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National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012)

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NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS, 567 U.S. 519 (2012)

JUSTICE ELIZABETH WEEKS, CONCURRING IN PART AND DISSENTING IN PART

I join the Chief Justice's decision with respect to Parts I (granting amicus curiae) and II (holding that the Tax Anti-Injunction Act does not bar this claim).

I also join the Chief Justice's decision, but not its reasoning, on Part III. I agree that the Patient Protection and Affordable Care Act's (ACA) Shared Responsibility Payment, 26 U.S.C. § 5000A(b)(1), commonly called the individual mandate, is a valid exercise of federal taxing and spending power. U.S. Const. art. I, § 8, cl. 1. I also agree, however, with Justice Ginsburg that the provision is valid under the commerce power. U.S. Const. art. I, § 8, cl. 3. I write separately to emphasize the ways in which the individual mandate is a critical and constitutionally permissible exercise of congressional power to regulate the existing interstate market for health care. Health care is a robust, nationwide industry that inevitably serves all Americans, healthy and unhealthy, male and female, young and old. The individual mandate essentially operates as a regulation of the way that individuals pay for services that they necessarily already are receiving and has the associated effect of broadening access to health care markets for all. The commerce power allows for such regulation on a national scale. As further justification for the mandate's constitutionality, I explain that the ACA in many respects operates as a civil rights law, consistent with several existing antidiscrimination statutes previously enacted under the commerce power. *See*, for example, Civil Rights Act of 1964, Title II; *see also Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964) (prohibiting discrimination by hotel operators); *Katzenbach v. McClung*, 379 U.S. 294 (1964) (prohibiting discrimination by restaurant owners).

I dissent from the Chief Justice's decision in Part IV, holding that the ACA's expansion of Medicaid to low-income individuals, irrespective of other categorical eligibility, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), exceeds the congressional spending power. Again, many of Justice Ginsburg's points regarding prior amendments to and expansion of the Medicaid program are well-taken. I write separately to further elucidate the errors in the Chief Justice's description of the history and operation of the Medicaid program. I depart from both the Chief Justice's and Justice Ginsburg's opinions on the question of remedy. Upon holding Congress' duly enacted amendment to the Medicaid program

unconstitutional, the Chief Justice relies on the Medicaid Act's own severability provision, 42 U.S.C. § 1303, to cure the defect. Specifically, the Chief Justice holds that the Medicaid Act's penalty for noncompliance with federal regulations, 42 U.S.C. § 1396c, applies only to the states' existing Medicaid programs. In other words, if a state declines to extend coverage to the ACA's expansion population, that state's existing federal Medicaid dollars are not at risk. This second-best remedy provides some solace inasmuch as it does not fully strike down the ACA's Medicaid expansion. But I fear that such an approach invites a race to the bottom, as states opt in or out, or individually negotiate with federal authorities to include particular features for their state programs, including new barriers to access, eligibility requirements, and benefits models that harm the very individuals whom the program was enacted to serve. While state flexibility is a hallmark of the Medicaid program, it should not be allowed to eviscerate the program's very purpose.

The overarching question in this case, in both parts of the opinion, is whether Congress' attempts to nudge the nation closer to universal health care, while retaining our persistent private-public hybrid health care design, was constitutional. Although the instinct behind both the individual mandate and Medicaid challenges derives from core American values of autonomy and "the right to be let alone," *see Olmstead v. United States*, 277 U.S. 438, 478 (1928) ("[The Framers] conferred, as against the government, the right to be let alone – the most comprehensive of rights and the right most valued by civilized men."); *see also United States v. Katz*, 389 U.S. 347, 349 (1967) (citing Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 Harv. L. Rev. 193 [1890]). These claims are brought instead as structural constitutional challenges, not as individual rights challenges. The individual mandate is challenged as exceeding Congress' power under the interstate commerce clause; although ultimately, the Chief Justice upholds it under Congress' power to tax and spend for the general welfare. Medicaid expansion is challenged as exceeding previously articulated limits on Congress' "conditional" spending power. *See Coll. Sav. Bank v. Fla. Prepaid Postsecondary Ed. Expense Bd.*, 527 U.S. 666, 686 (1999); *South Dakota v. Dole*, 483 U.S. 203, 205–206 (1987) (conditioning federal highway funds on states raising their drinking age to 21); *id.* at 211–212 (describing limits on conditional spending power).

The core of the dispute over the mandate is that individuals do not want to be compelled to purchase health insurance. Healthy individuals do not want to be compelled into a group risk pool that would have the effect of making health insurance more affordable (and, thereby, more accessible) for others, including those with preexisting conditions and appreciable health risks. The

Medicaid expansion challenge more clearly implicates states' rights; however, the argument is grounded in fundamental objections to expansion of both federal authority and public welfare programs. Opponents seem to hew to a view that able-bodied adults should and, therefore, must provide for themselves, rather than receiving government assistance.

By contrast, the ACA's private market reforms reflect a different policy preference with respect to the role of government with respect to individuals and access to health care that is more communitarian than individualistic. That view, with the individual mandate as a linchpin to the strategy, was not an easy sell in Congress, but the various interconnected elements of the Act managed to garner enough votes to pass. *See* H.R. Rep. No. 43, 111th Cong. (Mar. 21, 2010), [https://perma.cc/9F6Y-8Z62]. Health care still is viewed largely as a personal matter, a private-market transaction between patient and health care provider. Third-party payment for health care evolved in fits and starts since the early 1900s; it was driven by various forces, including competition among employers, Paul Starr, *Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915–1980*, 72 Am. J. Pub. Health 78 (1982), and, later, generous federal tax subsidies to employers. Earnings spent on employee benefits are not taxed, 26 U.S.C. § 3121(a)(2)(B), while the same earnings paid toward salary or wages are. § 3121(a). Those remain the dominant incentives for employers to provide health insurance to their workers. The ACA continues to lean heavily on private employers to cover the costs of health care in the United States and even further cements that reliance by adding nudges in the form of an enrollment default rule, which passed Congress but quickly was repealed. Section 18A of the FLSA, as added by Section 1511 of the Affordable Care Act, directs an employer who is subject to FLSA and has more than 200 full-time employees to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law). Additionally, large employer "free rider" penalties are triggered if an employer fails to offer health insurance, or affordable, minimum essential coverage and an employee receives subsidized coverage on the health insurance exchanges. 26 U.S.C. § 4980H. Outside of employer-sponsored group plans, commercial health insurance historically has been treacherous terrain. Pre-ACA, state regulations varied widely regarding plan substance, Timothy Stoltzfus Jost, *The Regulation of Private Health Insurance*, Nat'l Acad. of Soc. Ins., 1, 11–24 (2009), [https://perma.cc/RYD7-JPV9], but there was little to no regulation of plan pricing. *Id.* at 11 (noting that "state approval was generally not required before policies or rates went into effect"). Using its commerce power, Congress enacted the ACA in an effort to rationalize the commercial health care market on a

nationwide scale, seeing that state-level solutions were not working. *NFIB v. Sebelius*, 567 U.S. 519 (2012) (Ginsburg, J., concurring).

