



ARTICLE

What Is Federalism in Healthcare For?

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Abstract. The Affordable Care Act (ACA) offers a window into modern American federalism—and modern American nationalism—in action. The ACA’s federalism is defined not by separation between state and federal, but rather by a national structure that invites state-led implementation. As it turns out, that structure was only a starting point for a remarkably dynamic and adaptive implementation process that has generated new state-federal arrangements. States move back and forth between different structural models vis-à-vis the federal government; internal state politics produce different state choices; states copy, compete, and cooperate with each other; and negotiation with federal counterparts is a near constant. These characteristics have endured through the change in presidential administration.

This Article presents the results of a study that tracked the details of the ACA’s federalism-related implementation from 2012 to 2017. Among the questions that motivated the project: Does the ACA actually effectuate “federalism,” and what are federalism’s key attributes when entwined with national statutory implementation? A federal law on the scale of the ACA presented a rare opportunity to investigate implementation from a statute’s very beginning and to provide the concrete detail often wanting in federalism scholarship.

The findings deconstruct assumptions about federalism made by theorists of all stripes, from formalist to modern. Federalism’s commonly invoked attributes—including autonomy, cooperation, experimentation, and variation—have not been dependent on any particular architecture of either state-federal separation or entanglement, even though

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theorists typically call on “federalism” to produce them. Instead, these attributes have been generated in ACA implementation across virtually every kind of governance model—that is, regardless whether states expand Medicaid; get waivers; or operate their own insurance exchanges or let the federal government do it for them. This makes it extraordinarily challenging to measure which structural arrangements are most “federalist,” especially because the various federalism attributes are not always present together.

The study also uncovers major theoretical difficulties when it comes to healthcare: Without a clear conception of the U.S. healthcare system’s goals, how can we know which structural arrangements serve it best, much less whether they are working? If healthcare federalism is a mechanism to produce particular policy outcomes, we should determine whether locating a particular facet of healthcare design in the states versus the federal government positively affects, for example, healthcare cost, access, or quality. If, instead, healthcare federalism serves structural aims regardless of policy ends—for instance, reserving power to states in the interest of sovereignty or checks and balances—we should examine whether it does in fact accomplish those goals, and we should justify why those goals outweigh the moral concerns that animate health policy. The ACA did not cause this conceptual confusion, but it retained and built on a fragmented healthcare landscape that already was riddled with structural and moral compromises.

This does not mean that federalism is an empty concept or that it does not exist in the ACA. Federalism scholars tend to argue for particular structural arrangements based on prior goals and values. The ACA’s architecture challenges whether any of these goals and values are unique to federalism or any particular expression of it. At the same time, the ACA’s implementation is clearly a story about state leverage, intrastate democracy, and state policy autonomy within, not apart from, a national statutory scheme. Its implementation illustrates how federalism is a proxy for many ideas and challenges us to ask what we are really fighting over, or seeking, when we invoke the concept in healthcare and beyond.

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Introduction

Federalism is all the rage in health policy again. For the past eight years, President Obama's Patient Protection and Affordable Care Act (ACA), which designated the states as its frontline implementers, has been cited as a particularly prominent example of modern federalism.¹ Indeed, the ACA has been deemed a prototypical example of federalism in dozens of articles—many of them not only about healthcare.² With the new Administration, federalism has stayed at the forefront of the healthcare policy conversation. The bills proposed to replace the ACA, as well as the executive branch's administrative efforts, are heavy on state options and waiver opportunities.³ But every Republican proposal likewise has kept the federal government squarely in the picture, preserving many of the ACA's distinctive national-level interventions while also preserving the ACA's state-centricity.⁴ At the same time, and despite the laser focus on state-federal relations under the law, little detail has emerged on how the ACA's federalism actually operates in practice and what, if anything, is noteworthy about it.

This Article builds on a research effort we conducted with colleagues at the University of Pennsylvania that tracked the details of the ACA's federalism-related implementation from 2012 to 2017. The work was driven by many questions. Central among them were: Does the ACA actually effectuate "federalism," and what are federalism's key attributes when it is entwined with national statutory implementation? How did the ACA's federalism take shape,

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1. See, e.g., Abbe R. Gluck, Essay, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 539-40 (2011) (describing some of the many modern federalism structures in the statute); see also Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code).
 2. See, e.g., Jessica Bulman-Pozen, *Executive Federalism Comes to America*, 102 VA. L. REV. 953, 969 (2016); Erwin Chemerinsky et al., *Cooperative Federalism and Marijuana Regulation*, 62 UCLA L. REV. 74, 118 (2015); Heather K. Gerken, Lecture, *Windsor's Mad Genius: The Interlocking Gears of Rights and Structure*, 95 B.U. L. REV. 587, 598 (2015); Michael S. Greve, *Our Federalism Is Not Europe's. It's Becoming Argentina's*, 7 DUKE J. CONST. L. & PUB. POL'Y 17, 32 (2012); Orrin G. Hatch, *King v. Burwell and the Rule of Law*, 63 UCLA L. REV. DISCOURSE 2, 10 (2015); Gillian E. Metzger, Essay, *Agencies, Polarization, and the States*, 115 COLUM. L. REV. 1739, 1772 (2015); Hannah J. Wiseman, *Regulatory Islands*, 89 N.Y.U. L. REV. 1661, 1686-87 (2014); Josh Bendor & Miles Farmer, Note, *Curing the Blind Spot in Administrative Law: A Federal Common Law Framework for State Agencies Implementing Cooperative Federalism Statutes*, 122 YALE L.J. 1280, 1287 (2013).
 3. See, e.g., American Health Care Act of 2017, H.R. 1628, 115th Cong. (as passed by House, May 4, 2017); 163 CONG. REC. S5682-95 (daily ed. Sept. 13, 2017) (SA 1030); see also *Compare Proposals to Replace the Affordable Care Act*, KAISER FAM. FOUND., <https://perma.cc/S7GR-NBRW> (archived Apr. 23, 2018).
 4. See *Compare Proposals to Replace the Affordable Care Act*, *supra* note 3.

and what was its purpose? A federal law on the scale of the ACA presented a rare opportunity to investigate how modern federalism works from a statute's very beginning.

