance, as several states did in the months before the ACA was passed.[23]

After President Obama signed the ACA into law, states continued to express vigorous opposition through various channels, including proposing state legislation purporting to nullify or opt out of the new federal health law.[24] Although the most frequent target of proposed state nullification statutes and constitutional amendments was the individual health insurance mandate, states also attempted to opt out of new federal requirements on employers

19. Leonard, *supra* note 4, at 113, 167–68 (citing Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (codified as amended in scattered sections of 26, and 42 U.S.C.)).

20. *See* Elizabeth Weeks Leonard, *Can You Really Keep Your Health Plan? The Limits of Grandfathering Under the Affordable Care Act*, 36 J. CORP. L. 753, 763 (2011) (describing the history of state regulation).

21. *See infr*a notes 139–41 and accompanying text (discussing the effects of the Employee Retirement Income Security Act of 1974).

22. An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 77 (codified as amended in scattered sections of the General Laws of Mass.).

23. Leonard, *supra* note 4, at 113–14; *see, e.g.*, VA. CODE ANN. § 38.2-3430.1:1(Cum. Supp. 2011) ("No resident of this Commonwealth . . . shall be required to obtain or maintain a policy of individual insurance coverage . . . .").

24. Leonard, *supra* note 4, at 113–15.

and state regulators.[25] As a matter of federal supremacy, those state laws without question lacked legal effect and force. Similarly, states' lawsuits challenging the constitutionality of the ACA, filed within hours of the Act's enactment, seemed to have little legal merit. In the early days of the ACA, states also registered objection by refusing to cooperate with the federal government in implementing particular provisions of the Act. When I wrote previously, states were vociferously rejecting the federal government's invitation to establish state high-risk insurance pools, which were to be in place just three months after the ACA's enactment.[26]

Most commentators dismissed states' legislation,[27] lawsuits, and other forms of resistance as mere symbolic acts, political theater, or Tea Party gamesmanship.[28] While I agreed that the state resistance movement largely lacked legal merit, I suggested that the rhetoric of state resistance, specifically, invocation of structural concerns regarding states' rights and limits on federal power, were valuable in their own right.[29] States' tactics did not universally foster salutary benefits for the federalist system but nor were they necessarily damaging to it. I articulated six specific values of "rhetorical federalism" derived from state-based dissent to the ACA that included: (1) bringing transparency to the implementation process, (2) educating the electorate on discrete issues of the law, (3) expressing minority views, (4) depoliticizing the issues, (5) codifying dissent, and (6) highlighting the increased role of government in health care delivery.[30] With one notable exception, the state-based health reform resistance movement continues to promote those values. My suggestion that rhetorical federalism could depoliticize the issues and diffuse par-

25. *Id.* at 113–15, 155; *see also* Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2011*, THE NAT'L CONF. OF ST. LEGISLATURES, http://www.ncsl.org/?tabid=18906 (last updated Jan. 27, 2012).

26. Leonard, *supra* note 4, at 140–44 (regarding high-risk insurance pools).

27. State legislation took various forms, modeled on the American Legislative Exchange Council's "Freedom of Choice in Health Care Act." *See ALEC's Health Care Freedom Initiative*, AM. LEGIS. EXCHANGE COUNCIL, http://www.alec.org/initiatives/health-care-freedom-initiative/ (last visited Feb. 24, 2012).

28. Leonard, *supra* note 4, at 116–18.

29. *Id.* at 117–18 (suggesting that "[r]ather than dismiss the [state nullification] trend, its persistence and pervasiveness warrants consideration" and identifying positive effects for "federal-state relations deriving from the federalism objections being voiced by health reform opponents").

30. *Id.* at 162–68.

tisan political fights over the ACA, however, is almost laughable given the current climate. Structural federalism objections have hardly mitigated the rancor but have become the central, defining contention. The rhetoric has indeed hit the road.

If nothing else, this ongoing project of examining state-based resistance confirms my failure as a health reform prognosticator. At the time of the previous article, I confessed surprise that Congress managed to pass a comprehensive, sea-changing package of health reform legislation.[31] Now I must admit that I did not expect the federalism rhetoric animating the health reform debate to be accorded serious legal merit. That not just one, but seven, separate petitions for certiorari, from four circuit courts, including two challenges involving states as plaintiffs, were filed with the Supreme Court is remarkable.[32] The fact that the case and main substantive issue that the Court has agreed to hear involves twenty-six states' challenges to the scope of federal power to regulate individual citizens[33] is potentially both a stunning endorsement of New Federalism and a novel recognition of enforceable Tenth Amendment rights.[34]

In this essay, I revisit the five previously identified fronts of state resistance, providing a two-year update of successes and failures. I also describe states' new strategies, including requesting waivers from various provisions of the ACA, declining or returning federal funding for the ACA implementation, enacting state legislation and multi-state compacts purporting to opt out of the ACA, and adopting novel litigation postures. Although states' tactics, in many cases, still stand on shaky legal grounds, the rhetoric of federalism has gained better traction than other com-

31. *Id.* at 113.

32. *See* Seven-Sky v. Holder, 661 F.3d 1 (D.C. Cir. 2011), *petition for cert. filed*, ___ S. Ct. ___ (U.S. Nov. 30, 2011) (No. 11-679); Thomas More Law Ctr. v. Obama, 651 F.3d 529 (6th Cir. 2011), *petition for cert. filed*, ___ S. Ct. ___ (U.S. July 26, 2011) (No. 11-117); Virginia *ex rel.* Cuccinelli v. Sebelius, 656 F.3d 253 (4th Cir. 2011), *petition for cert. filed*, ___ S. Ct. ___ (U.S. Sept. 30, 2011) (No. 11-420); Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011), *cert. granted*, 132 S. Ct. 604 (U.S. Nov. 14, 2011) (No. 11-400).

33. *See supra* note 32; *see also Florida* ex rel. *Attorney Gen.*, 648 F.3d at 1282 (addressing the constitutionality of the individual mandate under commerce power); Bradley Joondeph, *Handicapping the Questions Presented*, ACA LITIG. BLOG (Oct. 10, 2011, 2:30 PM), http://acalitigationblog.blogspot.com/2011/10/handicapping-questions-presented.html.

34. *See infra* Part III (describing the existing paradox in individual mandate litigation).

mentators and I initially predicted. Expressions of state resistance resonate deeply, not just in public debate, but also in judicial opinions. In light of the shifting battleground, I reconsider the values of rhetorical federalism.

III. FIVE FRONTS OF STATE RESISTANCE

A. *Medicaid Expansion*

As the ACA provision with the clearest state nexus, Medicaid expansion has proven the most impenetrable to state challenges. Medicaid is the quintessential cooperative federalism program.[35] States voluntarily agree to implement state-based health care programs that meet broad federal requirements in exchange for federal funding commensurate with state spending on those programs.[36] For almost two decades before the ACA's enactment, all fifty states voluntarily agreed to participate in the cooperative federal-state Medicaid program in order to provide health care to low-income and other qualified needy individuals.[37]

The Florida lawsuit brought by twenty-six states, two private plaintiffs, and a business organization challenged the ACA's expansion of Medicaid squarely on Tenth Amendment grounds.[38] In particular, the plaintiffs argued that the ACA's new requirement to extend Medicaid to all children, parents, and childless adults under 133% of federal poverty level amounted to coercion, in violation of judicially recognized limits on federal conditional spending power in *South Dakota v. Dole*.[39] The states' Medicaid challenge was rejected by Judge Roger Vinson,[40] the Florida federal

35. Harris v. McRae, 448 U.S. 297, 308 (1980) (describing Medicaid as "a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons"); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 419 (2008) ("Medicaid is a classic example of cooperative federalism . . . .").

36. *See* 42. U.S.C. § 1396 (2006).

37. *See* Leonard, *supra* note 4, at 135 & n.159.

38. *Florida* ex rel. *Attorney Gen.*, 648 F.3d at 1240, 1262–64.

39. *Id.* at 1261–62 (citing 42 U.S.C. § 1396(a)). In *South Dakota v. Dole*, the Supreme Court stated that "[o]ur decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which pressure turns into compulsion." 483 U.S. 203, 211 (1987).

40. Florida *ex rel*. Attorney Gen. v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1263, 1266, 1269–70 (N.D. Fla. 2011), *aff'd in part and rev'd in part*, 648

district judge who struck down the ACA in its entirety,[41] after holding the individual mandate unconstitutional.[42] The Eleventh Circuit affirmed Judge Vinson's Medicaid ruling,[43] holding that because states continue to have a real choice whether to participate, the ACA's expanded Medicaid eligibility did not amount to coercion.[44]

In particular, the Eleventh Circuit noted that, from its inception, the Medicaid statute reserved Congress's right to alter, amend, or repeal the Medicaid Act.[45] Moreover, the court reasoned that states received ample notice of the ACA's eligibility changes, effectively, four years from the Act's enactment—given that the federal government will pay all the costs of covering newly eligible enrollees for the first two years.[46] The Eleventh Circuit's conclusion seems well-supported by previous challenges to congressional amendments to Medicaid and similar conditional spending acts.[47] Despite the court's reasoning and the absence of a circuit split, the Supreme Court agreed to hear the plaintiffs' Medicaid challenge.[48]

F.3d 1235 (11th Cir. 2011).

41. *Id.* at 1304–05.

42. *Id.* at 1298–99.

43. *Florida* ex rel. *Attorney Gen.*, 648 F.3d at 1268.

44. *Id.* at 1267–68.

45. *Id.* at 1267 ("The right to alter, amend, or repeal any provision of this chapter of the [Medicaid Act] is hereby reserved to the Congress." (quoting 42 U.S.C. § 1304 (2006)) (internal quotation marks omitted)).

46. *Id.* at 1267–68 (citing 42 U.S.C. § 1396d(y)(1) (Supp. IV 2010)).

47. *See, e.g.*, Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 22 (1980) (finding the Developmentally Disabled Assistance and Bill of Rights Act created shared responsibilities between the federal and state governments); Steward Mach. Co. v. Davis, 301 U.S. 548, 593–95 (1937) (rejecting the claim that the Social Security Act's tax collection and unemployment benefits distribution infringes on state sovereignty); Helvering v. Davis, 301 U.S. 619, 640 (1937) (explaining the concept of conditional spending power); *see also Florida* ex rel. *Attorney Gen.*, 648 F.3d at 1267 (discussing the history of Medicaid Act amendments); Padavan v. United States, 82 F.3d 23, 29 (2d Cir. 1996) (finding that "Medicaid is a voluntary program in which states are free to choose whether to participate"); California v. United States, 104 F.3d 1086, 1092 (9th Cir. 1989) (upholding an additional Medicaid requirement to cover emergency medical care to illegal immigrants); Oklahoma v. Schweiker, 655 F.2d 401, 416–17 (D.C. Cir. 1981) (holding that the pass through provision of the Social Security Act was a "conventional and appropriate" use of congressional power under the spending clause). In *Texas v. Leavitt*, the plaintiffs requested for original jurisdiction to review Medicare Part D "clawback," which required states to pay a portion of the new Medicare prescription drug benefit. Plaintiffs' Reply Brief at 1, Texas v. Leavitt, 547 U.S. 1204 (2006) (No. 135), 2006 WL 1491289. The Supreme Court was unwilling even to hear the challenge, denying the states' petition for original jurisdiction. *Texas*, 547 U.S. at 1204.

48. *See* Florida v. U.S. Dep't of Health & Human Servs., No. 11-400, ___ U.S. ___,

Other than the Florida lawsuit challenging the ACA's Medicaid expansion, no state has taken the next and obvious step of simply declining to participate in the federal program. If the new federal requirements are objectionable, states can simply opt out of them. No federal law compels state participation, but states receive federal funding only if they voluntarily agree to establish a state Medicaid program in compliance with federal standards.[49] States could choose to provide no public health care to low-income residents or to establish fully state-administered, state-funded indigent health care programs. Only one state's governor and former presidential candidate, Rick Perry, in November 2010 blustered about the possibility of Texas opting out of Medicaid, but fairly quickly backed off of that threat.[50]

States' continued cooperation with federal Medicaid requirements or, at least, continued acceptance of federal Medicaid dollars, would, in one view, seem to support the coercion argument. Indeed, the plaintiff states argued that the new Medicaid eligibility requirements are coercive inasmuch as states simply cannot afford to decline federal Medicaid funding, no matter how onerous the new conditions.[51] It seems just as plausible, however, that the federal government would be hard put to fully fund and operate indigent health programs in all fifty states without state cooperation. Given federal dependence on continued state cooperation in Medicaid, states should retain some political power to influence the debate and shape the Medicaid program going forward.[52]

Thus far, however, states' proposed innovations mostly take the form of requesting federal funding with few strings attached—that is, Medicaid block grants.[53] A similar notion under-

2011 WL 5515165, at *1 (U.S. Nov. 14, 2011).

49. 42 U.S.C § 1396a(b) (Supp. IV 2010); Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Harris v. McRae, 448 U.S. 297, 302 (1980).