Thus, enter the two provisions at issue in this case, two components of a complex, interconnected plan to achieve near-universal coverage. The individual mandate sought to broaden access to and moderate pricing in the private insurance market by bringing more people into the insurance risk pool. The Medicaid expansion recognized that a cohort of previously excluded needy individuals deserved to have access to health care via a public benefits program. Since at least 1965, when Medicare and Medicaid were enacted, federal health care policy has maintained the view that at least some individuals' ability to access health insurance should not be determined by the private market. I turn now to consider each challenge in turn.

Contrary to the Chief Justice's reasoning, there are two reasons why the individual mandate is constitutionally within Congress' power to regulate interstate commerce. First, dysfunctions that characterize the US health care market call for national solutions, consistent with the purpose underlying the commerce power. *See N. Am. Co. v. SEC*, 327 U.S. 686, 705 (1946) ("This broad commerce clause does not operate so as to render the nation powerless to defend itself against economic forces that Congress decrees inimical or destructive of the national economy. Rather it is an affirmative power commensurate with the national needs."). Second, the ACA's interconnected provisions, grounded in the individual mandate, operate as civil rights laws, a previously recognized and well accepted use of federal commerce power. *See Heart of Atlanta*, 379 U.S. at 257 (noting "the overwhelming evidence of the disruptive effect that racial discrimination has had on commercial intercourse"); *see also Katzenbach*, 379 U.S. at 303 ("Congress has determined for itself that refusals of service to Negroes have imposed burdens both upon the interstate flow of food and upon the movement of products generally").

I

Contrary to the Chief Justice's and the Dissents' conclusions, regulation of health care and health insurance markets is well within Congress' power to regulate interstate commerce, as it has done repeatedly. As Justice Ginsburg's opinion emphasizes, "Under the Articles of Confederation, the Constitution's precursor, the regulation of commerce was left to the States. This scheme proved unworkable, because the individual States, understandably focused on their own economic interests, often failed to take actions critical to the success of the Nation as a whole." *NFIB*, 567 U.S. at 599–600 (Ginsburg, J., concurring) (citing *Vices of the Political System of the United States*, in James

Madison: Writings 69, 71, ¶ 5 [J. Rakove ed. 1999]) (As a result of the "want of concert in matters where common interest requires it," the "national dignity, interest, and revenue [have] suffered."). Health care, historically, has been the province of state regulation, but it has become clear that approach is unworkable. *See* Br. for Am. Ass'n of People with Disabilities et al. as Amici Curiae at 9, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11–398) (describing several states' failed attempts at health care market regulation in the 1990s); *see also* Br. for Gov't of Wash. Christine Gregoire as Amicus Curiae at 11–14, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11–398) (describing health insurance "death spiral" that states experienced enacting insurance ratemaking reforms). And, thus, federal response is warranted. As Justice Ginsburg asserted, "States cannot resolve the problem of the uninsured on their own." *NFIB*, 567 U.S at 594. State variation is a hallmark of federalism, but, in this case, states that offer more generous public benefits and consumer protections for health insurance risk attracting in-state migration from less generous states. Absorbing those additional individuals comes at a cost to the state and may require tax increases, which further encourages individuals and businesses to leave. Thus, federal response "was needed to overcome this collective-action impasse." *NFIB*, 567 U.S at 595.

Addressing the health insurance crisis is well within Congress' power, given the settled authority that the Commerce Clause permits regulation of both the insurance industry and health care services. *See*, *for example*, *United States v. Se. Underwriters' Ass'n*, 322 U.S. 533, 539 (1944). Indeed, Congress repeatedly has enacted now well-established statutes regulating health care and health insurance markets. In 1945, Congress passed the McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015, following our decision in *South-Eastern Underwriters Ass'n*, which held that federal antitrust laws do apply to the business of insurance. McCarran-Ferguson does not actually provide substantive federal regulation of insurance, but it confirms Congress' authority to regulate in that space, as long as states have not done so.

With *South-Eastern Underwriters Ass'n* and McCarran-Ferguson both allowing federal regulation of health insurance, Congress has repeatedly legislated in that space. In 1974, Congress passed the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, which regulates employee pension and other benefit plans, including employer-sponsored health plans. As noted above, employer-sponsored plans dominate the private health insurance market and, thus, so too does federal regulation of that market. Congress further regulated employer-sponsored plans with The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936, which protects employees' health insurance coverage as

they change jobs by restricting employers' ability to impose preexisting conditions or lengthy waiting periods. The Genetic Information Nondiscrimination Act of 2008 ("GINA"), 42 U.S.C. §§ 2000ff–2000ff-12, prohibits use of genetic information in employment and insurance, specifically, prohibiting plans from denying coverage or charging higher premiums based on genetic predisposition to disease. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Pub. L. No. 110-343, 122 Stat. 3881, prevents employer-group health plans and other health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical or surgical benefits. Thus, it is clear that Congress repeatedly has exercised its interstate commerce power to regulate health insurance, with particularly broad authority over employer-sponsored plans.

The ACA continues in that well-established tradition of federal regulation of the interstate commerce for health insurance, adding requirements for employer-sponsored plans as well as broader federal regulation of the individual and small group market. Health care, and the myriad ways of paying for it, quite clearly is interstate commerce. As Justice Ginsburg observes: "Not only do those without insurance consume a large amount of health care each year; critically, as earlier explained, their inability to pay for a significant portion of that consumption drives up market prices, foists costs on other consumers, and reduces market efficiency and stability." *See NFIB*, 567 U.S. at 603 (Ginsburg, J., concurring). Given these far-reaching effects on interstate commerce, the decision to forgo insurance is hardly inconsequential or equivalent to "doing nothing," *NFIB*, 567 U.S. at 552 (Roberts, C.J., opinion); it is, instead, an economic decision Congress has the authority to address under the Commerce Clause." *NFIB*, 567 U.S. at 603.