The deep description that we develop in this Article gives rise to an almost unmanageable number of questions about federalism theory. It deconstructs assumptions about federalism made by theorists of all stripes—not just constitutional law-oriented federalists, who focus on formal separation, but also those who call themselves the “new school” federalists, who acknowledge and celebrate the importance of states' role in the administration of modern federal statutes.⁵ The findings also uncover a theoretical muddle when it comes to healthcare law and policymaking: Without a clear conception of the U.S. healthcare system's goals, how can we know which structural arrangements serve it best, much less whether they are working?

Our key descriptive findings are summarized in Part I. In brief, we find the ACA's federalism to be exceedingly *dynamic and adaptive*. The statute's framework has turned out to be only a starting point for a robust vertical and horizontal process of intergovernmental bargaining, through which states and the federal government implement the law through copying, negotiating, and adapting. The statute's structural architecture is also decidedly *nonessentialist* from a federalism perspective⁶: That is, federalism's commonly cited attributes—including autonomy, cooperation, variation, and experimentation—have been generated across virtually every kind of state-federal arrangement in the statute's implementation. Those federalism benefits, in other words, have not been dependent on any architecture of either state-federal separation or entanglement.

As one example, take Medicaid, the public insurance program for low-income individuals. Some states expanded Medicaid eligibility precisely as the

5. Compare, e.g., Heather K. Gerken, *The Supreme Court, 2009 Term—Foreword: Federalism All the Way Down*, 124 HARV. L. REV. 4, 11-13 (2010) (describing the classic sovereignty account of federalism) [hereinafter Gerken, *Federalism All the Way Down*], with, e.g., Heather K. Gerken, *Federalism and Nationalism: Time for a Détente?*, 59 ST. LOUIS U. L.J. 997, 1005 (2015) (arguing for a modern understanding of federalism that incorporates national power) [hereinafter Gerken, *Federalism and Nationalism*], Erin Ryan, *Response to Heather Gerken's Federalism and Nationalism: Time for a Détente?*, 59 ST. LOUIS U. L.J. 1147, 1152-53, 1159-60 (2015) (noting the importance of state-federal bargaining as the critical element of modern federalism), and Ernest A. Young, *The Rehnquist Court's Two Federalisms*, 83 TEX. L. REV. 1, 130-36 (2004) (noting that federalism in practice occurs through statutory doctrines such as preemption due to the Supreme Court's broad interpretation of Congress's enumerated powers).

6. See Judith Resnik, *Accommodations, Discounts, and Displacement: The Variability of Rights as a Norm of Federalism(s)*, 17 JUS POLITICUM 208, 221, 225 (2017) (rejecting as an “essentialist claim” “the presumption of the naturalness of federal or of state exclusivity, as if certain kinds of activities were intrinsically only to be left to a particular level”).

ACA's text laid out; others chose not to expand at all; still others negotiated (and renegotiated) waivers to tailor Medicaid to their liking, in ways less than ideal to the Obama Administration.⁷ All of these states experienced autonomy; all of their choices generated policy localism and experimentation. Waiver states arguably cooperated with the federal government and dissented simultaneously. Were the waiver states more or less cooperative than other expansion states? Were they more or less autonomous than states that did not expand at all? In the end, it proved impossible to assign weights to the different ways in which federalism attributes emerged and to the structural architectures that produced them because they emerged from virtually every possible state-federal arrangement under the law.

This does not mean that we conclude that federalism is an empty concept or that it does not exist in the ACA. Instead, we stake out a new place on federalism's messy spectrum. On one end, some scholars insist on an all-or-nothing conception, one in which state power is derived from separation from the federal government and the Constitution draws the critical lines.⁸ On another point on the spectrum are those who see arrangements like the ACA and say that federalism does not exist at all; they instead see mere decentralization and use of states in a subservient and managerial way.⁹ Still others brand themselves modern federalists and see state activity within federal frameworks as nonsovereign activity that both serves nationalism and works as a safety valve for the expression of dissenting views.¹⁰ The details of the ACA's implementation do not fully support any of those stories.

To the contrary, our findings make clear that the ACA's implementation is indeed a story about state leverage, intrastate governance, and state policy autonomy, even within a national statutory scheme. That these, and other common federalism values, were effectuated independently of any particular structural arrangement or formal separation may be difficult for some federalism aficionados to swallow, but it is a key conclusion of this Article and one we think offers a new perspective. It also complicates what it means to be an essential attribute of federalism. For instance, we found that policy variation and experimentation—two oft-referenced federalism attributes¹¹—were generated as much in the various nationally run insurance exchanges as

7. See *infra* Part IV.

8. See Gerken, *Federalism All the Way Down*, *supra* note 5, at 11-13.

9. Cf. MALCOLM M. FEELEY & EDWARD RUBIN, *FEDERALISM: POLITICAL IDENTITY AND TRAGIC COMPROMISE*, at ix (2008) (suggesting, prior to the ACA, that some aspects of modern federalism are actually just “managerial decentralization”).

10. See Gerken, *Federalism and Nationalism*, *supra* note 5, at 1005.

11. See, e.g., Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 923-24 (1994) (describing the variation produced by experimentation as an “instrumental argument for federalism”).

in the state-run exchanges. Those attributes thus do not seem unique to federalist arrangements, even though theorists typically call on federalism to produce them. Sovereignty does not seem absolutely necessary either, although it played a key role at times. And with respect to autonomy, full structural separation of states from the ACA (i.e., total nationalization) would have diminished state power far more than did giving states the lead implementation role that they had. More than anything else, we found that state participation and choice, rather than any particular structural allocation, gave states the most power under the statute.