50. *Texas Gov. Perry Backs Away from Medicaid Dropout Threat*, KAISER HEALTH NEWS (Dec. 4, 2010), http://www.kaiserhealthnews.org/daily-reports/2010/december/04/news-detail.aspx.

51. *See* Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1266 (N.D. Fla. 2011) (summarizing states' coercion argument), *aff'd in part and rev'd in part*, 648 F.3d 1235 (11th Cir. 2011).

52. *See* Bulman-Pozen & Gerken, *supra* note 8, at 1266–68 (describing states' power as "servants" on which the federal government depends to administer federal programs); Leonard, *supra* note 4, at 138 (discussing the Bulman-Pozen & Gerken theory in context of the ACA Medicaid resistance).

53. *See Are Block Grants the Wave of the Future for Medicaid?*, 19 ST. HEALTH WATCH, Sept. 2011, at 1, 1–3 [hereinafter *Block Grants*] (discussing states' efforts to reform Medi-

lies Medicaid Section 1115 ("Section 1115"),[54] a long-standing, pre-ACA provision that allows the Secretary of Health and Human Services to waive certain federal Medicaid requirements or provide federal matching dollars for state Medicaid costs that otherwise would not qualify.[55] Section 1115 waivers allow states to experiment with alternative approaches to the problem of access to health care and tailor their Medicaid programs to particular state needs.[56] Over the years, states have received Section 1115 waivers of varying scope and purpose and have implemented unique Medicaid strategies and programs to varying success.[57] The ACA affirms the availability of Section 1115 waivers but provides additional administrative and congressional oversight, somewhat limiting state flexibility.[58]

Concerned over the expected increased costs of adding millions more people to Medicaid rolls in 2014, states have proposed even more comprehensive waivers in the form of lump sum payments, rather than the current federal percentage-on-the-dollar match.[59]

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caid with less federal involvement).

54. 42 U.S.C. § 1315 (2006).

55. *Id.* § 1315(a).

56. *See Medicaid Waivers and Demonstrations List*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (last visited Feb. 24, 2012) (listing 459 projects); *Medicaid* Waivers *and Demonstration Projects Through Map of States*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html (last visited Feb. 24, 2012) (cataloguing all fifty states demonstration projects).

57. *See Block Grants*, *supra* note 53, at 2–3 (describing Tennessee and Oregon experiments); Daniel M. Fox & Howard M. Leichter, *State Model: Oregon The Ups and Downs of Oregon's Rationing Plan, Health Affairs*, 12 HEALTH AFFAIRS, no. 2, 1996, at 66–67 (discussing Oregon's "Reform Demonstration" for waiving different Medicaid requirements); Peter D. Jacobson & Rebecca L. Braun, *Let 1000 Flowers Wilt: The Futility of State-Level Health-Care Reform*, 55 KAN. L. REV. 1173, 1185–86 (2007) (describing Massachusetts's 1996 Section 1115 waiver); Cyril F. Chang, *Evolution of TennCare Yields Valuable Lessons*, MANAGED CARE, Nov. 2007, at 45. *See generally* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 438 (2011) (describing various forms of state waivers, including Section 1115 waivers, which "offer[] the most flexibility and allow[] state experiments").

58. 42 U.S.C. § 713 (Supp. IV 2010).

59. Mary Agnes Carey & Marilyn Werber Serafini, *How Medicaid Block Grants Would Work*, KAISER HEALTH NEWS (Mar. 6, 2011), http://www.kaiserhealthnews.org/Stories/2011/March/07/block-grants-medicaid-faq.aspx? (describing several state governors' demands for Medicaid block grants); Peggy Venable, *Medicaid Block-Grant Momentum Builds*, ODESSA AM. ONLINE (July 14, 2011), http://www.oaoa.com/articles/state-68506-medicaid-health.html (Texas state director of Americans for Prosperity, advocating for state waiver to "give Texas the opportunity to run our own Medicaid program, tailored to the unique needs and priorities of our citizens"); *see also infra* note 238 and accompanying text (discussing the Health Care Freedom Compacts).

Former Massachusetts governor and Republican presidential candidate Mitt Romney's economic plan proposed Medicaid block grants nationwide.[60] It may be no coincidence that Massachusetts's comprehensive state health reform was made politically feasible, in large part, by the threatened expiration of that state's Section 1115 waiver.[61] States urge that block grants would allow them to administer their own Medicaid programs more efficiently and better tailored to their residents' needs than presently allowed under federal requirements.[62] Moreover, they note that the current conditional funding approach incentivizes cost inflation, not cost containment, because the more states spend, the more federal matching dollars they receive.[63] Under a block grant, states would receive finite funding and would have an incentive to control costs.[64]

Critics of Medicaid block grants express concern that states will undermine the Medicaid safety net by dropping needy people from their programs to reduce costs, as infamously occurred under TennCare.[65] Moreover, experience with the state Children's Health Insurance Program ("CHIP"), a block-grant program, demonstrates that states struggled to control their budgets and required additional federal funding to sustain the programs.[66] Concerns about decreased state accountability under federal block grants are exacerbated by judicial limits on individual causes of action to enforce federal Medicaid requirements against

60. *See* Sam Baker, *Romney Plan Calls for Medicaid Block Grants, Repeal of Obama Health Law*, THE HILL (Sept. 6, 2011, 4:03 PM), http://thehill.com/blogs/healthwatch/politics-elections/179725-romney-plan-calls-for-medicaid-block-grants-repeal-of-obama-health-law.

61. Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 KAN. L. REV. 1283, 1297 (2007).

62. *See* Carey & Serafini, *supra* note 59; Huberfeld, *supra* note 57, at 548–49 (citing New York and Massachusetts as examples of successful Section 1115 waivers); Venable, *supra* note 59.

63. Carey & Serafini, *supra* note 59; Huberfeld, *supra* note 57, at 474–76; Venable, *supra* note 59.

64. *See* Carey & Serafini, *supra* note 59; Huberfeld, *supra* note 57, at 572; Venable, *supra* note 59.

65. *Block Grants*, *supra* note 53, at 1. Matthew Mitchell, noted that Tennessee's expansion of Medicaid resulted in the state "dramatically draw[ing] back eligibility," and "[o]vernight, 200,000 people were dropped from the Medicaid rolls." *Id*. (internal quotation marks omitted).

66. *See* Huberfeld, *supra* note 57, at 582 & n.205 (suggesting that states overspent federal CHIP allotments, requiring expanding federal funding through program reauthorization).

states.[67] In the past, individual Medicaid enrollees and providers could bring § 1983 lawsuits against state authorities to compel compliance with federal Medicaid requirements.[68] Recent judicial decisions, however, have severely limited the availability of those entitlement claims.[69] Some courts, while rejecting the § 1983 cause of action, have allowed individuals to challenge state Medicaid policies on federal supremacy grounds.[70] The viability of those challenges is before the Supreme Court this term.[71] But if states are allowed to act freely under block grants without having to comply with federal conditions, there would be little basis for either a § 1983 challenge or a preemption challenge to potentially radical state Medicaid cuts.

An alternative to block grants, which dissenting states have not advocated, is to federalize Medicaid, thereby placing full responsibility for indigent health care on the federal government.[72] The ACA moves in the direction of federalizing the program by requiring the federal government to bear the full costs of newly eligible Medicaid recipients for the first two years of the program's expansion and 90% of the cost of new enrollees perpetually, beginning in 2020.[73] The generous federal funding for the ACA's Medicaid expansion, not surprisingly, has drawn no appar-

67. *See* Jerry L. Mashaw & Dylan S. Calsyn, *Block Grants, Entitlements, and Federalism: A Conceptual Map of Contested Terrain*, 14 YALE L. & POL'Y REV. 297, 305–06, 311 (1996) (observing that "eliminating entitlements in connection with a shift to block grants moves power away from the people, not just the central government, in order to give that power to state government").

68. *See* 42 U.S.C. § 1983 (2006) (allowing a private cause of action for individuals injured by a state official's "deprivation of any rights, privileges, or immunities secured by" federal laws); Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 523–24 (1990) (allowing an association of hospitals to enforce the Medicaid requirement that states provide reasonable and adequate payment to participating providers).

69. *E.g.*, Gonzaga Univ. v. Doe, 536 U.S. 273, 290–91 (2002) (narrowing the availability of a § 1983 cause of action pertaining to the nondisclosure provisions of the Family Educational Rights and Privacy Act of 1974).

70. *E.g.*, Lankford v. Sherman, 451 F.3d 496, 509–13 (8th Cir. 2006).

71. Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly, 590 F.3d 725, 727 (9th Cir. 2009), *cert. granted*, 131A S. Ct. 992 (2011) (No. 09-958) (challenging state legislation reducing Medi-Cal provider payments on supremacy clause grounds); *see* Sara Rosenbaum, *Equal Access for Medicaid Beneficiaries—The Supreme Court and the* Douglas *Cases*, NEW ENG. J. MED., Dec. 15, 2011, at 2245, 2245–46.

72. *See* Huberfeld, *supra* note 57, at 435–36; Mashaw & Calsyn, *supra* note 67, at 320 ("The sensible approach to the Medicaid issue would seem to be for the federal government to fund and regulate all Medicaid activities . . . ."); Moncrieff & Lee, *supra* note 9, at 282–84 (discussing the advantages of federalizing Medicaid).

73. 42 U.S.C. § 1396d(a)(y)(1)(A), (E) (Supp. IV 2010).

ent state opposition.[74] But states stop short of simply passing off responsibility for Medicaid to the federal government. Why states continue to cling to the indigent health care budget and policy hot-potato is not entirely clear. The continued grudging cooperation between states and the federal government in Medicaid funding and administration reveals a sort of dysfunctional functional federalism.[75] While neither partner seems entirely satisfied with the level of effort, support, and commitment that the other invests, neither has proposed a radical new approach.

In the unlikely event that the Supreme Court holds the ACA's Medicaid expansion unconstitutional, the playing field would be dramatically altered. First, Medicaid expansion is expected to account for more than half, or close to sixteen million of the thirty-two million newly insured individuals under the ACA.[76] If Medicaid cannot be expanded to cover those individuals, the exchanges, commercial insurance market regulations, and other proposals would have to be reconsidered and expanded to meet the ACA's goal of near universal health insurance coverage. Second, numerous existing and new initiatives under the ACA rely on conditional spending power.[77] As a practical matter, any further limitations that the Court imposes would restrict Congress's authority to amend existing programs in which states already participate, or to implement new cooperative programs. Finally, any such decision from the Court would signal a broad shift in the allocation of power between the federal government and state governments. In sum, although seemingly settled, the Supreme Court's grant of review leaves the Medicaid front very much still in play.

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74. *See* Cauchi, *supra* note 25.

75. *Cf.* David Freeman Engstrom, *Drawing Lines Between* Chevron *and* Pennhurst: *A Functional Analysis of the Spending Power, Federalism, and the Administrative State*, 82 TEX. L. REV. 1197, 1222–23 (2004) (describing functional federalism and examining theory in Medicaid context).

76. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, House of Representatives, tbl.2 (Mar. 18, 2010), *available at* http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf (predicting that by 2019, sixteen million more people with be covered by Medicaid and CHIP, above the thirty-five million Americans who currently receive Medicaid, to reduce the overall number of uninsured by thirty-two million people).

77. *See, e.g.*, Bradley Joondeph, *Big News Is the Medicaid Grant*, ACA LITIG. BLOG (Nov. 14, 2011, 7:36 AM), http://acalitigationblog.blogspot.com/2011/11/big-news-is-medicaid-grant.html.