The plaintiffs do not challenge any of the ACA's substantive regulations of health insurance, only the ACA's shared responsibility payment, or individual mandate. In accepting that challenge, the Chief Justice was persuaded by the argument that the individual mandate, rather than regulating existing commercial activity, compels individuals into the market and then purports to regulate them. To him, there is a critical distinction between commercial activity, which Congress can regulate, and inactivity, which it cannot regulate. *See NFIB*, 567 U.S. at 555–556. The Chief Justice's suggestion is that the failure to purchase insurance may "[have] a substantial and deleterious effect on interstate commerce" by creating a cost-shifting problem, but it does not regulate existing commercial activity. Instead, he suggests, it regulates inactivity by compelling individuals to *become active*, which cannot be regulated under the Commerce Clause.

As Justice Ginsburg's opinion articulates, that argument is a fallacy given the inevitability of need for health care treatment. At the point that an individual does need health care treatment, then, one way or another, there must be payment for those services and supplies. The individual mandate thus merely regulates the payment for medical treatment, commercial activity already in effect. The Chief Justice's suggestion that any such inevitability must be more immediate is not well supported by authority. Indeed, the Framers recognized that the country's needs would shift over time and that Congress possesses authority to respond as needed, not just to immediate crises. "There ought to be a CAPACITY to provide for future contingencies [,] as they may happen; and as these are illimitable in their nature, it is impossible safely to limit that capacity." The Federalist No. 34, pp. 205, 206 (John Harvard Library ed., 2009) (emphasis in original). To allow Congress a merely reactive, rather than proactive, mode of action would be unduly restrictive. The reality of health care illustrates that point particularly well: If the individual mandate were limited to individuals in immediate need of health care, the insurance system could not function. As discussed more fully below, the ACA espouses a commitment to ending health status discrimination in health insurance; accordingly, delaying the mandate to purchase insurance until the time of immediate medical need would require insurers to carry high-risk individuals without the risk pooling offset of lower-risk individuals, including individuals who are not yet, but inevitably will become, in need of medical care. Even if Congress disavowed the antidiscrimination aim of the ACA, insurers then would charge prohibitively high premiums to individuals seeking coverage at the time of immediate medical need.

Both issues in this case – the constitutionality of the individual mandate and Medicaid expansion – call for considering the essential nature of health insurance as a means of providing access to health care. The ACA's patchwork of strategies to extend insurance coverage through both the commercial market and government health care programs reflects our country's continued resistance to embracing any sort of universal approach to health care. Congress surely could have gone about health care reform by enacting a comprehensive federal program, akin to the Social Security Act, 42 U.S.C. ch. 7, and its Medicare provisions, *id*. subch. XVIII. Congress' power to enact those now-cornerstone public benefits programs is beyond question.

But against resistance to enlarging the federal administrative state, Congress instead compromised on an incremental approach, retaining and building on core market-based elements and at the same time extending public coverage to a discrete, particularly needy, group of low-income individuals through Medicaid expansion. To a somewhat higher income group, Congress

extended government subsidies to assist those individuals' purchase of private insurance. 26 U.S.C. § 36B (Refundable credit for coverage under a qualified health plan); 42 U.S.C. § 18071 (Reduced cost sharing for individuals enrolling in qualified health plans). Indeed, the suggestion to compel purchase of private health insurance by those who are able to afford it has its origins as a market-driven counterproposal to President Bill Clinton's failed comprehensive health care reform proposal. Stuart M. Butler, *Assuring Affordable Health Care for All Americans*, Heritage Found. 1, 5 (1989), [https://perma.cc/4QH6–7M53] ("Mandate all households to obtain adequate insurance. . . . This mandate is based on two important principles[:]" (1) "that health care protection is a responsibility of individuals, not businesses[,]" and (2) "it assumes that there is an implicit contract between households and society, based on the notion that health insurance is not like other forms of insurance protection."). Thus, ironically, in hewing to a more conservative, private market approach to expanding health insurance coverage, Congress drew greater constitutional scrutiny than it would have had it enacted a comprehensive, "Medicare for All," federal health insurance program.

Policymakers continue to push for privatization of complex social problems, including health care. *See, for example*, Martha Albertson Fineman, *Feminist Legal Theory*, 13 J. Gender, Soc. Pol'y, & L. 13, 21 n. 40 (2005) (citing Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 U.S.C. § 608, as an example, "seeking to solve teenage parenting concerns by requiring denial of public assistance to teenage parents unless they live with their own parents"). Economic models of efficiency and utility prevail, *see id.* at 20; individuals and firms are motivated to maximize their own welfare, with the belief that such conduct will increase overall welfare for society. The belief is that private actors, rather than the government, are the best judges of their own welfare-maximizing desires and strategies. Accordingly, the government has no business telling them how to spend their resources. Applied to health care markets, the suggestion is that those who value that particular product will spend accordingly, and those who do not will place their resources elsewhere. Those who go bare must have prioritized other expenditures. Except for certain select groups, health insurance and health care remain private-market goods and matters of individual responsibility. The ACA encompasses that view by steering individuals to obtain health insurance through the workplace and incentivizing, through penalties and default rules, private firms to take on that arguably public function.

The Chief Justice's decision concluding that the individual mandate exceeded Congress' power to regulate interstate commerce perpetuates that public-private dichotomy, a distinction that is overdrawn in our national

politics. Feminist legal scholar Catharine MacKinnon once famously declared: "the personal is the political," Catharine A. MacKinnon, *Toward a Feminist Theory of the State* 95 (1989), meaning that women's issues and problems are not hers alone but must be addressed by society as a whole. It would require breaking down the public law-private law distinction for law and policymakers to see beyond the traditional view of health insurance as a commercial product providing individual financial protection against risk and instead to view it as effecting a risk pool premised on cross-subsidization of the health care "haves" by the health care "have-nots." The ACA achieved that shift in perception, but obliquely and incompletely. By compelling individuals to obtain health insurance, even before they have an immediate health care need, the ACA pulls some presently healthy individuals into the risk pool, along with individuals already in need of medical care.