To be sure, aspects of the ACA's implementation will not resonate with federalism scholars at all. For starters, we begin with the view that national intervention in healthcare is unavoidable and that the ACA was not a unique interloper in an otherwise exclusive sphere of state authority. That will be anathema to the constitutional law-tethered federalists. But as we illustrate, the ACA is only the latest instance in a long pattern of incremental, national healthcare interventions.¹² That history renders mostly irrelevant constitutional arguments about federalism in healthcare and the views of classic federalists who slice the world into separate compartments of federal and state authority. Instead, state-federal allocation in healthcare has been, from the beginning, a feature of congressional design more than of any constitutional mandate requiring exclusive domains. One of us has called this "intrastatutory federalism": federalism arrangements produced by federal statutes themselves.¹³

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

In the end, however, these different expressions and aims of federalism matter only once we define what federalism is supposed to be and what it is for. Federalism is a term that today is difficult to pin down.¹⁴ The complications our study uncovers underscore how federalism has tended to stand in for so many different values, as well as for many different types of structural arrangements—whether separation, checks and balances, variation, autonomy, or experimentation. They also reveal that these attributes do not always line up coherently, even within the same statute.

12. See *infra* Part II.

13. See Gluck, *supra* note 1, at 538.

14. See generally The Federalist Soc'y, *Is Everyone Now for Federalism?*, YOUTUBE (Nov. 17, 2017), <https://perma.cc/2485-Z4MY>.

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

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

The second problem we encountered was a problem of health policy theory: *What is healthcare federalism even for?* Most of the healthcare policy literature has failed to engage this threshold question why we are focused on state-federal allocation in healthcare in the first place.¹⁵ (This problem could be generalized to most any field, we suspect,¹⁶ but we confine our analysis to healthcare.) For instance, we might view healthcare federalism as about federalism for *federalism's sake*—federalism for political or constitutional values—reserving some power over healthcare for states in the interest of state sovereignty and balance of power, regardless of the effect on healthcare coverage, cost, access, or quality. If so, we should examine whether it does in fact accomplish those goals. If, on the other hand, healthcare federalism is a mechanism for producing particular *policy* outcomes, we should examine instead whether locating a particular facet of healthcare design in the states versus the federal government positively affects, for example, healthcare coverage, cost, access, quality, innovation, or some other health policy aim.

15. The most extensive treatment comes in a terrific 2003 Urban Institute volume, which posits different reasons why federalism might be favored in healthcare. See John Holahan et al., *Federalism and Health Policy: An Overview*, in *FEDERALISM & HEALTH POLICY* 1, 5-7 (John Holahan et al. eds., 2003). The authors conclude: "U.S. health policy reflects a shared approach to federalism There is little agreement that either level of government would necessarily do better than the current arrangement." *Id.* at 6.

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

Complicating matters further is the lack of theoretical foundation in the field of health law in general. The field remains caught in a centuries-old, unresolved tension between the so-called “social solidarity” model—which posits that every person should be guaranteed some minimal level of healthcare; and the “individual responsibility” model—which posits that a person should receive only the healthcare she can pay for.¹⁷ The ACA built on a fragmented system that compromised on both sets of values and, while the ACA itself pushed the needle toward solidarity by enacting policies aimed at universal coverage, it did not go all the way and still leaves the field without clear core principles.¹⁸

As such, federalism becomes even more difficult to measure because the menu of potential health policy goals is not necessarily coherent. For instance, health policy that decreases costs for the federal government is not difficult to construct, and such a policy might also be deemed states’ rights- or federalism-friendly if it pushes policy choices to the states. But such a policy could well reduce access to care, especially for the poor,¹⁹ and it would not be state-friendly if it increased the financial or regulatory burdens on states beyond what they could meet. As another example, health policy that allows for interstate variation might be a benefit of federalism, but it also leads to significant inequality when it comes to healthcare access across the country.²⁰ For some, a moral belief in equality might trump whatever other benefit (like policy variation) a federalist structure could generate. This is why, without a clear goal, it is impossible to know whether federalism is simply a structural preference regardless of its effect on healthcare or a substantive choice whose success warrants verification.

This Article unfolds as follows: Part I summarizes the key findings. The ACA’s implementation was marked by structural dynamism, negotiation, administrative pragmatism, complex intrastate politics, and interstate

17. See, e.g., Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 227 (2008) (“The peculiarly American mix of entitlement and personal responsibility in today’s health reform proposals may . . . mask deep divisions in beliefs about whether society or the individual ought to be responsible for health. Trying to have it both ways may make it impossible to agree on sustainable reform.”); see also Abbe Gluck, Opinion, *America Needs to Decide: Is Health Care Something We Owe Our Citizens?*, VOX (updated Mar. 18, 2017, 9:36 AM EDT), <https://perma.cc/763M-NAQM> (describing current debates’ failures to engage with the tension Mariner identified).

18. See Gluck, *supra* note 17.

19. See *infra* Part III.A.

20. See, e.g., Samantha Artiga et al., *The Impact of the Coverage Gap for Adults in States Not Expanding Medicaid by Race and Ethnicity*, KAISER FAM. FOUND. (Oct. 26, 2015), <https://perma.cc/J6VR-BNXH> (documenting significant health disparities in states that chose not to expand Medicaid).

horizontal competition and learning. Part II provides an abbreviated history of federalism and nationalism in healthcare and situates that history in modern theories of federalism. Part III details the ACA's federalism structure and provides background on our study of the implementation of two of the ACA's key pillars, which were also its most state-centered components: the Medicaid expansion and the health insurance marketplaces (called exchanges).²¹ Parts IV and V offer a deep dive into the federalism features of the Medicaid and exchange implementations, respectively. Part VI circles back to the question what federalism in healthcare is for and extrapolates lessons that can be learned.

We conclude that the ACA's story substantiates the existence of some federalism attributes within federal administration under the right circumstances. For instance, state leverage and policy flexibility seem real—even within a national law—when states have choices to make that are important to the statute's success. Those characteristics in turn serve state sovereignty, as we discuss. But other federalism attributes may not be dependent on states being involved at all—including the famous Brandeisian federalism values of experimentation and variation.²² We saw those values emerge from nationally run aspects of the ACA, too, and did not see any evidence that state-run components did any better. Perhaps these no longer should be thought of as classic federalism values.