B. *High-Risk Insurance Pools*

One of the earliest ACA provisions to be implemented was the Pre-Existing Condition Insurance Plan (the "PCIP"), aimed at one of the most frequent consumer complaints about the health insurance industry—the inability of individuals who most need insurance to obtain it.[78] Insurance companies, quite rationally, prefer not to issue policies to individuals with costly, pre-existing health conditions. Insurers that are willing to write policies for such individuals, absent the loss-spreading advantages of large group risk pools, typically charge very high premiums. Accordingly, many individuals diagnosed with grave or chronic illnesses either cannot obtain coverage or cannot afford the insurance plans offered by the insurance companies.[79]

Effective 2014, all health insurers participating in the exchanges will be prohibited from denying coverage to anyone based on health status[80] and from considering patient-specific factors other than individual or family policy, geography, and, to limited extents, age and tobacco use, in setting premiums.[81] Those guaranteed issue and community rating provisions, combined with rationalization and standardization of health insurance markets through the exchanges,[82] are designed to make meaningful, affordable health insurance available to all. In the meantime, however, people with pre-existing conditions who have been without health insurance face the existing market discrimination. Accordingly, the ACA includes a temporary high-risk insurance program, or the PCIP, as a stopgap until the crucial 2014 underwriting restrictions and health insurance exchanges are in place.[83]

78. *See* Press Release, U.S. Dep't of Health & Human Servs., HHS Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan (July 1, 2010), http://www.hhs.gov/news/press/2010pres/07/20100701a.html. Secretary Kathleen Sebelius expressed concern that "[f]or too long, Americans with pre-existing conditions have been locked out of our health insurance market." *Id.*

79. *See generally* Thomas More Law Ctr. v. Obama, 651 F.3d 529, 546 (6th Cir. 2011) (describing medical underwriting practices); Robert H. Jerry, II, *Health Insurance Coverage for High-Cost Health Care: Reflections on* The Rainmaker, 26 U. MEM. L. REV. 1347, 1365 (1996) (describing insurance industry practices regarding pre-existing health conditions); Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419, 464 (2001) (describing experience rating and its effect on premiums).

80. 42 U.S.C § 300gg-4(a) (Supp. IV 2010).

81. *Id.* § 300gg(a)(1).

82. *Id.* § 300gg-4(a).

83. HENRY J. KAISER FAMILY FOUND., EXPLAINING HEALTH REFORM: QUESTIONS

The PCIP was to be in place no later than ninety days after the ACA's enactment[84] and guarantees coverage to individuals who have a pre-existing condition and have been uninsured for six months.[85]

The ACA placed primary responsibility on the Secretary of Health and Human Services ("HHS"), Secretary Kathleen Sebelius, to implement the PCIP but gave her the option of contracting with states and nonprofit organizations to assist.[86] Accordingly, Secretary Sebelius invited states to cooperate with the federal government in establishing and administering the state-based PCIPs.[87] Twenty-seven states elected to operate their own PCIPs and receive federal funding.[88] Twenty-three states and the District of Columbia declined the Secretary's offer and allowed the federal government to administer the PCIPs in their borders.[89]

The ultimate federal-state equilibrium did not easily fall into place, however. Immediately following the ACA's enactment, several states took advantage of the Secretary's invitation by noisily refusing any cooperation with the federal government in implementing the ACA.[90] Eighteen months later, the rancor died down, and the near even split of federal and state PCIPs seems to operate without debilitating federalism friction. The greatest concern and surprise about the PCIPs has been the relatively low uptake by potential beneficiaries. Four months after implementation, enrollment numbers nationwide remained below 8,000,[91] perhaps

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ABOUT THE TEMPORARY HIGH-RISK POOL 1 (2011); Press Release, U.S. Dep't of Health & Human Servs., *supra* note 78.

84. 42 U.S.C. § 18001(a) (Supp. IV 2010).

85. *Id.* § 18001(c)–(d). *See generally* Pre-existing Condition Insurance Plan Program, 75 Fed. Reg. 45,014, 45,015, 45,019–20 (proposed July 30, 2010) (to be codified at 45 C.F.R. pt. 152) (The CIP programs "offer [high-risk] individuals guaranteed access to coverage without pre-existing condition exclusion at a standard premium, if they are uninsured for at least six months.").

86. 42 U.S.C. § 18001(a)–(b) (Supp. IV 2010).

87. *See Sebelius Begins Push for High-Risk Pools*, N.Y. TIMES, Apr. 2, 2010, http://prescriptions.blogs.nytimes.com/2010/04/02/sebelius-begins-push-for-high-risk-pools/.

88. *State by State Enrollment in the Pre-existing Condition Insurance Plan* as of Aug. 31, 2011, HEALTHCARE.GOV, http://www.healthcare.gov/news/factsheets/2011/10/pcip10142011a.html (last visited Feb. 24, 2012) [hereinafter *Enrollment*].

89. *Id.*

90. *See* Leonard, *supra* note 4, at 141–43 (describing early objections).

91. *State by State Enrollment in the Pre-existing Condition Insurance Plan Archived Enrollment Data,* HEALTHCARE.GOV, http://www.healthcare.gov/news/factsheets/2011/02/pcip02102011b.html (last updated Jan. 13, 2012); *see also* Arthur Delaney, *PCIP: Enrollment in High-Risk Pools Inches Up to 12,000*, HUFFINGTON POST (Feb. 11, 2011, 12:01

due to the public's lack of awareness of the program and strict eligibility rules. But according to the government's August 31, 2011 report, enrollment had exceeded 30,000 individuals.[92]

States' decisions whether to cooperate with PCIP implementation does not correspond to their litigant and non-litigant status. Among the twenty-eight states suing the federal government over the constitutionality of the ACA, thirteen elected to operate state-based PCIPs, and fifteen allowed the federal government to operate their PCIPs.[93] It may seem anomalous for litigant states, urging the importance of limiting federal power and reclaiming state power in their litigation posture, to prefer fully federal operation of intrastate insurance pools. As a structural matter, however, there is no apparent constitutional problem with parallel state-federal operation of PCIPs. In my earlier article, I characterized the emerging PCIP dynamic as an example of functional federalism.[94] States have the right not to be commandeered into federal service but may voluntarily bargain and contract for use of their services.[95] Accordingly, a bare majority of states accepted the federal offer while the rest declined. Thus far, the functional federalism approach to the PCIP administration has not impaired federal-state relations and has produced a workable (albeit undersubscribed) temporary solution for covering previously uninsurable individuals.

C. *Exchanges*

The experience of federal-state cooperation in the PCIP should provide useful lessons for the implementation of Health Benefit Exchanges,[96] an intricate set of the ACA provisions that are more

PM), http://www.huffingtonpost.com/2011/02/11/pcip-enrollment-in-high-risk-pools-inches-up_n_821871.html (noting that PCIP program has had a slow start).

92. *Enrollment*, *supra* note 88; *see also Enrollment Tops 30,000 in Health Reform's Temporary High-Risk Pool*, CCH (Oct. 4, 2011), http://hr.cch.com/news/benefits/100411.asp.

93. *See Enrollment*, *supra* note 88; Ilya Somin, *Number of States Challenging the Constitutionality of Obamacare Rises to 28*, THE VOLOKH CONSPIRACY (Jan. 19, 2011, 2:45 AM), http://volokh.com/2011/01/19/number-of-states-challenging-the-constitutionality-of-obamacare-rises-to-28/; *26 States Join Suit Against Obama Health Law*, FOXNEWS (Jan. 19, 2011), http://foxnews.com/politics/2011/01/18/states-join-obama-health-care-law suit-fla/.

94. Leonard, *supra* note 4, at 143–44.

95. *See* Hills, *supra* note 8, at 816–17 (describing the "functional" theory of cooperative federalism).

96. *See* 42 U.S.C. § 18031(b) (Supp. IV 2010).

expansive, longer lasting, and more critical to the ACA's overall success than the PCIP. The ACA aims to reduce the percentage of uninsured Americans to single digits[97] through expansion of three existing channels: (1) employer-sponsored health insurance, (2) public health insurance (primarily Medicaid), and (3) the individual and small group health insurance market.[98] The exchanges are the linchpin to expanding the individual and small group markets and will house a variety of regulatory structures and substantive requirements making it economically feasible for insurers to offer meaningful, affordable products.[99]

The PCIP and exchanges both leave states a clear option to refuse cooperation with the federal government, thereby shielding those programs from "commandeering" challenges.[100] The PCIP operates from the baseline of state autonomy, with the federal government having the option to purchase states' administrative services.[101] By contrast, the ACA places primary responsibility for establishing and administering exchanges on states, with the threat of a federal take-over if they do not.[102] States have until January 1, 2013 to demonstrate to the Secretary of HHS that

97. *See* Elmendorf, *supra* note 76 (predicting that by 2019 under ACA, the insured share of nonelderly population will be 92%, or 95%, excluding unauthorized immigrants).

98. *See* Barry R. Furrow, *Health Reform and Ted Kennedy: The Act of Politics . . . and Persistence*, 14 N.Y.U. J. LEG'S & PUB. POL'Y 445, 445–56 (2011).

99. *See* Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1727, 1755–56 (2011) (describing exchanges as "a central feature" of insurance market reforms that "will promote transparency for consumers"); Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 284–93 (2010–2011) (describing the operation of exchanges); *see also Creating a New Competitive Marketplace: Health Insurance Exchange Establishment Grants Awards List*, HEALTHCARE.GOV, http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html (last updated Nov. 29, 2011) [hereinafter *Creating a New Competitive Marketplace*] (describing anticipated effects of exchanges on individual and small group insurance markets).

100. *Compare* South Dakota v. Dole, 483 U.S. 203, 210–12 (1987) (upholding a federal law conditioning federal highway funds on states enacting laws limiting alcohol sales to minors and introducing limits on conditional spending power), *and* Oklahoma v. U.S. Civil Serv. Comm'n, 330 U.S. 127, 143 (1947) (recognizing that the Tenth Amendment does not forbid Congress from "fix[ing] the terms upon which its money allotments to states shall be disbursed"), *with* Printz v. United States, 521 U.S. 898, 933 (1997) (holding that federal commandeering of state officials violated the Constitution), *and* New York v. United States, 505 U.S. 144. 174–75 (1992) (holding that congressional conditions "crossed the line distinguishing encouragement from coercion").

101. 42 U.S.C. § 18001(a)–(b) (Supp. IV 2010).

102. *Id.* § 18031(b)(1) (providing that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange"); *see* Leonard, *supra* note 4, at 144–45 (describing different baselines for the PCIP and exchanges).

they will have fully operational exchanges up and running in January 2014.[103] The ACA authorizes the Secretary to provide grants to states for exchange implementation until January 1, 2015,[104] after which time, state exchanges must be self-sustaining.[105] If states cannot or will not establish exchanges, the federal government will step in and do so for them.[106] In other words, the exchanges allocate federal-state authority as a matter of federal preemption, rather than as autonomous contracting parties.

Should states opt to establish state-based exchanges under the ACA, they must provide themselves with the necessary legal authority.[107] At present, over one-third of states have enacted state legislation to establish exchanges, and several others, by legislation or executive order, are continuing to study the feasibility of establishing state-based exchanges.[108] All but one of these states accepted modest federal Exchange Planning Grants of up to $1 million to investigate and research options for creating exchanges.[109] Six states and one consortium of states received substantial Early Innovator Grants, ranging from $6 million to $48 million, to develop information technology systems to support the exchanges.[110] Ideally, innovator states will develop strategies that other states can later adopt.[111] In January 2011, HHS also announced the availability of Exchange Establishment Grants, which several states subsequently received.[112]

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103. 42 U.S.C. § 18041(b) (Supp. IV 2010); *see also* Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,867 (proposed July 15, 2011) (to be codified 45 C.F.R. pts. 155–56) (describing the ACA provisions on exchanges).

104. 42 U.S.C. § 18031(a)(4)(B) (Supp. IV 2010).

105. *Id.* § 18031(d)(5)(A).

106. *Id.* § 18041(c)(1).

107. Sara R. Collins & Tracy Garber, *State Health Insurance Exchange Legislation: A Progress Report*, THE COMMONWEALTH FUND BLOG (Jan. 11, 2012), http://www.commonwealthfund.org/Blog/2011/Jun/State-Health-Insurance-Exchange-legislation.aspx.

108. HENRY J. KAISER FAMILY FOUND., ESTABLISHING HEALTH INSURANCE EXCHANGES: AN UPDATE ON STATE EFFORTS, FOCUS ON HEALTH REFORM 1–2 tbl.1 (2011) [hereinafter KFF UPDATE]; Collins & Garber, *supra* note 107.

109. KFF UPDATE, *supra* note 108, at 7.

110. *States Leading the Way on Implementation: HHS Awards "Early Innovator" Grants to Seven States*, HEALTHCARE.GOV, http://www.healthcare.gov/news/factsheets/2011/02/exchanges02162011a.html (last updated May 7, 2011) [hereinafter *States Leading the Way*].