The Chief Justice ultimately upholds the individual mandate as a "tax," constitutionally enacted under Congress' enumerated power to "lay and collect Taxes." U.S. Const. art. I, § 8, cl. 1, *NFIB*, 567 U.S. at 561; that approach does not require recognizing any collective responsibility for health or refocusing of the welfarist frame. While taxes, even when intended to affect individual behavior (here, by incentivizing the purchase of health insurance as a way to avoid the tax), intrude somewhat on individual autonomy, such laws are well accepted as limited intrusions, as long as they do not cross the line of becoming penalties. *See*, for example, *United States v. Butler*, 297 U.S. 1 (1936); *Bailey v. Drexel Furniture Co.* (*Child Labor Tax Case*), 259 U.S. 20 (1922). Despite Congress' explicit use of the word "penalty," 26 U.S.C. §§ 5000A(b), (g)(2) (describing the "[s]hared responsibility payment" imposed on those who forgo health insurance not as a "tax," but as a "penalty"), the Chief Justice concludes that the law lacks the hallmarks of a penalty for constitutional purposes, and instead operates as a tax. Words matter to the Chief Justice on other occasions, *see*, for example, *Dep't of Homeland Sec. v. Maclean*, 135 S. Ct. 913, 919 (2015) ("Congress generally acts intentionally when it uses particular language in one section of a statute but omits it in another."), including with respect to the ACA. *NFIB*, 567 U.S. at 543–544. But, here, the Chief Justice elided both Congress' "penalty" label as well as, more tellingly, its "shared responsibility payment" label. Note the dictionary definitions: *shared* – "used, done, belonging to, or experienced by two or more individuals," Merriam-Webster, and *responsibility* – "having a duty to deal with something." Oxford Dictionaries. Those words indicate Congress' intention and understanding that health care is a collective concern, requiring a collective response. The Court simply did not parse that text or acknowledge that congressional intent.

II

The individual mandate also is constitutionally within Congress' power to regulate interstate commerce as a core component of a civil rights law, similar to other such laws enacted under the commerce power. The Commerce Clause has been consistently understood to authorize Congress to address the impact on interstate commerce resulting from discriminatory exclusions and to promote equality and inclusion. As discussed above, the ACA aims to extend health insurance coverage to more Americans and, in so doing, all but eliminates health status discrimination in health insurance underwriting and ratemaking. The ACA also aims to address other types of discrimination, correcting a wide range of practices that historically disadvantage women. In short, the ACA was widely understood as an antidiscrimination statute. *See, for example*, 145 Cong. Rec. H8105 (July 15, 2009) (statement of Rep. Edward Perlmutter, suggesting that insurers' refusal to provide coverage to his epileptic daughter is "probably unconstitutional under the Fourteenth Amendment to the United States Constitution"); 145 Cong. Rec. 8881 (July 28, 2009) (statement of Rep. Steven Kagen, stating: "Isn't it a fact that we all agree that it's time to end discrimination in health care where insurance companies are allowed to discriminate against you because of a preexisting condition? I think it's time. We secured equal treatment at the lunch counter 50-some years ago; and this year, we're going to come to some agreement here in the House to end the discrimination in health care . . . .").

The ACA expressly extends existing federal civil rights laws addressing discrimination on the basis of race, color, national origin, sex, age, or disability. 42 U.S.C. § 18116 (expressly incorporating Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975). Section 1557 prohibits discrimination on those bases in all plans offered on the health insurance exchanges and all health care programs or activities that the US Department of Health and Human Services funds or administers. In addition to extending existing civil rights law to health insurance and health care, the ACA adds a number of other provisions aimed at correcting long-standing discriminatory practices, particularly against women. Those provisions, which are made possible by the individual mandate, are well within Congress' commerce power.

A

Several prior federal laws recognize that unequal treatment of individuals, especially on the basis of sex, has a significant economic impact that calls for a

federal response. *See, for example*, Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241; Equal Pay Act of 1963, Pub. L. No. 88-38, 77 Stat. 56 ("Congress hereby finds that the existence ... of wage differentials based on sex ... depresses wages and living standards for employees necessary for their healthy and efficiency; ... prevents the maximum utilization of the available labor resources; ... tends to cause labor disputes, thereby burdening, affecting, and obstructing commerce; ... burdens commerce and the free flow of goods in commerce ... ."); Family and Medical Leave Act, Pub. L. No. 103-3, 107 Stat. 6 (1993) (stating that one of its purposes is to "balance the demands of the workplace with the needs of families" and to discourage employment discrimination on the basis of sex, which thus promote the stability of the economy). These economic consequences require confronting inequality and discrimination.

This Court and other federal courts have repeatedly recognized that discrimination impairing individuals' ability to participate in society affects interstate commerce. *See Heart of Atlanta*, 379 U.S. at 257 (noting "overwhelming evidence of the disruptive effect that racial discrimination has had on commercial intercourse"); *United States v. Virginia*, 518 U.S. 515, 532 (1996) ("[T]he Court has repeatedly recognized that neither federal nor state government acts compatibly with the equal protection principle when a law or official policy denies to women, simply because they are women, full citizenship stature – equal opportunity to aspire, achieve, participate in and contribute to society based on their individual talents and capacities."); *see also United States v. Allen*, 341 F.3d 870, 881 (9th Cir. 2003) (upholding federal hate crimes legislation under the Commerce Clause); *Groome Reg. Ltd. v. Parish of Jefferson*, 234 F.3d 192 (5th Cir. 2000) (upholding the Fair Housing Amendments Act (FHAA) and emphasizing the "strong tradition of civil rights enforced through the Commerce Clause ... we have long recognized the broadly defined 'economic' aspect of discrimination"). The ACA's provisions addressing long-standing discrimination in health insurance and health care, a critical pillar of which is the individual mandate, are in keeping with the recognition that inequality disrupts commerce.