We recognize that thus deconstructing federalism's key attributes poses dizzying complexities not only for conceptualization but also for legal doctrine. As one of us has detailed elsewhere, federalism doctrine has barely moved past the separate-spheres conception.²³ But it must if the various values we associate with federalism are worth protecting, because they now clearly emerge outside of separate-spheres design. Moreover, the values are many and are not always produced together by the same state-federal structural arrangement. Yet we continue to invoke federalism as a single placeholder for all of these different things. Recognizing these developments and concretizing what is essential to federalism is necessary to effectuate and evaluate it—not only in the ACA but also beyond.

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

22. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”), *abrogated by* *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937).

23. See Abbe R. Gluck, Essay, *Our [National] Federalism*, 123 YALE L.J. 1996, 2022-43 (2014).

I. Summary of Key Findings

Several of our findings should be of particular interest to federalism experts, health-oriented or not. First, we found the ACA's federalism to be *dynamic, negotiated, adaptive, and horizontal*. It was marked by robust intergovernmental activity. States copied other states and leveraged the success of forerunners for more gains in later negotiations.²⁴ The federal government adapted each time, setting the stage for the next round of activity. This federalism was multidirectional, not an on-off switch: States have changed structural architecture in both directions, moving between state-led and federally led models and vice versa.²⁵ State choices have moved in waves.²⁶

Second, the ACA's federalism generated some fascinatingly pragmatic and creative *hybrids* of national and state-level solutions that we have not seen theorized elsewhere in the federalism literature and that emerged only in implementation. The ACA's initial framework, it turned out, was a mere starting point for the ultimate allocation of authority. The hybrids that emerged were notable in striking a middle ground between one and fifty options—those two extremes being the typical way that state-federal allocation of power questions are considered, and the typical kind of choice Congress makes in designing statutes in areas that implicate the states. The ACA's story reveals instead that some lower number of structural options—say, four or eight—might be the sweet spot between variety and efficiency.

We also found that many states were eager to accept the kind of federal help for which the federal government has particular economies of scale, including administrative and technical assistance, even as they wished to retain control over policy decisions.²⁷ These hybrid solutions had negative byproducts too. Most importantly, they jeopardized transparency. Some states that took advantage of the hybrid approach did so because it allowed them to *hide* the fact they were getting federal help from their constituents and, in some cases, hide it even from parts of their own governments.²⁸ The hybrids thus gave red-state officials cover to entrench the ACA but arguably came at a steep price when it comes to accountability. One official colorfully called it the “secret boyfriend model” of state-federal relations—a relationship coveted by

24. The account of the negotiations we offer substantiates much of Erin Ryan's work. *See generally* Ryan, *supra* note 5, at 1159-60 (discussing the breadth and importance of bargaining between states and the federal government in the context of contemporary federalism).

25. *See infra* Parts IV-V.

26. *See infra* Parts IV-V.

27. *See infra* Part V.B.

28. *See infra* Part V.B.2.

the states, but one that states were unwilling to admit publicly for political reasons.²⁹

Third, the ACA's federalism story highlights the importance of *intrastate* governance.³⁰ Each state is an individual republic of its own, even as most federalism scholars still talk about "the states" as a monolithic bloc.³¹ But states had different laws going into the ACA, which shaped policymaking decisions under the law. For instance, some states had generous preexisting insurance requirements, which affected the design of their exchanges. Other states had laws about Medicaid policy, which influenced governors in their negotiations over whether and how to expand Medicaid in their own states under the ACA.

State actors also have significant differences among them. State insurance commissioners (most of whom are elected) view health policy differently from governors, who themselves take a different position from legislators—even those within the same party. The ACA's implementation saw many governors bucking legislators in their own party to take advantage of the ACA's benefits to their states—often using preexisting features of state law to do so—underscoring the different priorities of different members of state government and the different structures of the state governments themselves. These internal dynamics within states have a profound, and mostly unrecognized, influence on national policy.³²

Fourth, Parts IV and V take a deep dive into implementation that deconstructs federalism's commonly touted attributes and so reveals the complications for empirically measuring federalism in healthcare and beyond. We suggest that many of the most common "federalism" questions are unanswerable or at least seriously oversimplified. Take for instance the popular question whether states are engaging in cooperative or uncooperative (disobedient) federalism, as well as the related question whether certain structural arrangements serve state autonomy.³³ The ACA allowed states to choose whether to operate their own health insurance exchanges or to have the

29. Interview with Former Federal Executive Branch Healthcare Officials 2, 3, and 4 (Aug. 5, 2016) (on file with authors). Because many interviewees were sitting officials, or formerly sitting officials, we granted all of them confidentiality to allow for more candid discussion.

30. See *infra* Parts IV.B, V.D.

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

32. Our account responds to Rick Hills's longstanding call to "dissect" the states and develop a federalism story that recognizes the differences both among the states and among various governmental players within each state. See *id.*

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

federal government do so for them.³⁴ Many believe that blue states cooperated by establishing their own state-run exchanges and that red states rebelled by defaulting to a federally run exchange. This binary is too simplistic. When Oregon, for example, switched from a state-run to a federally supported exchange,³⁵ did it suddenly become uncooperative? Or was Oregon still cooperating by defaulting to the national exchange, even though the common wisdom is that red states that did the same thing were not cooperating and were more autonomous?

As for rebellious states, were they more sovereign, autonomous, and uncooperative in the context of the exchanges—even though, as a result of their refusal to implement the exchanges themselves, they paradoxically *welcomed* the federal government takeover of their insurance markets?³⁶ Or did other states instead better exert and increase their own sovereign power when they implemented the ACA themselves, typically making their own policy choices and passing state laws to do so? Regardless of the structural arrangement chosen, it is clear that states would have enacted far fewer healthcare-related laws—and been in control of far less health policy—had they been left out of the ACA entirely. In other words, constitutional federalism’s preference for formalist and exclusionary structural arrangements would not have served the values here that those arrangements are supposed to serve. States exerted power—leverage and checks on the federal government, in addition to control of policy—from within the statute, not from outside it.