111. *Id.*; *see also* KFF UPDATE, *supra* note 108, at 7.

112. KFF UPDATE, *supra* note 108, at 8; *Creating a New Competitive Marketplace*, *supra* note 99.

In August 2011, federal officials concluded that "the vast majority of states have already taken the crucial early steps" in establishing state-based exchanges and "have already expressed interest in applying to future [funding] rounds to build a robust Exchange for their residents."[113] The federal government's optimism, however, may be overstated. Roughly the same number of states that enacted or intend to enact state-based exchanges considered, but failed to enact, state exchange legislation by July 2011.[114] Governors in eight states where legislation failed are considering alternative ways of establishing exchanges in the face of legislative resistance.[115] Ten other states had not considered legislation even with the January 2013 deadline looming.[116]

For a time, many states participating in lawsuits challenging the ACA's constitutionality continued preparations to establish state-based exchanges. Close to half of the twenty-eight litigant states, including Virginia, have enacted legislation or are actively studying the feasibility of state-based exchanges.[117] Several also applied for and received generous federal grants, beyond the routine Exchanges Planning Grants. Plaintiff states Kansas, Oklahoma, and Wisconsin were awarded generous Early Innovator Grants for approximately $31.5, $54, and $38 million, respectively.[118] Several months later, however, the Republican governors of Kansas and Oklahoma issued prominent statements returning the grants to the federal government.[119] Wisconsin's governor also made a show of returning $9 million in federal grants, but not the

113. *Creating a New Competitive Marketplace*, *supra* note 99.

114. *See* KFF UPDATE, *supra* note 108, at 3 (noting that "there was no [state] legislative activity on exchanges in 26 states, as of July 2011").

115. Collins & Garber, *supra* note 107.

116. *Id.*

117. *See id.* (including a map showing the "Status of State Legislation to Establish Exchanges, as of January 2012"); *see also* HENRY J. KAISER FAMILY FOUND., *State Action Toward Creating Health Insurance Exchanges* as *of Dec. 22, 2011*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/comparetable.jsp?ind=962&cat=17&sub=205&yr=1&typ=5&o=a&sortc=1 (last visited Feb. 24, 2012).

118. *States Leading the Way*, *supra* note 110.

119. HENRY J. KAISER FAMILY FOUND., *Total Health Insurance Exchange Grants, 2011*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/comparetable.jsp?ind=964&cat=17&sub=205&yr=200&typ=4 (last visited Feb. 24, 2012) [hereinafter KFF, *Exchange Grants*] (noting return of grants); Isabel Lyman, *Okla. Gov. Fallin Rejects Federal Grant for Health Insurance Exchange*, THE NEW AM. (Apr. 17, 2011), http://thenewamerican.com/usnews/health-care/150-okla-gov-fallin-rejects-federal-grant-for-state-health-insurance-exchange; Scott Rothschild, *Brownback Says State Is Returning to Feds $31.5 Million Health Care Reform*, GRANT LAWRENCE J. WORLD (Aug. 9, 2011), http://www2.ljworld.com/news/2011/aug/09/brownback-says-state-returning-feds-315-million-he/.

full $38 million Early Innovator Grant.[120] Only three litigant states—Alaska, Florida, and Louisiana—have refused all federal funding related to exchange implementation.[121]

The range of state responses to the January 2013 exchange deadline reveals alternate federalism values and approaches. Some states, having failed to prevent the ACA from being enacted, are pursuing a second-best strategy of preventing it from being effectively implemented by blocking state exchange legislation and refusing federal financial assistance. That obstinacy effectively cedes control of exchanges to the federal government, a move that contradicts the federalism rhetoric of states' rights and limited federal powers. One Montana legislator, who opposes the ACA and also sought to block state exchange legislation, explained that as long as a state-based exchange is established under the federal "mandate," there is "nothing Montana-made about it."[122] Alaska's governor Sean Parnell offered a different rationale, citing Senior District Court Judge Roger Vinson's opinion striking down the ACA as the "law of the land."[123] In Parnell's mind, any steps toward implementing exchanges would be "proceed[ing] down an unlawful course,"[124] despite the fact that Judge Vinson's

120. Igor Volsky, *Scott Walker Cuts State Health Services, Then Rejects Health Reform's Public Health Grants*, THINKPROGRESS.ORG (Aug. 5, 2011, 12:08 PM), http://thinkprogress.org/health/2011/08/05/289193/wisconsin-rejects-grants-from-health-law-despite-cutting-health-services-in-state-budget/; *see also* Sarah Kliff, *Will Wisconsin's Scott Walker Implement Health-Care Reform?*, WASH. POST (Aug. 11, 2011), http://www.washingtonpost.com/blogs/ezraklein/post/willwisconsinsscottwalkerimplementhealthcarereform/2011/07/11/glQALBOb8l_blog.html.

121. *See* Kevin Sack, *Opposing the Health Law, Florida Refuses Millions of Dollars*, N.Y. TIMES, Aug. 1, 2011, at A10; KFF, *Exchange Grants*, *supra* note 119 (summarizing total federal grants to states and noting those three states did not receive a federal grant); Yereth Rosen, *Alaska Won't Seek U.S. Health Exchange Grants*, REUTERS (Feb. 17, 2011), http://www.reuters.com/article/2011/02/18/us-alaska-healthcare-idUSTRE71H0UC20110218.

122. Sarah Kliff, *Tea Party Notches Health Reform Wins*, POLITICO (Mar. 30, 2011, 1:32 PM), http://www.politico.com/news/stories/0311/52231.html. Discussing the resistance establishing state-based exchanges, Michael Cannon, director of health policy studies at the Cato Institute, stated that "[t]here remains an inherent contradiction where you have governors saying they think Obamacare is unconstitutional but [are] also trying to implement the law." *Id.* (internal quotation marks omitted).

123. Althea Fung, *Alaska Governor Refusing to Apply for Exchange Grants*, NAT'L J. (Feb. 18, 2011), www.nationaljournal.com/member/healthcare/alaska-governor-refusing-to-apply-for-exchange-grants-2011-2-18?mrefid=site_search (internal quotation marks omitted) (citing Florida *ex rel*. Attorney Gen. v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1304–05 (N.D. Fla. 2011), *aff'd in part and rev'd in part*, 648 F. 3d 1235 (11th Cir. 2011)).

124. *Id.*(internal quotation marks omitted).

decision was binding only in the Northern District of Florida and only until overturned by the Eleventh Circuit.[125]

Other states have followed a more pragmatic strategy of simultaneously challenging the constitutionality of the ACA while taking affirmative steps toward establishing state-based exchanges, thus hedging their bets in the event that the lawsuits are unsuccessful. The preference for state-based, rather than federally operated, exchanges strikes a more consistent ideological posture regarding states' traditional powers to regulate health care and health insurance under the Tenth Amendment. To that end, Oklahoma's governor and legislative leaders plan to move forward with establishing a state-based exchange solely with state and private dollars.[126] Similarly, Colorado has touted its bipartisan health insurance exchange and decision not to opt out of the ACA implementation.[127] Wisconsin applied for its Early Innovator Grant[128] under former Democratic Governor Jim Doyle, holding itself out as technical expert and leader for state-based health care programs.[129] Even under the current Republican governor, Wisconsin has not returned the Early Innovator Grant and maintains a prototype Wisconsin Health Insurance Exchange website.[130]

The lack of a unified response to exchanges implementation among states opposing the ACA suggests the array of values that federalism encompasses, more than incoherence in states' strategies. Like the PCIP implementation, states' litigation postures do not necessarily align with their varying preferences for exchange implementation. Yet both the pragmatic and obstinate strategies are grounded in the federalism rhetoric. Some states take offense at any federal requirements being imposed on states and, there-

125. *Florida* ex rel. *Attorney Gen.*, 780 F. Supp. 2d at 1304–05 (striking down the ACA in its entirety after finding the individual mandate unconstitutional); 648 F.3d at 1323 (holding that the district court erred in invalidating the ACA).

126. *See* Lyman, *supra* note 119 ("The intent is to satisfy ObamaCare's requirement of establishing an exchange, and do it with state and private dollars.").

127. Nancy Lofholm, *Colorado Stands Against Anti-Health-Reform Tide*, DENV. POST, Nov. 3, 2010, at B2.

128. *Wisconsin a Model for Creating Healthcare Insurance Exchanges*, ALTER CARE BLOG (Apr. 12, 2011, 11:52 AM), http://www.altergroup.com/alter-care-blog/index.php/healthcare/wisconsin-a-model-for-creating-healthcare-insurance-exchanges/.

129. *Id.*

130. *See generally* WISCONSIN HEALTH INS. EXCHANGE, https://exchange.Wiscon sin.gov (last visited Feb. 24, 2012) (proving information regarding the Wisconsin Health Insurance Exchange).

fore, refuse any cooperation with exchange implementation.[131] Other states appear more troubled by the notion of federal authorities taking over state functions and, therefore, take steps to ensure state control of exchanges and avoid federal preemption.[132]

The intermingling of federal and state exchange implementation demonstrates familiar federalism values of voice, diversity, and exit.[133] Rather than a one-size-fits-all approach, states are exploring alternative funding, legislation, and coordination strategies. States may satisfy diverse tastes and priorities through a choice of fully federal, fully state, or cooperative federal-state strategies.[134] Indeed, the choice between a national exchange and state-based exchanges was exhaustively vetted through the political process in congressional debates, with the latter carrying the final vote.[135] Critics of state-based exchanges nevertheless raise practical concerns about some states' risk pools being too small for exchanges to operate effectively and the qualified success of existing pre-ACA state exchanges.[136] More to the point of this essay, commentators fault the "state-centric framework" for creating an ongoing opportunity for states to obstruct implementation and perpetuate political battles.[137] The preceding description undoubtedly confirms that dynamic but does not compel the normative conclusion that it necessarily is a bad thing. That sort of friction and jarring, which "promot[ed] deliberation and circumspection," was part of the Framers' design.[138] Although the system of health insurance exchanges ultimately implemented by the states and the federal government may be different from

131. *See* Leonard, *supra* note 4, at 112–13, 134; Kliff, *supra*, note 122.

132. *See* Bailey McCann, *Nebraska, Ohio Push Forward on Insurance Exchanges Despite Opposition*, CIVSOURCE (Jan. 6, 2012), http://www.civsourceonline.com/2012/01/06/nebraska_ohio_push_forward_on_insurance_exchanges_despite_opposition/.

133. *See* Moncrieff & Lee, *supra* note 9, at 276–78; *see also* Leonard, *supra* note 4, at 121 & nn.57–59 (providing further discussion on the values of voice, diversity, and exit-rights).

134. *See* Adler, *supra* note 9, at 203–07 (emphasizing the importance of matching policies with local tastes, preferences, and economic conditions).

135. Leonard, *supra* note 4, at 145. *Compare* America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong. § 208(a)–(b) (2009) (discussing the federal requirements states must meet to opt-in and operate their own exchanges), *with* Affordable Health Choice Act, S. 1679, 111th Cong. §§ 3105(a), 3106(e)(1)–(2) (2009) (enacted) (creating a state-based exchange).

136. Moncrieff & Lee, *supra* note 9, at 293–94.

137. *Id.* at 291–92.

138. THE FEDERALIST NO. 70, at 425 (Alexander Hamilton) (Clinton Rossiter ed., 2003).

Congress's vision or single-payer adherents' preferences, at least it will be a system with which most participants can live.[139]

It remains to be seen how credible the federal government's preemption threat will be in the face of pervasive state resistance.[140] If the federal government cannot marshal sufficient financial and administrative resources to overcome states' resistance to implementing exchanges, the response could threaten the overall success of the ACA. Or, states' uncooperativeness could force a change in policy.[141] But if state-based and federally operated exchanges can comfortably coexist as "marble cake" alternatives,[142] like the PCIP, then state resistance may have little effect in altering the path of federal health reform.

D. *Federal Insurance Market Regulations*

In my previous article, I included the ACA's federal health insurance market regulations among the targets of state resistance.[143] The lack of resistance to the ACA's significant reallocation of authority to the federal government to regulate in an area of traditional state concern was particularly notable.[144] Health care and health insurance regulation has long been the primary domain of states.[145] The federal government's previous

139. *See* Adler, *supra* note 9, at 202–03 (noting that "among competing values and interests for which there is no single 'right' answer . . . a decentralized system will result in greater net satisfaction of individual policy preferences than will a uniform federal system").