B

A major purpose of ACA is to confront discrimination in health insurance and health care. The individual mandate facilitates that objective by making private health insurance more available and affordable, especially for women. Those aims are particularly significant as women are disproportionately poor, uninsured, and struggling with medical debt. *See* Elizabeth Warren et al.,

Medical Problems and Bankruptcy Filings, Norton's Bankr. Adviser 1, 10 (2000) (noting that "the number of women filing alone who identify a medical reason for their bankruptcies is nearly double that of men filing alone"). The individual mandate is critical to that strategy by bringing most Americans under a health plan and into the insurance risk pool. By requiring insurers to provide coverage to all who seek it, regardless of health status, it remedies long-standing practices of refusing to sell insurance to women with "preexisting conditions" such as pregnancy, previous cesarean section, or history of having survived domestic abuse. Br. of the Nat'l Women's L. Ctr. et al. as Amici Curiae Supporting Petitioner on the Minimum Coverage Provision at 2, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11-398); *see, for example*, *What Women Want: Equal Health Care for Equal Premiums: Hearing Before the S. Comm. on Health, Education, Labor, and Pensions*, 111th Cong. 3 (2009) (statement of Marcia D. Greenberger, President, National Women's Law Center), [https://perma.cc/9K3U-DBSU] (stating that "simply having had a Cesarean section is grounds enough for insurance companies to reject a woman's application"). These guaranteed issue and community rating provisions of the ACA, 42 U.S.C. §§ 300gg–1, 300gg–3, 300gg–4(a), function because of the broader, more inclusive risk pool that the individual mandate effects. *See Hearings before the House Ways and Means Committee*, 111th Cong., 1st Sess., 10, 13 (2009) (statement of Uwe Reinhardt) ("[I]mposition of community-rated premiums and guaranteed issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with . . . a mandate on individual[s] to be insured."); *see NFIB*, 567 U.S. at 597.

In other respects, the ACA explicitly targets practices that discriminate against or disadvantage women. For one, the ACA makes gender rating illegal nationwide in both the individual and small group markets. *See* Pub. L. No. 111-148, § 1201. It also makes maternity coverage universal, including maternity and newborn care in the package of ten "essential health benefits" ("EHB"). Pub. L. No. 11– 148, § 1302(b)(D). The EHB package also includes "first dollar" coverage, without copayments or coinsurance, for preventive care, which includes essential benefits for women, such as Pap tests, mammograms, and family planning. *See* H.R. Rep. 111– 299(III) at 104 (2009) (describing intent to require EHB package to "include the full range of medical services for women's unique health needs, at all stages of life, including.., preventive screenings such as mammograms, annual gynecological exams, diagnostic, routine care, and recommended treatments"); *see, for example*, 155 Cong. Rec. S12027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand) ("With Senator Mikulski's amendment, even more preventive screening will be covered,

including for postpartum depression, domestic violence, and family planning."). Moreover, health plans will no longer be permitted to require prior approval for women seeking obstetric or gynecological care. 29 CFR § 2590.715-2719A(a)(3). The law also supports nursing mothers, requiring employers with more than fifty employees to provide break times and private locations other than bathrooms for employees to express breast milk. 29 U.S.C. § 207(r)(1)(A). These various provisions evidence the ACA's design and intent as a civil rights law that addresses historical discrimination, especially against women.

The importance of the ACA to providing access to health insurance and health care, and ending historical discriminatory practices, is quite evident in the provisions described above. Characterizing the ACA as a civil rights law offers an additional justification for the constitutionality of the individual mandate, beyond the economic justifications that predominate the Chief Justice's opinion and Justice Ginsburg's concurrence.

III

I dissent from the Chief Justice's decision in Part IV on the issue of the constitutionality of the ACA's expansion of Medicaid and write separately from Justice Ginsburg, first, to further explain the Chief Justice's errors in characterizing the expansion as a new program, rather than an amendment to an existing program. Second, I disagree with both the Chief Justice and Justice Ginsburg that any unconstitutionality with the ACA's Medicaid expansion can be remedied by applying the Medicaid Act's statutory penalty for state noncompliance to only part of the overall program.

A

Medicaid, the national health insurance program for low-income people, plays a critical role in providing health coverage for women. Women are more likely to be poor, and thus Medicaid disproportionately benefits them. *See* Sarah Collins et al., *Realizing Health Reforms' Potential: Women and the Affordable Care Act of 2010*, Commonwealth Fund (July 30, 2010), www.commonwealthfund.org/publications/issue-briefs/2010/jul/realizing-health-reforms-potential-women-and-affordable-care-act; *see also* H.R. Rep. 111-388, at 91 (2009). Even before the ACA's expansion, women comprised about three-quarters of the program's nonelderly adult beneficiaries, and more than one in ten women received coverage through Medicaid. *See* Kaiser Family Foundation, *Women's Health Insurance Coverage* 1 (2011). An additional 8.4

million women became newly eligible for Medicaid as a result of the ACA. Br. of Nat'l Women's L. Ctr. et al. as Amici Curiae Supporting Petitioner on the Minimum Coverage Provision at 19, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11-398) (citing Sarah Collins et al., *Realizing Health Reforms' Potential: Women and the Affordable Care Act of 2010*, Commonwealth Fund [July 30, 2010]). As a result of the Chief Justice's decision, those women and other newly eligible individuals may effectively be denied access to any affordable health insurance coverage option.

1

The individual mandate, discussed in Part I of this opinion, derives from Congress' long-standing authority to regulate the commercial health insurance market. As another component of the ACA's design to bring health insurance coverage to most Americans, Congress expanded eligibility for an existing public insurance program, namely, Medicaid. Congress enacted the Medicaid statute in 1965, at the same time as Medicare, Social Security Amendments of 1965 § 121(a), Pub. L. No. 89-97, 79 Stat. 286, has always covered lower income individuals with health care needs. *See* S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, p. 9 (1965); *see also* § 121(a), 79 Stat. 343 (noting that the purpose of Medicaid is to enable States "to furnish . . . medical assistance on behalf of [certain persons] whose income and resources are insufficient to meet the costs of necessary medical services"). The ACA expanded that core definition to include all low-income adults earning less than 133% of federal poverty level, irrespective of other "categories" of eligibility. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2006 & Supp. IV).

While Medicare is a fully federal public insurance program, Medicaid is jointly funded and administered by the federal government and the states. 42 U.S.C. § 1396a. States elect whether to participate and retain considerable flexibility in the state plan design. *Id*. As long as the state plan complies with broad federal requirements, or individually negotiated federal waivers, participating states receive a percentage-on-the-dollar federal match for every state dollar spent. 42 U.S.C. §§ 1396b, 1396(c). Since the mid-1980s, all fifty states have participated in the Medicaid program. *See* Christie Provost & Paul Hughes, *Medicaid: 35 Years of Service*, 22 Health Care Fin. Rev. 141 (2000). The federal spending power permits Congress to define the contours of programs financed with federal funds, which basic cooperative federalism design this Court has never doubted. *See, for example*, *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981).