In exploring all these topics, we build upon the recent wave of new federalism scholarship—work that has been occupied with mapping and explicating federalism across all subjects in an age of national power.³⁷ As we elaborate in Parts VI, our findings challenge areas of this research. Contrary to

34. See *infra* Part III.A.

35. See Louise Norris, *Oregon Health Insurance Marketplace: History and News of the State’s Exchange*, HEALTHINSURANCE.ORG (Jan. 5, 2018), <https://perma.cc/776P-P9UP> (“Oregon initially had a fully state-run exchange—Cover Oregon—but it was plagued with technological failures, and never worked as planned.”).

36. See *infra* Part V.

37. See, e.g., Jessica Bulman-Pozen, *Federalism as a Safeguard of the Separation of Powers*, 112 COLUM. L. REV. 459, 461 (2012) (arguing that states increasingly use cooperative federalism to challenge federal executive power and enforce federal statutes); Gluck, *supra* note 23, at 1998 (arguing that modern federalism is a “National Federalism” created by federal statutory design); Greve, *supra* note 2, at 34-35 (highlighting the United States and Argentina as examples of federal states increasingly using cooperative federalism); see also Ryan, *supra* note 5, at 1151-55 (situating environmental law in a theory of federalism that collapses national and federal); Ernest Young, William Howard Taft Lecture, *Federalism as a Constitutional Principle*, 83 U. CIN. L. REV. 1057, 1067, 1076-77 (2015) (describing the enumerated powers strategy of protecting federalism through constitutional law and advocating for the importance of political and sociological forces in supporting modern federalism).

what some new federalism scholars would argue, the ACA's federalism does more than serve nationalist ends. It also gives the states more power than the new federalism account allows. At the same time, the ACA's story demolishes the utility of the concept of cooperation in federalism, beloved by modern federalism scholars, because that concept illuminates nothing in this context. Indeed, it challenges even more broadly the very notion that any particular structural arrangement is required to produce most of the values we associate with federalism at all.

Finally, this Article also responds to a particular weakness of federalism scholarship in general by pausing to examine the deep details of the ACA's federalism in operation. As one of us has chronicled, federalism theory tends to be high on abstraction and low on concreteness.³⁸ Detailed exposition situated in both history and theory is wanting, and we hope to provide that here.

II. Healthcare Federalism, Old and New

From the time the ACA was introduced, debates about the law's desirability have been entangled with debates about American federalism. Politicians, commentators, and scholars alike have portrayed the ACA as a federal takeover, a uniquely nationalist intervention in the terrain of state health policy.³⁹ Others have incorrectly theorized about the ACA's structural arrangements as a new and unique violation of constitutional lines of division between states and the federal government in healthcare.⁴⁰

In fact, the ACA follows on a long history of national interventions into state health regulation, many with similar structural features to the ACA itself. And it is not the case that any of the recent proposals to repeal or replace the ACA would restore some erased constitutional dividing lines between state and federal. Indeed, each Republican proposal has kept intact the major federal

38. See Gluck, *supra* note 23, at 1998 (arguing that when it comes to federalism theory and doctrine, “[w]e are still muddling through”); see also Robert A. Schapiro, *Toward a Theory of Interactive Federalism*, 91 IOWA L. REV. 243, 285 (2005) (arguing that modern federalism lacks “rules of engagement”).

39. 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, 199 (2011) (arguing that the ACA “extend[s] and deepen[s] federal regulation of health insurance”); Richard A. Epstein, *Bleak Prospects: How Health Care Reform Has Failed in the United States*, 15 TEX. REV. L. & POL. 1, 10-11 (2010) (describing the ACA’s approach as “a profound transformation of how we think about the role of government”); Melinda Henneberger, *Frankly, It’s Bull---: Kathleen Sebelius Is Fighting Mad About Obamacare Attacks*, KAN. CITY STAR (updated Oct. 13, 2017, 7:49 PM), <https://perma.cc/QA4N-J86U> (“‘It’s just nonsense’ the way it’s been portrayed as a government takeover of health care, [Sebelius] said” (quoting Kathleen Sebelius, former U.S. Secretary of Health and Human Services)).

40. See *infra* Part II.C.

programs and laws (for example, Medicaid and Medicare) and massive federal subsidies (the most important example being the employer tax deduction for healthcare that helps to insure half of all Americans).⁴¹

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

Interestingly, and consistent with the story we tell about the ACA, neither federalism nor nationalism has ever been fully embraced in healthcare policy. When it comes to federalism, it was the case long before the ACA that classic federalism values such as states as “laborator[ies]” of “experiment[ation]”⁴² had often been effectuated in health policy not by traditional federalism (the preservation of separate spheres of state authority) but by nationalism (federal laws setting a baseline and inviting state participation with funding nudges).⁴³ States have been limited in what they can accomplish alone in healthcare experimentation.⁴⁴ Disincentives, such as industry exit, prevent a single state from bearing all of the costs of innovation risk that would arise if it were one of the few making costly regulatory demands.⁴⁵ Federal laws that allow for state experimentation *within federal law* often provide a steadier path toward

41. See *infra* Part II.C; see also JESSICA C. BARNETT & EDWARD R. BERCHICK, U.S. CENSUS BUREAU, U.S. DEP’T OF COMMERCE, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2016, at 3, 4 tbl.1 (2017), <https://perma.cc/98XQ-JFZW>; Jonathan Gruber, *The Tax Exclusion for Employer-Sponsored Health Insurance* 3-5 (Nat’l Bureau of Econ. Research, Working Paper No. 15,766, 2010), <https://perma.cc/54XP-DA7K>.

42. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting), abrogated by *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937).

43. See Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists’ Gamble*, 81 FORDHAM L. REV. 1749, 1750 (2013).

44. See Susan Rose-Ackerman, *Risk Taking and Reelection: Does Federalism Promote Innovation?*, 9 J. LEGAL STUD. 593, 594, 610-11 (1980) (analyzing the economic impacts of and lack of incentives for risky state experimentation); Rubin & Feeley, *supra* note 11, at 925-26 (noting that federal financial and organizational assistance aids states in overcoming the free-rider problem); David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541, 582-83 (2008) (describing states’ hesitation to experiment with welfare policies due to population mobility); see also Gluck, *supra* note 43, at 1764 (describing the ACA as a federal law incentivizing states to increase experimentation).