140. Hills, *supra* note 8, at 868 (describing the federal-state dynamics of conditional preemption and noting that "Congress is constrained by its limited regulatory capacity . . . [and] cannot obtain the condition unless it can make a credible threat of preemption").

141. *See* Bulman-Pozen & Gerken, *supra* note 8, at 1266–67 ("One main source of the servant's power is dependence, [and] . . . . [s]tates similarly wield power against a federal government that depends on them to administer its programs.").

142. *See* MORTON GRODZINS, THE AMERICAN SYSTEM: A NEW VIEW OF GOVERNMENT IN THE UNITED STATES, Part II, 60–153 (Daniel J. Elazar ed., 1984) (1966) (discussing "layer cake" and "marble cake" federalism models).

143. Leonard, *supra* note 4, at 150–55.

144. *See id.*; *see also* Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1302–07 (11th Cir. 2011) (finding insurance and health care to be areas of traditional state concern).

145. *Id.* at 1305; Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619, 644 (1994) ("[B]efore ERISA state law was viewed as the primary source of standards for plans."); Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J. L. MED. & ETHICS (SPECIAL SUPP.) 88, 89 (2009) ("Traditionally, states are responsible for regulating health care delivery, and litigation against health care providers is resolved under state law."); Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-*

intrusion into health insurance regulation, specifically directed at employer-based health insurance plans through the Employee Retirement Income Security Act of 1974 ("ERISA"),[146] is largely an empty letter in terms of real, substantive regulation.[147] ERISA infringes on state authority by broadly preempting affirmative state regulation of employer health insurance but imposes few specific requirements on health plans, much less on states.[148] The ACA, by contrast, adds an extensive new overlay of federal regulations applicable to employer-based health insurance plans as well as individual and small group plans, which historically were regulated by states.[149] The ACA's health insurance market regulations apply uniformly nationwide, thus limiting the space for state variation. States may continue to regulate health insurance plans and health insurers as long as state laws supplement and do not conflict with the ACA.[150]

Many of the new federal health insurance regulations have broad popular support[151] and are aimed at some of the most objectionable practices by commercial insurers, including pre-existing condition exclusions,[152] premium discrimination,[153] post-claims underwriting and rescission[154] and annual and lifetime benefits caps.[155] New federal laws that prohibit or severely limit those practices take effect in 2014, the same effective date as the ex-

Sponsored Health Insurance Under ERISA, 31 LOY. U. CHI. L.J. 29, 33 (1999) (noting that states' inherent police powers include the authority to regulate insurance).

146. Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144(a) (2006) (providing that federal law preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"); *see also id.* § 1132(a)(1)(B) (providing a civil action as the exclusive remedy for benefits disputes).

147. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 29 (2001) ("The result of this statutory framework is to leave employment-based health insurance effectively unregulated, since ERISA contains no substantive regulation of health benefits."); Jacobson, *supra* note 145, at 89 (noting that ERISA provides "minimal federal regulation").

148. *See* Hyman & Hall, *supra* note 147; Leonard, *supra* note 4, at 152–53.

149. *See* Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1884–87 (2011).

150. *See* 42 U.S.C. § 300gg-1 (Supp. IV 2010) ("Nothing in this title shall be construed to preempt any state law that does not prevent the application of this title.").

151. HENRY J. KAISER FAMILY FOUND., NATIONAL HEALTH INSURANCE—A BRIEF HISTORY OF REFORM EFFORTS IN THE U.S. 1 (2009).

152. 42 § U.S.C. 300gg-1 (Supp. IV 2010)

153. *Id.* § 300gg.

154. *Id.* § 300gg-12.

155. *Id.* § 300gg-11.

changes and the individual mandate.[156] Other coverage and underwriting requirements, including the ban on pre-existing condition exclusions for children,[157] extension of dependent child coverage up to age twenty-six,[158] and coverage of preventive services without cost-sharing,[159] took effect in 2011.[160] The ACA also attempts to rein in insurance companies' excess profits, executive compensation, and other largess by limiting non-medical, administrative expenditures to specified percentages of premium revenues.[161] This so-called Medical-Loss Ratio (the "MLR") provision also took effect in 2011.[162]

Given the popularity of those reforms among the general public,[163] it is not surprising that ACA opponents have not expended much political capital fighting them. But as a structural matter, the lack of resistance to federal health insurance market regulation seems inconsistent with states' objection to the expansion of federal power and intrusion on areas of traditional state authority. As 2014 nears, states have begun to gently push back against uniform federal standards and requirements, seeking to tailor certain insurance regulations to their particular markets. So far, states have not taken the Obama Administration's invitation to opt out of the ACA's insurance market regulations entirely and design unique, state-specific approaches.[164]

The only significant state resistance to federal health insurance regulation has come in the form of requests for waivers from the MLR. Effective January 2011, health insurers are required to meet certain MLR targets.[165] Insurance companies must spend

156. *Implementation Timeline*, *supra* note 12.

157. 42 U.S.C. § 300gg-3.

158. *Id.* § 300gg-14.

159. *Id.* § 300gg-13.

160. *Implementation Timeline*, *supra* note 12.

161. 42 U.S.C. § 300-18.

162. *Implementation Timeline, supra* note 12.

163. HENRY J. KAISER FAMILY FOUND., HOW POPULAR IS THE IDEA OF REPEALING HEALTH REFORM? 2–3 (2010) (describing polling results revealing that even among respondents who favor repealing ACA, many favor keeping particular provisions, including guaranteed issue, the PCIP, dependent child coverage, and exchanges); Reed Abelson et al., *Major Changes in Health Care Likely to Last*, N.Y. TIMES, Nov. 15, 2011, at A1 (noting provisions of health reform that "are already well cemented and popular").

164. *See* 42 U.S.C. § 18052 (Supp. IV 2010) ("Waiver for State Innovation"); Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 13,553 (proposed Mar. 14, 2011) (to be codified at 31 C.F.R. pt. 33 and 45 C.F.R. pt. 155).

165. *Implementation Timeline*, *supra* note 12.

80% (in the individual and small group market) or 85% (in the large group market) of premiums on direct patient care and quality improvement.[166] Only 15% or 20%, of premium revenues, depending on the market, may be spent on non-claims costs, including administrative expenses, overhead, executive salaries, and marketing.[167] Health plans that do not meet the targets must provide rebates to their customers, effective January 1, 2012.[168]

Several state insurance commissioners expressed concern about the effect of the MLR on local markets. In particular, smaller insurance companies might have difficulty meeting the 20% requirement as quickly as the ACA required, which could cause those companies to stop offering policies or leave the market altogether.[169] Alternatively, insurers might try to comply with the MLR targets by decreasing brokers' commissions, thereby causing brokers to leave the market.[170] In either case, the effect would undermine the availability of insurance, contrary to the ACA's goal of expanding health insurance coverage. In response, the Secretary of HHS adopted a regulation allowing states to request waivers from the MLR "if there is a reasonable likelihood that application of the requirement" will destabilize the individual health insurance market in the state.[171] Seventeen states, including several litigant states, requested MLR waivers, ranging from 65% to 75%.[172] The Secretary approved, with modifications,

166. 42 U.S.C. § 300gg-18(b)(1)(A)(i)–(ii) (Supp. IV 2010); *see also* Dep't of Health & Human Servs., Health Insurance Issues Implementing Medical-Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, 75 Fed. Reg. 74,864, 74,901 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158).

167. 42 U.S.C. § 300-gg-18(b)(1)(A)(i)–(ii).

168. *Id.* § 300gg-18(b)(1)(A); Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 74,883.

169. Carrie Teegardin, *Feds Give Georgia Insurers More Time to Comply with Health Care Law*, ATLANTA-J. CONST., Nov. 9, 2011, at A1; Karoun Demirjian, *Nevada Secures Partial Waiver from Federal Health Care Law*, LAS VEGAS SUN (May 16, 2011), http://www.lasvegassun.com/news/2011/may/16/nevada-secures-partial-waiver-federal-health-care-/; Jason Millman, *Another State Wants Healthcare Reform Waiver*, THE HILL (Mar. 19, 2011, 4:48 PM), http://thehill.com/blogs/healthwatch/health-reform-implementation/150819-another-state-wants-health-reform-waiver; Margaret Dick Tocknell, *Understanding MLR Waiver Requests*, HEALTH LEADERS MEDIA (Jul. 27, 2011), http://www.healthleadersmedia.com/content/HEP-269094/Understanding-MLR-Waiver-Requests.html.

170. *See* Jonathan Block, *GAO: Insurers Cut Broker Commissions to Comply with Medical Loss Ratio Rules*, AIS HEALTH (Sept. 5, 2011), http://aishealth.com/archive/nhpw090511-02.

171. 45 C.F.R. § 158.301 (2011).

172. HENRY J. KAISER FAMILY FOUND., *Medical Loss Ratio Adjustments, 2011,*

six states' waivers for 2011, including four litigant states.[173] Resisting states tout those "partial waivers" from the ACA as incremental victories in an overall strategy of undermining the federal reforms.[174]

The ACA allows much broader state waivers from "all or any requirements" of significant portions of the statute, including the individual mandate, health insurance exchange implementation, employer penalties, essential health benefits, and the obligation to distribute federal subsidies for individuals and tax credits for businesses to help purchase insurance.[175] Section 1332 waivers are available beginning January 1, 2017[176] and are subject to the Secretary's approval.[177] Less than a year after the ACA was enacted, President Obama endorsed a bipartisan amendment that would fast-track Section 1332 waivers three years earlier, allowing states to obtain waivers as soon as January 1, 2014.[178] The President touted the Section 1332 waiver provision and his support for a shorter timeframe in his February 2011 address to the National Governors Association.[179] So far, however, only a few states—and no litigant states—have submitted such proposals. The most prominent Section 1332 proposal came from Vermont in

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STATEHEALTHCAREFACTS.ORG, http://www.statehealthfacts.org/comparetable.jsp?ind=90&cat=17 (listing Georgia, Iowa, Maine, and Nevada) (last visited Feb. 24, 2012).

173. *Id.*

174. *See* Demirjian, *supra* note 169 (noting that Republicans claim waiver "as a political victory" and "fresh fodder for an acrimonious debate about health care").

175. 42 U.S.C. § 18052 (Supp. IV 2010).

176. *Id.* § 18052(a).

177. *Id.* § 18052(a)(1)–(2) (listing the ACA requirements subject to waiver); *see* Katherine Hayes & Sara Rosenbaum, *Waivers for State Innovation*, HEALTH REFORM GPS (Mar. 21, 2011), http://www.healthreformgps.org/resources/waivers-for-state-innovation/ (listing the essential health benefit requirement, exchanges, premium assistance, employer responsibility, and the individual mandate among waivable requirements).

178. Sarah Kliff, *Some States Seek Flexibility to Push Health-Care Overhaul Further*, WASH. POST, Oct. 17, 2011, at A3; Meredith Hughes, *Health Reform Flexibility and the Wyden-Brown Waiver for State Innovation*, BIPARTISAN POL'Y CTR. (Mar. 4, 2011), http://www.bipartisanpolicy.org/blog/2011/03/health-reform-flexibility-and-wyden-brown-waiver-state-innovation; *Preparing for Innovation: Proposed Process for States to Adopt Innovative Strategies to Meet the Goals of the Affordable Care Act*, HEALTHCARE.GOV, http://www.healthcare.gov/news/factsheets/2011/03/stateinnovation03102011a.html (last updated Nov. 16, 2011) [hereinafter *Preparing for Innovation*].

179. Press Release, Bernie Sanders, U.S. Senator for Vt., President Endorses State Waiver Proposal (Feb. 28, 2011), http://sanders.senate.gov/newsroom/news/?id=44a664de-8e92-43f4-a871-d26e0b5a252d; *see* Sheryl Gay Stolberg & Kevin Sack, *Altering Stand on Health Law, Obama* Offers *Waiver Opinion*, N.Y. TIMES, Mar. 1, 2011, at A1; *see also Preparing for Innovation* (describing proposed waiver regulations as "[b]uilding on President Obama's commitment to give states the flexibility to innovate and implement health care solutions that work best for them").