Nothing about the ACA changed the essential arrangement, purpose, or design of the Medicaid program. Moreover, the program has not been static over the years but has been amended and expanded on numerous occasions – more than fifty times since 1965 by Justice Ginsburg's count. *NFIB*, 567 U.S. at 627. The Chief Justice, however, held that this particular amendment was unconstitutionally coercive because states are required to cover the expansion population on pain of losing their federal matching dollars for their existing Medicaid beneficiaries. That potential has been a feature of the Medicaid program since its inception and with each subsequent amendment. The relationship between the federal government and states through the Medicaid program has been characterized as "much in the nature of a contract," *Barnes v. Gorman*, 536 U.S. 181 (2002) (quoting *Pennhurst State Sch. & Hosp.*, 451 U.S. at 1), and here the contract specified the penalty for noncompliance clearly to all parties. In reality, the Secretary has never once exercised this "nuclear option" of withdrawing all of a state's federal Medicaid dollars; rather, more typically, the state agrees to a plan for curing the noncompliance or otherwise negotiates an arrangement with the Secretary. 42 U.S.C. §§ 1396(c), 1396(n) (providing the Secretary of Health and Human Services the power to discretionarily waive certain requirements under Subchapter XIX for States); *see also* Julia Bienstock, Note, *Administrative Oversight of State Medicaid Payment Policies: Giving Teeth to the Equal Access Provision*, 39 Fordham Urb. L.J. 805, 841 (2012) (citing Mark H Gallant, *Federal Remedies for Noncompliance by States*, 2 Health L. Prac. Guide § 27:7 [2011]).

Congress' repeated amendment of Medicaid over the years includes other dramatic expansions, particularly in the 1980s and 1990s. Originally, Medicaid eligibility was tied to cash assistance, either the federal Supplemental Security Income (SSI) program, or Aid to Families with Dependent Children (AFDC), and later Temporary Assistance for Needy Families (TANF). Accordingly, the program singled out the poor aged, blind, and people with disabilities and certain parents and children. In the 1980s, Congress extended eligibility to pregnant women with family incomes up to 133% of the federal poverty level, children up to age six at the same income levels, and children aged six to eighteen with family incomes up to 100% of the poverty level. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i), 1396a(l); Medicare Catastrophic Coverage Act of 1988, § 302, 102 Stat. 750; Omnibus Budget Reconciliation Act of 1989, § 6401, 103 Stat. 2258; Omnibus Budget Reconciliation Act of 1990, § 4601, 104 Stat. 1388–166; *see also Lessons from the Medicaid Expansions for Children and Pregnant Women: Implications for Current Policy: Testimony before the Subcomm. on Health of the H. Comm. on Ways and Means*, 105th Cong. (1997) (statement of Lisa Dubay & Genevive M. Kenney, Senior Fellows,

Urban Institute). During that same time period, Congress also required states to make additional disproportionate share hospital (DSH) payments to hospitals that serve especially large numbers of Medicaid and other low-income individuals. Omnibus Budget Reconciliation Act of 1981 (OBRA-81), 95 Stat. 357. In the 1990s, Congress severed Medicaid eligibility from eligibility for cash assistance under AFDC and TANF, establishing a new mandatory Medicaid eligibility group for low-income households. Personal Responsibility and Work Opportunities Act (PRWOA) of 1996, 110 Stat. 2105. In each case, states' continued acceptance of federal Medicaid funding was contingent on including those new beneficiaries and requirements. In no case were these changes deemed unconstitutionally coercive of states.

Nevertheless, the Chief Justice deems the ACA's amendments to the Medicaid program to cross the line where "pressure turns into compulsion." *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937). To reach that conclusion, the Chief Justice frames the ACA's Medicaid expansion as not merely another in consistent series of statutory amendments to eligibility and coverage over the program's forty-five-year history, but as an entirely new program. Thus, the Chief Justice maintains, Congress could not condition state's federal matching dollars for participation in one program ("old" Medicaid) on their agreement to participate in a different program ("new" Medicaid). Based on that erroneous characterization, the Chief Justice held that the ACA's expansion of Medicaid coverage to low-income individuals below 133% of federal poverty level was unduly coercive and, therefore, violated the conditional spending power. 567 U.S. at 585 ("What Congress is not free to do is penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.").

Assuming without deciding that Congress cannot condition state funding for implementing one federal program on their agreement to implement a different and unrelated federal program, that scenario does not accurately describe the ACA's Medicaid expansion. Rather, the expansion is one in a series of amendments to the nearly five-decade-old Medicaid program, which amendments have repeatedly altered and expanded the program's benefits, eligibility, and other features. Congressional authority to amend, without qualification on the nature or extent of the amendments, has been expressly provided in the Medicaid statute itself, from the time of enactment. *See* 46 U.S.C. § 1304 (expressly reserving "[t]he right to alter, amend, or repeal any provision" of the Medicaid statute).

Notwithstanding Congress' clear statutory authority to amend the program and penalize noncompliance with program requirements, and the long

history of Medicaid amendments to expand eligibility, the Chief Justice here, for the first time, invokes the coercion analysis to strike down an act of Congress as exceeding the federal spending power. The only two previous decisions by this Court mentioning the spending power coercion doctrine found it inapplicable and upheld the federal laws in question – the unemployment-compensation provisions of the Social Security Act of 1935 in *Steward Machine Co. v. Davis*, 301 U.S. at 585–593, and the drinking age condition on highway funds in *South Dakota v. Dole*, 483 U.S. 203, 212 (1987). In each case, the Court recognized the theoretical possibility of a federal spending program unconstitutionally coercing states but found no coercion on the facts presented. Justice Cardozo in *Steward Machine* warned that enforcing the coercion doctrine would "plunge the law in[to] endless difficulties." 301 U.S. at 589–590.