45. See Super, *supra* note 44, at 557.

experimentation.⁴⁶ The ACA offers a striking example: It was modeled on a major Massachusetts experiment, which the state undertook not alone but rather with federal permission and funds (largely from the Medicaid program).⁴⁷

On the other side, healthcare nationalism often is characterized as an oppressive interloper in state domains, and has been so characterized with respect to the ACA.⁴⁸ But history shows not only that states sometimes need federal intervention to make their own healthcare systems work—federal intervention typically comes in response to some state regulatory or market failure—but also that federal intervention, when it comes, tends to be focused and incremental. Although Congress has debated fuller-scale national programs⁴⁹ and has occasionally enacted laws that are sweeping (still never universal), it typically enacts compromise legislation that instills piecemeal or targeted federal reform.⁵⁰

This strategy in turn has prevented a complete vision of healthcare nationalism from being realized. Uniformity and equality of access to healthcare are still wanting, and fragmentation of the U.S. healthcare system remains a salient problem.⁵¹ Federal intervention has tended to be highly incremental and therefore incomplete. Take the ACA again as an example: Despite being a major federal intervention in health policy, the ACA perpetuated and entrenched the fragmentation of U.S. healthcare by expanding the various and very differently structured healthcare programs already in existence—some state-led, some federal, some mixed—rather than starting fresh with a single, integrated approach.⁵²

46. See Gluck, *supra* note 43, at 1764; Rubin & Feeley, *supra* note 11, at 925-26.

47. See Ryan Lizza, *Romney's Dilemma*, NEW YORKER (June 6, 2011), <https://perma.cc/3WXQ-T9WK> (detailing how Massachusetts's health reform was made possible by a Bush Administration Medicaid waiver).

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

49. See generally, e.g., The Henry J. Kaiser Family Found., *National Health Insurance—A Brief History of Reform Efforts in the U.S.* (2009), <https://perma.cc/2H68-4ZWB> (summarizing the healthcare reform movements and failures of the twentieth century in anticipation of the then-nascent Obama Administration's effort).

50. See, e.g., Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-178, 117 Stat. 2066 (codified as amended in scattered sections of the U.S. Code) (adding prescription drug coverage to Medicare only); Emergency Medical Treatment and Labor Act, Pub. L. No. 99-272, § 9121(b), 100 Stat. 82, 164-67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2016)) (requiring only emergency medical treatment in hospitals).

51. See Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, in THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 1, 9-15 (Einer R. Elhauge ed., 2010).

52. See *infra* Part III.A.

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

A. An Abbreviated History of Federal Interventions in Healthcare

During the colonial era and beyond the Revolutionary War, medical care was the domain of state and local governments when not being addressed by private charities. But even in the early days of the republic, the federal government established payments for veterans' war injuries and, later, hospitals for veterans' care (as well as for merchant seamen).⁵³ A series of federal laws offered increasing responses to states' inability to provide for veterans, whose medical needs became even more pressing after the Civil War.⁵⁴ Ultimately, veterans' healthcare was fully federalized; Congress created the U.S. Veterans Bureau in 1921 to provide medical care for battle-injured World War I veterans; later, the Veterans Administration covered all medical care for veterans.⁵⁵ The same year, Congress passed the Sheppard-Towner Maternity and Infancy Act of 1921, which for the first time put the federal government into the area of health and the family by providing states with funds for prenatal and newborn care.⁵⁶

The turn-of-the-century industrialization, and later the Great Depression, World Wars I and II, and an influx of the war-wounded illuminated the states' inability to handle the relatively new phenomenon of medical policy or payment alone.⁵⁷ Although wealthier states were able to increase spending to

53. See TIMOTHY STOLTZFUS JOST, *DISSENTLEMENT?: THE THREAT FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 77 (2003) (tracing various early federal payments for healthcare, including those for veterans and merchant seamen); BARBARA MCCLURE, CONG. RESEARCH SERV., NO. 83-99 EPW, *MEDICAL CARE PROGRAMS OF THE VETERANS ADMINISTRATION* 1-4 (1983) (tracing the history of healthcare programs for veterans); JUDITH RESNIK & DENNIS CURTIS, *REPRESENTING JUSTICE: INVENTION, CONTROVERSY, AND RIGHTS IN CITY-STATES AND DEMOCRATIC COURTROOMS* 140-43 (2011) (noting that federal hospitals were among the few existing federal buildings prior to 1850). In 1811, Congress deducted a portion of naval sailors' pay to care for war veterans' injuries; in 1833, Congress opened a home for disabled naval officers, seamen, and marines; and in 1851, Congress established a home for disabled soldiers. See MCCLURE, *supra*, at 1-2.

54. See H. COMM. ON VETERANS' AFFAIRS, 90TH CONG., *MEDICAL CARE OF VETERANS* 30, 59-62 (Comm. Print 1967).

55. See MCCLURE, *supra* note 53, at 2-3.

56. See Pub. L. No. 67-97, 42 Stat. 224 (repealed 1929); *Historical Highlights: The Sheppard-Towner Maternity and Infancy Act*, HIST. ART & ARCHIVES, <https://perma.cc/PG4L-MFDG> (archived Apr. 25, 2018). Thanks to Rick Hills for this insight.