May 2011.[180] Its state legislature approved a single-payer health plan for the state and is working with the federal government to obtain necessary waivers.[181] Other states, including Oregon and Montana, have indicated intent to apply for more modest waivers to overhaul physician payment and to allow public employees to enroll in Medicaid.[182]

The ACA's invitation for broad state flexibility has been spurned by some of the most vocal opponents of federal health reform. Oklahoma Governor Mary Fallin charged that the federal requirements to receive a waiver are too onerous.[183] Kansas Governor Sam Brownback said that flexibility "is a positive thing" but "doesn't change the overall objection to the bill."[184] Senator Orrin Hatch of Utah calls the waiver provision a "gimmick."[185] South Carolina Governor Nikki Haley vowed to start crunching numbers to come up with a waiver proposal, concluding, "This is about saying we're going to fight this every step of the way and use every option possible."[186] Thus far, however, no South Carolina Section 1332 proposal has materialized.[187] Implementing regulations specify that states may qualify for Section 1332 waivers only if they can demonstrate their waiver plans will be "at least as comprehensive" as the exchanges with "coverage and cost sharing protections" that are "as least as affordable" as the ACA.[188] States also must demonstrate their plans "will provide coverage to at least a comparable number of [state] residents" as the ACA

180. Kliff, *supra* note 178.

181. *Id.*; *see also* Press Release, Bernie Sanders, *supra* note 179.

182. *Governors Push the Limits of Health Reform: Innovate State Leaders Hit Roadblock with Health Reform Waivers*, THE DAILY BRIEFING (Oct. 18, 2011), http://www.advisory.com/Daily-Briefing/2011/10/18/Democratic-governors.

183. *See* Hughes, *supra* note 178.

184. KHI News Service, *Obama Tells Governors He Backs Accelerated State Flexibility for Health Reform*, KAN. HEALTH INST. (Feb. 28, 2011), http://www.khi.org/news/2011/feb/28/obama-tells-governors-he-backs-accelerated-state-f/ (internal quotation marks omitted).

185. *See* Hughes, *supra* note 178 (internal quotation marks omitted).

186. Seanna Adcox, *Haley: Obama Might Let South Carolina Opt Out of Health Care*, POST & COURIER (Dec. 2, 2010), http://www.postandcourier.com/news/2010/dec/02/haley-obama-might-let-sc-opt-out-of-health-care/ (internal quotation marks omitted).

187. *Cf.* THE DAILY BRIEFING, *supra* note 182 (listing Democratic governors who have proposed Section 1332 waivers).

188. 42 U.S.C. § 18052(b)(1)(A)–(B) (Supp. IV 2010); *see also* Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 13,553, 13,561 (proposed Mar. 14, 2011) (to be codified at 31 C.F.R. § 33.108(a)(2)(iv)(C)(1), (4)) (listing and explaining the application conditions).

and "will not increase the Federal Deficit."[189] In effect, states may obtain waivers only if they can develop their own strategies to achieve the same coverage, consumer protection, and cost-containment goals as the comprehensive federal legislation.

States' relatively modest objections to a new swath of federal insurance market regulations and their unwillingness to innovate fully state-based solutions suggests federalism ambivalence. The ACA imposes a thick overlay of new federal rules and standards for health insurance plans, including small group and individual plans that traditionally have been regulated by states.[190] Despite the expansion of federal authority into state domain, states seem disinclined to challenge new federal laws that have broad popular appeal. States seeking modest MLR waivers cite policy objectives consistent with the ACA, namely ensuring access to health insurance in certain markets.[191] No litigant states have proposed comprehensive state innovation under the ACA Section 1332 waivers.[192] The ACA's goals of providing near universal access to meaningful health insurance coverage and high-quality health care while containing escalating health care costs are daunting. States are understandably reluctant to attempt similar broad reform without federal involvement. National regulation of health insurance offers advantages of scale, uniformity, spillover avoidance, and redistribution.[193] Insurance markets present unique collective action problems that may not be well-suited for state-by-state regulation.[194] Although opposing expansion of federal au-

189. 42 U.S.C. § 18052(b)(1)(C)–(D) (Supp. IV 2010); Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. at 13,561.

190. *See supra* notes 144–50 and accompanying text.

191. Letter from Jane L. Cline, President, Nat'l Ass'n Ins. Comm'rs, to Kathleen Sebelius, Sec'y Dep't of Health & Human Servs. (Oct. 27, 2010), *available at* http://www.Naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

192. *Cf.* THE DAILY BRIEFING, *supra* note 182.

193. *See* Moncrieff & Lee, *supra* note 9, at 271–72 (noting the lower per-unit cost of regulation at the national level, ease of compliance for companies operating in more than one state, avoidance of regulatory distortion, and redistribution of resources among states).

194. *See* Neil S. Siegel, *Four Constitutional Limits that the Minimum Coverage Provision Respects*, 27 CONST. COMMENT 591, 605–08 (2011) (discussing free rider and adverse selection problems in insurance markets that spill over state boundaries and thereby justify federal regulation); *see also* Akhil Reed Amar, *The Lawfulness of Health-Care Reform*, YALE L.J. ONLINE (forthcoming 2012) (manuscript at 22–26), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856506 (listing citizens' concerns about travel and mobility, imposition of unequal financial burdens on states, and race to the bottom concerns with individual state regulation of insurance).

thority in principle, states may pragmatically recognize that, for particular problems, centralized solutions may better achieve the interests and aims of their citizenry.

The fact that the ACA opponents are nuanced enough to recognize that federal regulation offers certain advantages and do not feel compelled to fall on their state autonomy sword reveals a strength rather than a weakness of "muddled" federalism. The problems facing the U.S. health care system are complex and multifaceted. There is no reason to expect that either an all-federal or all-state-based approach would achieve the entire range of objectives. The federalist structure, by design, allows that some problems are best addressed centrally while others are better suited to local solutions.

E. *Individual Mandate*

The centerpiece of state-based dissent to federal health reform continues to be the ACA's "minimum essential coverage" requirement, better known as the individual mandate.[195] Before the ACA was passed, over forty state legislatures entertained Health Care Freedom Acts ("HCFAs") purporting to protect their citizens and residents from any requirement to purchase or maintain individual health insurance.[196] Twenty-eight states are parties to lawsuits challenging the constitutionality of the individual mandate.[197] Even after the ACA's enactment, state legislators continue to introduce HCFAs and similar legislation or constitutional amendments,[198] despite the undeniable federal supremacy of the ACA. Another novel strategy used by the ACA opponents is the

195. 42 U.S.C. § 18091 (Supp. IV 2010) (requiring every U.S. citizen, other than those falling within specified exceptions, maintain a minimum level of health insurance coverage for each month beginning in 2014); *see also* 26 U.S.C. § 5000A (Supp. IV 2010) (imposing a federal tax penalty for noncompliance).

196. *See* Leonard, *supra* note 4, at 113–15, 159.

197. Lyle Denniston, *Health Care Case Advances in Court*, SCOTUSBLOG (Jan. 19, 2011, 6:01 PM), http://www.scotusblog.com/2011/01/health-care-case-advances-in-court/; *see also* Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011); Virginia *ex rel.* Cuccinelli v. Sebelius, 656 F.3d 253 (4th Cir. 2011); Complaint for Declaratory and Injunctive Relief, Oklahoma *ex rel.* Pruitt v. Sebelius, No. 611-cv-00030-RAW (E.D. Okla. Jan. 21, 2011) [hereinafter Complaint, *Oklahoma* ex rel. *Pruitt*].

198. *See* Cauchi, *supra* note 25.

proposal of interstate health compacts,[199] as if states could agree among themselves to override conflicting federal law.

1. Litigation Posture

The individual mandate, above all other fronts of the ACA resistance, is the states' rights rallying cry, despite the provision's tangential connection with federal-state allocation of power. The individual mandate requires nothing of states.[200] It is enacted under federal law, carries a federal tax penalty for noncompliance,[201] and will be enforced by federal authorities.[202] To be sure, there are plausible individual rights objections to the requirement to purchase health insurance from a private company, including interference with autonomous health care decision making and freedom of contract. But those claims, even if judicially cognizable, would garner only low-level rational relation scrutiny, which the individual mandate could likely withstand.[203]

Instead, the strongest constitutional argument against the individual mandate is structural, not substantive. Both individual and state litigants have alleged that the individual mandate exceeds the scope of federally enumerated powers, namely the taxing and commerce powers.[204] The Commerce Clause challenge, in particular, directly tests the limits of enumerated federal powers against states' reserved Tenth Amendment powers. The lawsuits allege that an individual's lack of health insurance does not con-

199. *See Some States Pursue Health Compacts*, Affordable CARE ACT: ST. ACTION NEWS (Nat'l Conference of State Legislatures, Washington, D.C.), June 3, 2011, at 2.

200. Health insurance exchanges are required to certify individuals as exempt from the individual mandate. 42 U.S.C. § 18031(d)(4)(H) (Supp. IV 2010). Accordingly, if states elect to operate their own exchanges, they would be required to perform that function.

201. 26 U.S.C. § 5000A(c) (Supp. IV 2010) (providing federal income tax penalty).

202. *Id.* § 5000A(g) (specifying federal enforcement).

203. *See* Mark A. Hall, *The Constitutionality of Mandates to Purchase Health Insurance*, 37 J.L. MED. & ETHICS (Special Supplement) 38, 44–47 (2009) (considering the individual rights claims); Abigail R. Moncrieff, *Safeguarding the Safeguards: The ACA Litigation and the Extension of Structural Protection to Non-Fundamental Liberties*, 64 FLA. L. REV. (forthcoming 2012) (manuscript at 4–6) (explaining "that, in most scholars' view, the individual mandate simply does not infringe liberty—at least not in any constitutionally meaningful way" and considering and dismissing various other arguments).

204. *See* Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1282, 1313 (11th Cir. 2011) (addressing the commerce power and taxing power claims); Thomas More Law Ctr. v. Obama, 651 F.3d 529, 540 (6th Cir. 2011) (addressing commerce power claim); Liberty Univ. Inc. v. Geithner, No. 10-2347, ___ F.3d ___, 2011 WL 3962915, at *5 (4th Cir. 2011) (addressing the tax power claim).

stitute an activity that substantially affects interstate commerce[205] and that the federal government cannot compel the purchase of health insurance.[206] The cases are poised for Supreme Court review, with circuit splits on both substantive and procedural grounds. The Eleventh Circuit held the individual mandate unconstitutional on both taxing and commerce grounds,[207] while the Sixth Circuit and the D.C. Circuit upheld the mandate as a valid exercise of federal commerce power.[208] The Supreme Court almost surely will resolve the merits of the constitutionality of the individual mandate during the 2012 term.

Procedurally, a question in the lower courts was whether states have standing to challenge the individual mandate, that is, whether states suffer injury-in-fact as a result of the mandate's operation.[209] As I noted, the minimum essential coverage requirement does not call for any state implementation or hardly any state administration.[210] In what now seems a strategic miscalculation, Virginia, and later Oklahoma,[211] filed separate lawsuits, apart from the other twenty-six states, asserting standing based on the minimum essential coverage provision's direct conflict with previously enacted state HCFAs.[212] In essence, those states argued unique injuries to their sovereign interest in enforcing validly enacted state laws, which the ACA contravened. In my earlier article, I agreed that Virginia would seem to have clearer standing to challenge the individual mandate as a violation of state sovereignty, as compared to states merely asserting an interest in protecting individual citizens' freedom, health, and wel-

205. *See* Nat'l Labor Relations Bd. v. Jones & Laughlin Steel Corp., 301 U.S. 1, 37 (1937) (describing the interstate character of some intrastate activities).

206. *E.g.*, *Florida* ex rel. *Attorney Gen.*, 648 F.3d at 1285 (summarizing the plaintiffs' argument); *Thomas More*, 651 F.3d at 543 (same).

207. *Florida* ex rel. *Attorney Gen*. 648 F.3d at 1241.

208. *Thomas More*, 651 F.3d at 534; Seven-Sky v. Holder, 661 F.3d 1, 20 (D.C. Cir. 2011).

209. U.S. CONST. art. III, § 2 (limiting federal courts' jurisdiction to "cases" and "controversies"); Lujan v. Defenders of Wildlife, 504 U.S. 555, 560–61 (1992) (listing three requirements for standing, including "injury in fact").