Nevertheless, the Chief Justice here held that the expansion of Medicaid to include a new category of beneficiaries was unconstitutionally coercive because the Secretary theoretically could withdraw all of a state's federal Medicaid funding in response to a state's failure to comply with the ACA's Medicaid provisions. To be sure, that possibility – loss of federal funding – has always existed with the Medicaid program, pursuant to 42 U.S.C. § 1396c, including with multiple prior amendments to and expansions of the program that have not been held unconstitutional. For reasons that remain unclear, the Chief Justice deemed this particular change to the program to render it a new federal program, rather than an amendment to an existing federal program. The opinion invites numerous interpretive questions and provides little guidance for answering them. At what point does a statutory amendment become *too much*? How related do the amendments have to be to the original statutory design? How much money must be on the line? And is the critical inquiry a dollar quantum, the percentage of the state's budget that the federal grant represents, or the percentage of the particular state program funding that the federal grant represents? Is there some limit on the size of the carrot that Congress can offer in the first place? That is, as Justice Ginsburg noted, Congress, without constitutional quibble, could have fully repealed the Medicaid Act and reenacted it, with the expanded population included. At that point, states would still be left with the choice of leaving a considerable sum of money on the table, but would that choice whether to enact the program be deemed coercive? In sum, the Chief Justice's characterization of pre-ACA Medicaid and post-ACA Medicaid as two separate and unrelated programs is both inaccurate and inapt.

2

In addition to its inaccuracy, the Chief Justice's new-old characterization is an artifice and evidences a fundamental discomfort with extending public assistance to the able-bodied who otherwise seem capable of providing for themselves on the private market. *See* Sara Rosenbaum, Anne Markus & Colleen Sonosky, *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. Health & Biomedical L. 1, 7–8 (2004); Sandra Tanenbaum, *Medicaid Eligibility Policy in the 1980s: Medical Utilitarianism and the "Deserving" Poor*, 20 J. Health Pol., Pol'y & L. 933, 933–934 (1995). That view is especially harmful to women, restricting their eligibility for public assistance to certain roles – child bearer, widow, and mother of a needy child. Medicaid expansion, like the individual mandate, is part of the ACA's posture as a civil rights law that addresses historical disadvantages women face in obtaining health insurance and health care.

With the ACA's amendments to Medicaid, Congress brought formal equality to the program, extending benefits based solely on income, without regard to age, gender, disability, or other individualized criteria. As noted above, Medicaid is an especially important source of health insurance coverage for women. Moreover, women are especially likely to suffer not only physically but financially due to lack of health insurance. *See* H.R. Rep. 111-388 at 84 (37% of women, compared to 29% of men, report problems paying medical bills); *id*. at 70 (over half of medical bankruptcies impact a woman); Elizabeth Warren et al., *Medical Problems and Bankruptcy Filings*, Norton's Bankr. Adviser 1, 10 (2000) (noting that "the number of women filing alone who identify a medical reason for their bankruptcies is nearly double that of men filing alone"). Extending Medicaid based on the sole criterion of indigency, rather than on other categories of eligibility, corrects the association of welfare with weakness and dependency.

According to the Chief Justice, "old" Medicaid drew the line at the "neediest among us;" his opinion notes that "[t]he original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children," and further urged that "[p]revious amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories." *NFIB*, 567 U.S. at 583 (citing 42 U.S.C. § 1396a(a)(10)). Note that those categories were limited to those unable to work due to age (either too young or too old), disability, maternity, or, in much more limited cases, adults caring for minor dependents. The Chief Justice asserts that by covering all low-income, nonelderly individuals up to 133% of the federal poverty line, Medicaid no longer

"care[s] for the neediest among us." *Id*. This is the fatal "shift in kind, not merely degree," *id.*, on which the Chief Justice justifies striking down this particular amendment to the Medicaid program.

The implicit assumption behind the Chief Justice's characterization is that a person is "needy" and thus deserving of government assistance if she cannot provide for herself due to being afflicted with a particular disability or condition but no longer is "needy" if she merely is poor. As Justice Ginsburg observed, surely an individual earning $14,856 per year (133% of the current federal poverty level) is "needy." Perhaps needy, but the unspoken question seems to be whether she is "deserving" of government assistance. For women, this historical distinction between the deserving and undeserving poor allowed the government to support women who hewed traditional family roles, such as marriage, childbearing, and caretaking, while excluding single adults who failed to secure sustainable income or who "chose" motherhood outside of marriage. *See* Johana Brenner, *Towards a Feminist Perspective on Welfare Reform*, 2 Yale J.L. & Feminism 99, 103 (1989). Women who were widowed or caring for injured husbands were especially deserving. *Id*.

At the same time, women who cared for their parents or elderly relatives, or other families, were not eligible because they did not fit within the specified categories. As a result, welfare policy historically fueled a market for low-waged, semi-skilled caretaker services. Denying public benefits to those who were able to work ensured a steady workforce for those and other low-wage jobs in domestic or other service industries, to the benefit of local economies. Those jobs, however, often came with limited benefits or job security, thus forcing women back into the dependency of marriage. *Id.* at 103. Extending public benefits to able-bodied yet low-income individuals recognizes the societal value of those services and liberates women – and men – to work in those positions. Public welfare programs have drawn criticism as merely redistributing wealth rather than growing the economy. *See, for example*, Elisabeth Bumiller, *McCain Embraces a G.O.P. Theme: No More Taxes*, N.Y. Times (Oct. 29, 2008), [https://perma.cc/9AJC-ZM4S]. But, as feminist scholar, Martha McClusky has asserted, "[f]eminist policies such as paid family leave, public childcare, and government health insurance are no more 'redistributive' than conservative-backed policies of economic development subsidies, trade regulation, or intellectual property rights." Martha McClusky, *Transcending the Boundaries of Law: Generations of Feminism and Legal Theory* 357 (Martha Albertson Fineman ed., 2011). Extending benefits to those who engage in caretaking – even if outside of marriage – recognizes the value of those roles to society and the economy.

Nothing in the history of Medicaid limits Congress' conception of the "neediest among us" to the traditional categories of eligibility. Indeed, as noted above, Congress formally severed Medicaid eligibility from eligibility for AFDC and TANF. With the ACA, Congress again, under its statutory authority to amend, untethered Medicaid from constrained categories that no longer accurately capture the program's aim. Defining "need" by reference to income does not create a new program but rather recognizes evolving views of the various ways that individuals participate in and contribute to society.