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

pay for their swelling medically needy populations, most other states had no means to add healthcare to the list of welfare programs they already supported, so states sought federal funding to care for the indigent.⁵⁸ President Roosevelt considered but did not include healthcare in the Social Security Act of 1935, and an attempt to include it again during World War II failed but was followed closely by Senator Wagner's proposed National Health Act of 1939, which would have directed federal funds through state administration.⁵⁹ President Truman likewise attempted to achieve national health coverage, but fears of "socialized medicine" proved then, as they have continued to be, an insurmountable obstacle to universal, nationalized reform.⁶⁰ After Truman's national health program was rejected, Congress took the smaller step of encouraging the construction of hospitals where medical needs were unmet through the Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Act.⁶¹ In return for this federal funding, new Hill-Burton hospitals had to provide care to low-income individuals, formalizing so-called charity care.⁶²

During this period, developments in the courts confirmed that healthcare could largely be handled—as a matter of law—as a national, rather than a state or local, problem. In 1944, the U.S. Supreme Court ruled that insurance was national commerce and could be regulated by Congress as such.⁶³ But Congress,

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

59. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 266-70, 275-77* (1982); see also Social Security Act, Pub. L. No. 74-271, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. §§ 301-1397mm (2016)); National Health Act of 1939, S. 1620, 76th Cong. One contemporaneous scholar described Senator Wagner's bill as "merely another step, albeit a long step, in the orderly development of existing federal health work, while the federal grants for medical care, and the disability compensation program, cannot be thought of as radical innovations, for they, too, have a broad body of precedent." Harold Maslow, *The Background of the Wagner National Health Bill*, 6 LAW & CONTEMP. PROBS. 606, 618 (1939).

60. See Special Message to the Congress Recommending a Comprehensive Health Program, PUB. PAPERS 475, 477, 488 (Nov. 19, 1945). In addition, opposition to national health insurance and other national benefits was rooted in part in racism because southern states were fearful that the federal government would use national health programs as a mechanism for desegregation. See DAVID G. SMITH & JUDITH D. MOORE, *MEDICAID POLITICS AND POLICY, 1965-2007*, at 8-10 (2008). In addition, the American Medical Association fought national health programs as "socialized" medicine. See *id.* at 25. The *Journal of the American Medical Association* went so far as to call President Truman's proposal an "attempt to enslave medicine." *Id.*

61. See Pub. L. No. 79-725, 60 Stat. 1040 (codified as amended at 42 U.S.C. § 209).

62. *Id.* sec. 2, § 622(f), 60 Stat. at 1043.

63. See *United States v. Se. Underwriters Ass'n*, 322 U.S. 533, 552-53 (1944).

in a moment unappreciated by most federalism scholars (especially those unwilling to recognize the concept of federalism as a congressional *option*), voluntarily gave that power back to the states with the passage of the McCarran-Ferguson Act of 1945.⁶⁴ That statute created a presumption that regulation of insurance remains with the states unless Congress explicitly declares otherwise (as it did in the ACA).⁶⁵

Concomitantly, the National War Labor Board was formed in 1942 and later ruled that World War II-related wage controls did not apply to fringe benefits such as pensions and insurance within certain limits, and a few years later, the National Labor Relations Board upheld unions' engagement in collective bargaining for benefits such as health insurance.⁶⁶ Such federal policies helped employers offer greater benefits to much-needed war-effort employees, as did an Internal Revenue Service (IRS) ruling in 1943 that employer-based healthcare would not be taxable income for the employee.⁶⁷ Labor unions used this valuable benefit as a bargaining tool throughout the late 1940s and into the 1950s, and the IRS further pushed the trend by ruling in 1954 that employer-sponsored health insurance was not taxable to employees or employers.⁶⁸

This significant series of interventions in private health insurance, as one of us has previously written, has turned out to be one of the most overlooked and underappreciated federal interventions in the typically state-based terrain of health insurance.⁶⁹ Modern policy experts who oppose the "socialization" of medicine (especially when it comes to healthcare for the poor) rarely acknowledge the more than \$200 billion each year that the federal government spent long before the ACA to subsidize the health insurance of working Americans.⁷⁰ Employer-sponsored health insurance benefits are still the source

64. See Pub. L. No. 79-15, 59 Stat. 33 (codified as amended at 15 U.S.C. §§ 1011-1015 (2016)).

65. See *id.* §§ 1-2, 59 Stat. at 33-34.

66. See COMM. ON EMP'R-BASED HEALTH BENEFITS, INST. OF MED., EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 70-71 (Marilyn J. Field & Harold T. Shapiro eds., 1993); JOST, *supra* note 53, at 77-80; TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 60 (2007) [hereinafter JOST, HEALTH CARE AT RISK].

67. See JOST, *supra* note 53, at 77-79.

68. See *id.* at 79 (discussing the 1954 IRS ruling's role); STARR, *supra* note 59, at 311-13 (discussing unions' role). For a thorough discussion of the role of labor unions in the growth of employer-sponsored health insurance, see JOST, HEALTH CARE AT RISK, *supra* note 66, at 62-64.

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

70. See *id.* at 18 (noting that the Congressional Budget Office valued these tax subsidies at \$248 billion as of 2013 even though this form of spending is "rarely discussed as such").

of health insurance coverage for about 56% of the U.S. population today,⁷¹ rendering this tax subsidy—for the wealthier, non-Medicaid population, no less—a major ongoing federal intervention.

Ongoing medical access failures led Congress to enact the Social Security Act Amendments of 1950, which provided federal grants-in-aid to states in the form of vendor payments—capped payments for specific services such as hospital, skilled nursing, and physician care.⁷² The legislation delegated payment delivery to states, allowing states and localities to vary widely in their use of the funding.⁷³ Even though vendor payments offered cost-shifting to the federal government while reinforcing the state role in medical services, many states resisted participating, in part because vendor payments were available only for individuals receiving welfare benefits. But increased federal funding improved participation over time.⁷⁴ With medical care tied to welfare administration, stigmatization of the medically needy population was virtually automatic.⁷⁵

Congress's next notable intervention was the Kerr-Mills program included in the Social Security Amendments of 1960, which offered the states additional money and included funding for elderly people who were “medically indigent” at a matching rate rather than a capped allocation.⁷⁶ Kerr-Mills continued the connection between welfare and medical payments for nonelderly indigent individuals, allowing states to determine eligibility and coverage.⁷⁷ In sum, Kerr-Mills offered incremental reform with more federal money and some federal standard setting, staving off grander federal intervention while preserving states' role in healthcare.⁷⁸ States were in a slightly better economic position for the existence of Kerr-Mills, but wide variation in state implementation led to confusion, inconsistencies and disparities in coverage and care, and state cost-shifting to the federal government in ways unintended

71. BARNETT & BERCHICK, *supra* note 41, at 4 tbl.1.

72. See Pub. L. No. 81-734, tit. III, 64 Stat. 477, 548-58 (codified as amended in scattered sections of 42 U.S.C.); see also STEVENS & STEVENS, *supra* note 57, at 23-24.