210. See *supra* notes 200–02 and accompanying text (describing operation of individual mandate).

211. Complaint, *Oklahoma* ex rel. *Pruitt*, *supra* note 197, at 2.

212. Virginia *ex rel.* Cuccinelli v. Sebelius, 656 F.3d 253, 266 (4th Cir. 2011); Memorandum in Support of Defendants' Motion to Dismiss the Complaint at 1, Oklahoma *ex rel.* Pruitt v. Sebelius, No. 6:11-cv-00030-RAW (E.D. Okla. Mar. 28, 2011) [hereinafter Memorandum, *Oklahoma* ex rel. *Pruitt*].

fare.[213] My suggestion was echoed by the American Legislative Exchange Council's ("ALEC") playbook, *The State Legislators Guide to Repealing ObamaCare*, urging states to enact HCFAs precisely for the purpose of "provid[ing] standing to a state participating in current litigation against the federal individual mandate."[214]

The Fourth Circuit, however, held just the opposite.[215] The essence of Virginia's claim, according to the court, was "to litigate as parens patriae by asserting the rights of its citizens."[216] The court declined to recognize any cognizable state interest in protecting a state's residents from operation of a federal statute.[217] Moreover, a state could not "acquire some special stake in the relationship between its citizens and the federal government merely by memorializing its litigation posture in a statute."[218] In sum, the Fourth Circuit held that the individual mandate implicates individual, not state, interests and, accordingly, denied Virginia standing to challenge the individual mandate. The U.S. government moved to dismiss the Oklahoma case on similar grounds.[219] By contrast, the Eleventh Circuit found that case justiciable because the plaintiffs included both state and private-party plaintiffs and the challenges were to both the individual mandate and Medicaid expansion.[220] Virginia's go-it-alone strategy, as it turned out, was flawed in two respects: first, it fails to include an individual litigant with a real stake in the individual health insurance mandate[221] or a Medicaid challenge, in which the state has a

213. Leonard, *supra* note 4, at 159.

214. AM. LEGISLATIVE EXCH. COUNCIL, THE STATE LEGISLATORS GUIDE TO REPEALING OBAMACARE 12 (2011) [hereinafter ALEC GUIDE].

215. *Virginia* ex rel. *Cuccinelli*, 656 F.3d at 272 (holding Virginia had no standing to challenge the individual mandate).

216. *Id.* at 268.

217. *Id.* at 270–71; *see* Timothy Stoltzfus Jost & Mark A. Hall, *Not So Fast—Jurisdictional Barriers to the ACA Litigation*, NEW ENG. J. MED., Oct. 20, 2011, at e34(1)–e34(2) (noting the Fourth Circuit's holding as "invoking well-settled law that states may not sue to protect their citizens from federal law, since state citizens are also federal citizens").

218. *Virginia* ex rel. *Cuccinelli*, 656 F.3d at 271.

219. Memorandum, *Oklahoma* ex rel. *Pruitt*, *supra* note 212, at 8–9.

220. Florida *ex rel*. Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1243 (11th Cir. 2011).

221. *See* Thomas More Law Ctr. v. Obama, 651 F.3d 529, 535–36 (6th Cir. 2011) (noting that individual plaintiffs demonstrated actual injury by showing that impending requirements to buy health insurance changed their spending and saving habits).

real interest.[222] Second, Virginia believed that enacting a state statute contrary to ACA could create an injury-in-fact where one otherwise did not exist.

In sum, according to at least one federate appellate court, states lack standing to challenge the health insurance mandate because the real injury is to individuals, not states. On the other hand, it is hard to see what interest individuals have in challenging the mandate on structural federalism grounds. The allegation is that Congress acted outside the scope of its limited, enumerated powers in requiring most Americans to maintain minimum essential health insurance coverage. Such a claim asserts injury to states' reserved powers, not individual rights. The litigation approach of individuals challenging the validity of federal laws on structural grounds is not unique to the ACA, however.[223] Affirming the availability of such a claim, a recent Supreme Court decision expressly recognized an individual's standing to challenge a federal statute, not even on a federal enumerated power, but on states' Tenth Amendment reserved powers,[224] noting: "An individual has a direct interest in objecting to laws that upset the constitutional balance between the National Government and the States when the enforcement of those laws causes injury that is concrete, particular, and redressable. Fidelity to principles of federalism is not for the States alone to vindicate."[225] But the strategy does present a paradox. States may lack standing to litigate the rights of their citizens while individuals may challenge federal infringement on states' rights.

222. *See Florida* ex rel. *Attorney Gen.*, 648 F.3d at 1244 (concluding that "the state plaintiffs undeniably have standing to challenge the Medicaid provisions").

223. *See, e.g.*, Gonzales v. Raich, 545 U.S. 1, 6–8 (2005) (Commerce Clause challenge to Federal Controlled Substances Act raised by users and growers of marijuana); United States v. Morrison, 529 U.S. 598, 604 (2000) (Commerce Clause challenge to Federal Violence Against Women Act raised by rape defendants); United States v. Lopez, 514 U.S. 549, 551–52 (1995) (Commerce Clause challenge to Federal Gun-Free School Zones Act brought by criminal defendant); Immigration & Naturalization Servs. v. Chada, 462 U.S. 919, 923, 928 (1983) (alien sought review of deportation order, challenging Federal Immigration and Nationality Act on separation of powers grounds); Pike v. Bruce Church, Inc., 397 U.S. 137, 138 (1970) (fruit grower challenged Arizona intrastate packing and processing requirement on dormant Commerce Clause grounds).

224. Bond v. United States, ___ U.S. ___, 131 S. Ct. 2355, 2360 (2011) (challenging conviction under 18 U.S.C. § 229, which forbids knowing possession or use, for nonpeaceful purposes, of a chemical that "can cause death, temporary incapacitation or permanent harm to humans") (quoting 18 U.S.C. § 229F(8)(A) (2006)) (internal quotation marks omitted).

225. *Id.* at 2364.

The Supreme Court will not have to reach that procedural conundrum to decide the merits of the individual mandate challenges because the Florida lawsuit, on which certiorari was granted, does not present the standing issue.[226] Accordingly, there may be no clarification on the question whether states may advocate for individuals' rights, consistent with New Federalism literature,[227] or whether individuals may advocate for states' rights, thereby invigorating the Tenth Amendment as an individually cognizable claim.[228] That uncertainty continues to muddle the justiciable federalism issues.[229]

2. State Legislation

In addition to litigation, states continue to express opposition to the individual mandate through state legislation. Lawmakers in at least forty-five states have introduced HCFAs or similar proposals.[230] To date, eighteen states have passed binding statutes, as well as two state constitutional amendments, opposing elements of the ACA.[231] Other states will consider resolutions in the current legislative term or on 2012 ballot items.[232] Nine states

226. *See* Consolidated Brief for Respondent, Nat'l Fed'n of Indep. Bus. v. Sebelius, Florida v. U.S. Dep't of Health & Human Servs., Nos. 11-393 & 11-400 (U.S. Oct. 17, 2011); Reply Brief for Petition, U.S. Dep't of Health & Human Servs. v. Florida, No. 11-398 (U.S. Sept. 28, 2011).

227. Leonard, *supra* note 4, at 130–31 (describing the New Federalism theory as advocating broadened recognition of individual rights by state governments and a shift in power from the federal government to states).

228. *See Bond*, ___ U.S. at ___, 131 S. Ct. at 2366–67; Garrett Epps, U.S. v. Bond*: Reexamining the Mysterious 10th Amendment*, THE ATLANTIC (Feb. 18, 2011), http://www.theatlantic.com/national/archive/2011/02/us-v-bond-reexamining-the-mysterious-10th-amendment/71436/ (suggesting that the case offers "oblique hints about how the Justices are thinking about the pending health-care challenge"); Frank Mintier, *Did the Supreme Court Tip Its Hand on ObamaCare?*, AM. THINKER (June 23, 2011), http://www.americanthinker.com/2011/06/did-the-supreme-court-tip-its-hand-on-obamacare.html (quoting Justice Kennedy's question during the *Bond* argument and suggesting it foreshadows "how he might rule on ObamaCare"). *But see* Adam Liptak, *Court Weighs the Power of Congress*, N.Y. TIMES, Feb. 23, 2011, at A11 (suggesting that unique facts of *Bond* "offer[s] only limited guidance on the health care law's prospects").

229. *See generally* Elizabeth Weeks Leonard, *Affordable Care Act Litigation: The Standing Paradox*, 36 AM. J.L. & MED. (forthcoming 2012), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1988311 (describing lower court decisions in ACA litigation and proposing that states be accorded standing to challenge the individual mandate, if they allege concrete, particularized injury to state interests, similar to individual plaintiffs' injury allegations).

230. Cauchi, *supra* note 25.

231. *Id.*

232. *Id.*

passed nonbinding resolutions or memorials.[233] In 2011, the year after the ACA was finally and validly enacted as federal law, eight additional states introduced legislation purporting to shield their residents from the ACA's requirement to maintain minimum essential health insurance coverage.[234]

The ongoing state legislative activity in the face of obvious federal preemption is curious. Urging states to continue enacting HCFAs, ALEC's playbook suggests, among other strategic effects, that the HCFAs "provide a state-level defense against ObamaCare's excessive federal power" and could support "additional, [Tenth]-Amendment-based litigation if the current lawsuits fail."[235] It is not clear what sort of state-level defense an obviously preempted state law might have, or how a Tenth Amendment challenge would fare any better than a challenge to the scope of particular enumerated federal powers.[236] More realistically, HCFAs may simply memorialize states opinions about individual rights and codify objection to federal health reform. It is also possible that HCFAs would reemerge as enforceable state laws, should the ACA in its entirety, or the individual mandate, specifically, be struck down.[237]

Even more curious is states' novel strategy of enacting the "Interstate Health Care Freedom Compact" (the "Compact").[238] The Compact includes elements of individual states' HCFAs but purports to operate as an agreement among states to resist federal

233. *Id.*

234. *See id.*

235. ALEC GUIDE, *supra* note 214, at 12.

236. The issue whether the Tenth Amendment operates as an additional limit on federal power is beyond the scope of this paper. *See generally* United States v. Darby, 312 U.S. 100, 124 (1941) ("The [Tenth] [A]mendment states but a truism that all is retained which has not been surrendered."); Kurt T. Lash, *James Madison's Celebrated Report of 1800: The Transformation of the Tenth Amendment*, 74 GEO. WASH. L. REV. 165, 167–69 (2006) ("Over a period of two hundred years, courts and commentators thus transformed the Tenth Amendment from a declaration of principle to an independent rule of construction."); Gary Lawson, *A Truism with Attitude: The Tenth [A]mendment in Constitutional Context*, 83 NOTRE DAME L. REV. 469, 470, 472 (2008) (examining the interaction between the Tenth Amendment and federal laws).

237. *See* Leonard, *supra* note 4, at 166.

238. *Some States Pursue Health Compacts*, *supra* note 199. *See generally* HEALTH CARE COMPACT, http://healthcarecompact.org (last visited Feb. 24, 2012) [hereinafter HEALTH CARE COMPACT] ("The Health Care Compact is an interstate compact—which is simply an agreement between two or more states that is consented to by Congress—that restores authority and responsibility for health care regulation to the member states . . . and provides the funds to the state to fulfill that responsibility.").

health reform. Three litigant states Texas,[239] Oklahoma,[240] and Georgia,[241] and one non-litigant state, Missouri[242] have enacted the Compact under state laws. The Compact legislation has also been introduced in at least fourteen other states.[243] Proponents and sponsors describe the Compact as "giv[ing] the health care decision making power back to the people instead of the bureaucrats in Washington,"[244] "[p]reserving [Tenth] Amendment rights so states can move forward with true health care reform,"[245] and allowing "each state [to] decide[] which plan is best for its citizens."[246] They further assert that compacts are neither "radical" nor unprecedented but simply "tools to allow states to solve problems together."[247] Broadly, Compact authorizes member states to "suspend by legislation the operation of all federal laws, rules, regulations, and orders regarding Health Care that are inconsistent with the laws and regulations adopted by the Member State pursuant to this Compact."[248] Further, the Compact purports to entitle states to receive federal block grants and prohibits such funding from being "conditional on any action of or regulation, policy, law, or rule being adopted by the Member State."[249]

239. Chuck Lindell, *Changes in Healthcare Sent to Perry*, AUSTIN-AM. STATESMAN, June 28, 2011, at B1 (discussing Senate Bill 7, including provisions that "would allow Texas to join a developing interstate health care compact").

240. Patrick B. McGuigan, *Texas Joins Missouri, Oklahoma, and Georgia in Historic Health Care Compact*, TULSA TODAY (July 19, 2011), http://www.tulsatoday.com/index.php?option=com_content&view=article&id=2732 (noting that Texas joined Missouri, Oklahoma, and Georgia).

241. GA. CODE ANN. § 31-48-1 (2011); *see* Press Release, Ga. Senate Press Office, Health Care Compacts Heads to Governor's Desk in Georgia (Apr. 18, 2011), *available at* http://senatepress.net/health-care-compact-heads-to-governors-desk-in-georgia.html.