B

The first part of my separate opinion on Medicaid tracks and buttresses Justice Ginsburg's arguments regarding the errors in the Chief Justice's conclusion that Medicaid expansion is unconstitutionally coercive. Conceding defeat on that point, Justice Ginsburg then joins the Chief Justice on the question of the remedy. Rather than striking down Medicaid expansion in its entirety, the Chief Justice allows states the option to expand, as the statute provides, or to continue limiting Medicaid benefits to the traditional categories of eligibility. In either case, the state's federal funding is conditional on compliance with the degree of participation it elects. That is, a state that declines to extend eligibility to low-income adults outside of the categorically eligible will not lose federal funding for those existing Medicaid beneficiaries. At the same time, a state that opts into expansion is required to comply with all federal requirements – both "old" and "new" Medicaid, to use the Chief Justice's labels – to receive federal funding.

The dissenters would have struck down the ACA in its entirety upon finding both the individual mandate and Medicaid expansion unconstitutional. The Chief Justice, however, concluded that the flawed Medicaid expansion could be severed, allowing the rest of the statute to stand. It bears emphasis that the Chief Justice applies the Medicaid Act's severability provision, 42 U.S.C. § 1303, to remedy the constitutional deficiency. Applying a long-standing provision of "old" Medicaid to the Chief Justice's recharacterized "new" Medicaid expansion program, belies the apparent separateness of the programs. In any event, while I applaud the preservation of the remainder of the statute, I maintain that the severability remedy is a second-best solution. Allowing states to opt in or out of core conception of "need" for public insurance risks eroding the nationwide regulation of health care markets, already recognized as a valid exercise of congressional authority in the discussion of the individual mandate above.

The Chief Justice's remedy to the unconstitutionality of Medicaid expansion under the ACA is to allow states the option to expand their state programs to cover the new population of beneficiaries, thereby gleaning the much more generous federal match (including full federal coverage for the first three years), 42 U.S.C. § 1396d(y)(1), or to decline to expand coverage and continue providing Medicaid to the existing categories of eligibility. *NFIB*, 567 U.S. at 585. While admittedly preferable to striking down the entire statute, the Chief Justice's approach fragments core elements of the Medicaid program and the ACA's overall design. State diversity and experimentation is a hallmark of programs implemented through the conditional spending power. *See Oregon v. Ice*, 555 U.S. 160 (2009); *United States v. Lopez*, 514 U.S. 549 (1995) (Kennedy, J., concurring) ("[T]he States may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear."); *New State Ice Co. v. Liebmann*, 285 U.S. 262 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."); *see also Bond v. United States*, 564 U.S. 211, 221, (2011) (noting that deference to state lawmaking "allows local policies 'more sensitive to the diverse needs of a heterogeneous society,' permits 'innovation and experimentation,' enables greater citizen 'involvement in democratic processes,' and makes government 'more responsive by putting the States in competition for a mobile citizenry.'" (quoting *Gregory v. Ashcroft*, 501 U.S. 452, 458 [1991]).

While those federalism policies are laudable in the abstract, applied here, the Chief Justice's approach likely will deny significant numbers of individuals access to any form of health insurance. Women will be especially impacted by the coverage gap that optional Medicaid expansion promises to leave in its wake. As noted above, Medicaid is an especially important source of coverage for women; more than half of the newly eligible Medicaid population are women; and women are especially at risk for medical bankruptcy. Having enacted the ACA, Congress recognized that increasing access to meaningful, affordable health insurance is a nationwide issue calling for a nationwide solution. The Chief Justice's Medicaid holding, however, fragments the solution and exacerbates the problems that necessitated congressional response in the first place.

In states that opt out of Medicaid expansion, those individuals who would have been newly eligible under the statute as enacted, but who are denied coverage by the state's decision to decline expansion, likely will have no affordable option for coverage. It is hard to image a state opting to cover their expansion population entirely with state dollars, given the dire financial effects

outlined by the plaintiffs here in opposition to the expansion. Thus, public insurance almost surely would be unavailable. A subset of the expansion population denied coverage might qualify for federal subsidies to purchase private insurance. Namely, individuals earning between 100% and 400% of federal poverty level may be eligible for federal premium assistance and/or cost sharing reduction subsidies to help them purchase private insurance through the exchanges. *See* 42 U.S.C. § 18071 (including cost sharing reduction payments to individuals with household incomes between 100% and 250% of federal poverty level); 26 U.S.C. § 36B (providing premium assistance tax credit for purchase of qualified health plan for individuals with household incomes between 100% and 400% of federal poverty level). But those below 100% of federal poverty level would qualify for neither subsidy nor, in opt-out states, Medicaid. Any private insurance plan, if available, would almost surely be unaffordable.

Given that Medicaid operates in the nature of a contract between the federal government and the participating states, it is easy to imagine that states will strike individual deals with the federal government, further fragmenting the program design. Medicaid allows waivers of federal requirements, if federally approved. 42 U.S.C. § 1315(a) (Demonstration Projects); 42 CFR subpart G (Section 1115 Waivers). Assuming those "old" Medicaid options apply to "new" Medicaid, it is conceivable that states might request waivers to expand to only a portion of the newly eligible population (such as those under 100% of federal poverty level who are ineligible for government subsidies for exchange plans); borrow a page from TANF, 42 U.S.C. § 607, and impose additional requirements (such as work activities); follow the model of many private employers, Amy Rossi, *Wellness Programs on the Rise*, 7 Biotechnology Healthcare 29–30 (2010), and encourage wellness program participation; or combine a Medicaid waiver with the ACA's provision for state waiver of other new federal requirements. 42 U.S.C. § 18052 (Waiver for State Innovation).

The array of responses that states may propose as they evaluate whether to expand Medicaid promises to be a study in federalism but a failure of social justice. The issue will be a political lightning rod, creating tiers of beneficiaries, contrary to the Medicaid program's long-standing commitment to equality. *See*, for example, 42 U.S.C. § 1396a(a)(1) (providing that a "State plan for medical assistance must . . . be in effect in all political subdivisions of the State. . ." [statewideness requirement]). Work and wellness requirements are significant policy choices that Congress did not include in the ACA's Medicaid provisions when crafting a federal response to the nationwide problem of lack of access to health insurance. The Chief Justice's optional Medicaid expansion remedy erodes the congressional findings and aim

underlying the ACA and invites stratification and stigmatization of public insurance beneficiaries, further undermining the law's civil rights objectives.

* * *

For the reasons stated, I agree with the Chief Justice that the judgment of the Court of Appeals for the Eleventh Circuit that the individual mandate is unconstitutional should be reversed. In my view, the provision is valid under both the commerce and taxing powers. Further, I would affirm the Eleventh Circuit's decision that the Medicaid expansion is within Congress' spending power.