242. *Missouri Enacts Health Care Compact*, COLUM. MISSOURIAN (July 14, 2011), http://www.columbiamissourian.com/stories/2011/07/14/mo-enacts-states-health-care-compact/.

243. *See* Guy Gugliotta, *Some States Seeking Health-Care Compact*, WASH. POST, Sept. 18, 2011, at A6.

244. Press Release, Ga. Senate Press Office, *supra* note 241 (quoting Eric O'Keefe, Chairman of the Health Compact Alliance) (internal quotation marks omitted).

245. *Id.* (quoting Georgia State Senator Charlie Bethel) (internal quotation marks omitted).

246. Leo Linbeck & Eric O. O'Keefe, Op-Ed, *Health Care Compact Among States Is the Alternative to Obamacare*, WASH. EXAMINER (Mar. 22, 2011), http://washingtonexaminer.com/opinion/op-eds/2011/03/health-care-compact-among-states-alternative-obamacare (expressing the opinions of the vice chairman and chairman of Health Care Compact Alliance).

247. Lois Kolkhorst, *Compacts Empower States to Decide Health Care Issues*, HOUST. CHRON., July 30, 2011, at B7.

248. H.B. 5, 82d Leg., 1st Called Sess. (Tex. 2011); *see also* S.B. 7, 82d Leg., 1st Called Sess. (Tex. 2011).

249. Tex. H.B. 5; *see also* Lindell, *supra* note 239 (describing Tex. S.B. 7, including the

The Texas Compact legislation asserts that the interstate Compact is a way to move control from the federal government to the states but acknowledges that the Compact is subject to congressional approval before it is enforceable.[250]

The ostensible authority for interstate compacts comes from Article I of the U.S. Constitution, providing that "[n]o State shall, without the Consent of Congress . . . enter into any Agreement or Compact with another State."[251] The converse suggestion is that with congressional consent, states may enter compacts with one another. Health Care Freedom Compact sponsors interpret that constitutional provision as a stealth weapon in the fight against federal health reform. Missouri State Representative Eric Burlison suggested that the "very same article in the Constitution [that] has been used for the federal government to grow its powers for many decades" can be used, instead, as "a very polite way [to] ask the federal government to give our authority back."[252]

The states' attempted reliance on the Compact Clause to band together in opposition of federal law is unprecedented and likely futile. While there is precedent for interstate compacts—over 100 have received congressional approval—they generally address cross-border problems such as transportation, water rights, drivers' licenses, and runaway juveniles.[253] In the health care context, states previously enacted interstate compacts allowing the transfer of institutionalized patients to ensure appropriate follow-up

compact provision, "which would let Texas distribute its Medicaid, Medicare and children's health insurance money as a federal block grant").

250. Tex. H.B. 5.

251. U.S. CONST. art. I, § 10, cl. 3.

252. Stephen Dinan, *State Compacts on Health Care Eyed as End Run Around Obama*, WASH. TIMES, Feb. 28, 2011, at A1 (internal quotation marks omitted).

253. *See, e.g.*, Tahoe Regional Planning Compact, Pub. L. 96-551, 94 Stat. 3233 (1980) (uncodified); Tahoe Regional Planning Compact, CAL. GOV. CODE §§ 66800–66801 (West 2009 & Cum. Supp. 2012); Virginia v. Tennessee, 148 U.S. 503, 519–20 (1893) (upholding boundary line established by 1803 compact between Virginia and Tennessee); Dinan, *supra* note 252 (suggesting that more than 100 compacts have passed); Kolkhorst, *supra* note 247 (listing examples and suggesting that more than 200 compacts are currently in operation). *See generally* Herbert H. Naujoks, *Compacts and Agreements Between States and Between States and a Foreign Power*, 36 MARQ. L. REV. 219, 224 (1953) (providing a list of areas in which compacts have been used); George William Sherk, *The Management of Interstate Water Conflicts in the Twenty-First Century: Is It Time to Call Uncle?*, 12 N.Y.U. ENVTL. L.J. 764, 766–67 (2005) ("There is no doubt that the framers of the Constitution expected the states to resolve conflicts among themselves through the use of interstate compacts.").

care.[254] Without question, interstate compacts must be approved by Congress to have any legal force and effect.[255] Any disputes among states arising under interstate compacts fall within the Supreme Court's original jurisdiction.[256] Accordingly, it is inconceivable that Congress, having passed the ACA barely two years ago, with Supreme Court review pending, would approve an interstate compact among states excusing themselves from compliance with the ACA and granting themselves open-ended, no-strings-attached federal funding.[257] The question, then, is whether the Compact sponsors fail to appreciate the futility of their actions, or whether they envision the compact as yet one more way to signal objection to the ACA.

State-based dissent to the individual mandate has taken two rather different paths. First, seemingly novel judicial challenges that are now deemed worthy of consideration by the highest Court in the land. Second, a variety of state legislative enactments and proposals of dubious legal merit. In both cases, objection to the mandate is framed as states' rights, but the essential contention is infringement on personal autonomy. Because the individual rights claims are weak, structural federalism arguments are doing the heavy lifting of bringing (and keeping) the issue to the public fore.[258] Skeptics dismiss federalism objections to the individual mandate as "opportunistic" fronts for substan-

254. *E.g.*, Interstate Compact on Mental Health, GA. CODE ANN. § 37-10-2 (2011).

255. U.S. CONST. art. I, § 10, cl. 3; Naujoks, *supra* note 253, at 225 (distinguishing compacts subject to congressional approval from agreements among states that do not alter the political power of the affected states, which do not require congressional consent); Sherk, *supra* note 253, at 766–67 & n.7 (discussing the congressional consent requirement relating to interstate water conflicts); Dinan, *supra* note 252 (quoting UCLA Law Professor, Adam Winkler, as noting that compacts need congressional consent); Sam Baker, *Healthcare "Compact" Advances in Two States*, THE HILL (May 18, 2011), http://thehill.com/blogs/healthwatch/state-issues/162015-healthcare-compact-advances-in-2-states ("[I]n order to take effect and supersede federal law, an interstate compact needs Congress's stamp of approval.").

256. U.S. CONST. art. III, § 2, cl. 2 (providing that the Court has original jurisdiction "[i]n all Cases affecting Ambassadors, other public Ministers and Consuls, and those in which a State shall be a Party"); *e.g.*, Texas v. New Mexico, 482 U.S. 124, 126 (1987); Jonathan Horne, *On Not Resolving Interstate Disputes*, 6 N.Y.U. J.L. & LIBERTY 95, 98, 147 (2011).

257. *See* Dinan, *supra* note 252 (quoting Professor Winkler as stating that "it doesn't seem likely you can get a bill through the House and Senate and have it signed by President Obama that exempts states from what is President Obama's signature achievement") (internal quotation marks omitted); Gugliotta, *supra* note 242 (Montana Democratic Gov. Brian Schweitzer, who vetoed that state's compact bill, stated that "'we will put a person on Neptune' before Congress approves the compact").

258. *See* Moncrieff, *supra* note 203 (manuscript at 2).

tive objections to the individual mandate, specifically, and federal health reform, generally.[259]

There is no doubt that libertarian, anti-Obama, partisan opposition fuels the health reform debate. Nevertheless, this essay aims to rebut the reductionist spin on the debate by considering the individual mandate opposition within the larger context of state resistance to ACA implementation. Although the individual mandate has garnered the most attention, several other ACA provisions bearing on federal-state allocation of power are also targets of resistance. States balk at increased burdens under Medicaid, hesitate to embark on new cooperative arrangements with the federal government under the PCIP and exchanges, and resist at least certain federal health insurance regulations. Moreover, the Supreme Court's willingness to consider the individual mandate challenge as presented and briefed by twenty-six state plaintiffs,[260] and to hear both state and individual challenges to the federal-state cooperative Medicaid program,[261] amply demonstrates that the federalism arguments are more than rhetorical. The outcome of those cases and the ongoing ACA implementation process will, without question, affirm, clarify, and perhaps alter the allocation of power between states and the federal government.

IV. CONCLUSION

To conclude, I reconsider rhetorical federalism and find the values[262] still tenable two years post-ACA enactment. The values of rhetorical federalism include bringing transparency to the task of implementing comprehensive laws, educating the electorate by distilling the law to discrete issues, giving voice to minority views, depoliticizing highly charged issues, codifying dissent, and

259. *See* Leonard, *supra* note 4, at 125–28 (describing "opportunistic federalism").

260. *See* U.S. Dep't of Health & Human Servs. v. Florida, No. 11-398, ___ U.S. ___, 2011 WL 5515164 at *1 (Nov. 14, 2011); Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11-393, ___ U.S. ___, 2011 WL 5515162 at *1 (Nov. 14, 2011) (consolidating case with Florida v. U.S. Dep't of Health & Human Servs. No. 11-400, ___ U.S. ___, 2011 WL 5515165 (Nov. 14, 2011).

261. *Florida* ex rel. *Attorney Gen.*, 648 F.3d at 1262–68 (rejecting the Medicaid challenge); *see* Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., ___ U.S. ___, 131 S. Ct. 992 (2011) (consolidating case with *Maxwell-Jolly v. Cal. Pharmacists Ass'n*, 131 S. Ct. 922 (2011) and *Maxwell-Jolly v. Santa Rosa Mem'l Hosp.*, 131 S. Ct. 996 (2011)).

262. See Leonard, *supra* note 4, at 161–68.

highlighting the increased role of government in health care delivery.

Continued state resistance to the ACA certainly highlights the complexity of implementing a comprehensive overhaul of the U.S. health care system. Discussions over Medicaid, the PCIP, and exchanges reveal the necessary, if at times acrimonious, involvement of both federal and state lawmakers and regulators to carry out those functions. States may be criticized for using the implementation process to perpetuate partisan fights over health reform. But the strategy of staging objections to discrete provisions as they roll out over the next several years does have the effect of parsing the massive package of reforms. As opinion surveys reveal, the public may disfavor the federal health reform law as a broad concept while actually supporting many particular provisions.[263]

Health insurance market regulations, which the public generally supports, and the individual mandate, which remains highly contested, both reveal the increased role of government in the health care system. I previously suggested that such awareness could provide a platform for public consideration of more sweeping reform, such as a single-payor system. While the public seems anything but ready to embrace a universal, government health care program, we are more aware of the tradeoffs. The validity of the individual mandate, by the federal government's own admission, turns on the complex interrelationship of that requirement with the ACA's guaranteed issue and community rating provisions.[264] The individual mandate debate may help ACA opponents further appreciate that they cannot have the sweet of insurance market reforms without the bitter of the individual mandate.

Other suggested values of rhetorical federalism are harder to gauge. One, giving voice to minority views, still seems true in theory but is less evident in fact. The 2010 midterm elections shifted the balance of power in the U.S. House of Representatives to Republicans, and the 2012 presidential election could go to either party. In late 2011, more Americans, and notably more Democrats, expressed a negative view about the law than supported

263. *See supra* note 163 (citing the KFF survey and other sources).

264. *See* Brief for Appellant at 28–32, Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011) (Nos. 11-11021 and 11-1107).

it.[265] Thus, health reform opposition may no longer be the minority view. The expressive function of state HCFAs, compacts, litigation, and implementation moratoria may have contributed to that opinion shift. If increased understanding of the law and time to carefully consider its effects have caused support to dwindle, that may simply be the political process at work rather than any disingenuous conduct by states. Another value of rhetorical federalism is codifying dissent. Even apparently unenforceable state laws and interstate compacts may memorialize state preferences, thus providing a jumping off point for future debate,[266] should the new presidential administration or Congress move to repeal the ACA in whole or in part.

Where I most clearly missed the mark in identifying values of rhetorical federalism was my suggestion that structural arguments over federal health reform could depoliticize the highly charged partisan debate. Clearly, in the current environment, that is anything but true. The issue of the proper scope of federal power vis-à-vis the states has become the central, signature issue of ACA opposition. Supreme Court resolution of those questions could usher in a new era of federal-state relations. Even if the state-based dissent to the ACA began as an opportunistic federalism strategy to oppose the substantive policies of health reform, the rhetoric has gained a firm foothold and will leave an indelible mark.

265. HENRY J. KAISER FAMILY FOUND., PUBLIC OPINION ON HEALTH CARE ISSUES 3 (2011).

266. *See supra* Part III.E.2 (describing state legislative activity, post-ACA enactment).