73. See STEVENS & STEVENS, *supra* note 57, at 23-24 (describing state “variations” in implementing vendor payments).

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

75. See SMITH & MOORE, *supra* note 60, at 30.

76. See Moore & Smith, *supra* note 74, at 46 (“A most important innovation in the Kerr-Mills Act was to extend medical benefits to a new category generally known as the medically indigent . . .”); see also Social Security Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924 (codified as amended in scattered sections of the U.S. Code).

77. See SMITH & MOORE, *supra* note 60, at 30-31.

78. See Huberfeld, *supra* note 58, at 443-44.

by the law.⁷⁹ Further, even though wealthier and heavily industrialized states were eager to take advantage of federal funds—California, Massachusetts, and New York accounted for more than half of enrollees in the program’s first year—many poorer states were reluctant to participate.⁸⁰

Poor states needed more funding for healthcare, but some did not have the necessary matching funds of their own to afford the federal assistance.⁸¹ Many of these states—especially in the South—also had particular anxieties about federal intervention in areas involving both the family and minority populations.⁸² This led those states to resist federal funding outright or to allow only limited participation⁸³ and, as with later federal reforms, to insist

79. See SUBCOMM. ON HEALTH OF THE ELDERLY, S. SPEC. COMM. ON AGING, 88TH CONG., MEDICAL ASSISTANCE FOR THE AGED: THE KERR-MILLS PROGRAM, 1960-1963, at 1-2 (Comm. Print 1963) (giving a harsh assessment shortly after Kerr-Mills’s enactment of the program’s failure to assist the elderly).

80. See Moore & Smith, *supra* note 74, at 46-47.

81. See *id.* (noting that poorer states were stingy with welfare, which carried over to medical welfare); see also STARR, *supra* note 59, at 368-70 (laying out historical developments before Medicaid and noting that the most industrialized states were most likely to participate in federal funding).

82. See Timothy Stoltzfus Jost, Remarks at the Yale Law School Conference on the Law of Medicare and Medicaid at 50, at 6-7 (Nov. 7, 2014) (transcript on file with authors) (detailing racist motivations for southern states to resist Medicaid’s public health insurance for the poor at its inception and throughout Medicaid’s history). Opposition to national health insurance and other national benefits was rooted in part in racism and the southern drive for cheap agricultural labor; southern states feared that the federal government would use national health programs as a tool for desegregation. See SMITH & MOORE, *supra* note 60, at 6-7. In fact, Medicaid’s devolution to states to determine eligibility and benefit levels can be directly traced to Senator Byrd’s efforts to defeat any possible federal interjection into “the Negro question.” See *id.* at 10 (quoting EDWIN E. WITTE, THE DEVELOPMENT OF THE SOCIAL SECURITY ACT 144 (1962)). And part of the reason Medicaid contains the very specific Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement of “a comprehensive unclothed physical exam,” see 42 U.S.C. § 1396d(r)(1)(B)(ii) (2016), is that southern doctors would not have touched black children without a federal rule telling them otherwise. When the Reagan Administration tried to remove this standard in 1981, the director of EPSDT from Mississippi’s Medicaid agency demanded that it remain for fear that “doctors [would] stop taking clothes off Black children to examine them.” See Attachment to Email from Sara Rosenbaum, Harold & Jane Hirsh Professor of Health Law & Policy, George Washington Univ. Sch. of Pub. Health, to Nicole Huberfeld, Professor of Health Law, Ethics & Human Rights, Bos. Univ. Sch. of Pub. Health & Sch. of Law (Aug. 25, 2017, 2:08 PM EDT) (on file with authors); see also Medicaid Requirements for State Programs of Early and Periodic Screening, Diagnosis, and Treatment of Individuals Under 21, 44 Fed. Reg. 29,420 (May 18, 1979) (codified as amended at 42 C.F.R. §§ 441.50-.62 (2017)) (formalizing EPSDT guidance into regulations).

83. See SMITH & MOORE, *supra* note 60, at 40 (noting that states in the South, the Southwest, and those with “rural or sparsely populated areas” were holdouts). After five years, ten states still had not implemented Kerr-Mills; three of those states had authorized use of federal funds but did not allocate state funds necessary to trigger the federal match. See Moore & Smith, *supra* note 74, at 47.

on structures that gave states control over their minority populations. This combination of distrust, conservative values, and racism also led states to demand a continued role for themselves in managing the federal distributions and preserving the political economy of the region.⁸⁴ It further allowed for less aggressive implementation by some states less eager to assist minority populations,⁸⁵ entrenching interstate coverage disparities.

By the early 1960s, it was clear more help was needed beyond existing state assistance for needy populations. First introduced by President Kennedy, and enacted as part of the Johnson Administration's War on Poverty in 1965, Medicare offered a radically different approach with a fully nationalized program for all elderly people designed to offer what was then comprehensive health insurance (hospital and physician care, not just one or the other).⁸⁶ It was to be funded and administered entirely by the federal government with no role preserved for states.⁸⁷ This shift to a totally federalized scheme resulted in part from successful lobbying by the elderly, who did not want their access to medical care to fluctuate depending on the economic whims and welfare biases of the states.⁸⁸ But also, Medicare was enacted as a federal program because states did not want to be responsible for elderly people's medical needs, evidenced in part by states' slow uptake of prior programs.⁸⁹

The push for nationalization did not extend to the nonelderly poor.⁹⁰ Although Medicaid was enacted with the same pen stroke as Medicare, Medicaid was structured differently, offering federal funding and statutory baselines while continuing shared state financing and a state-driven, welfare-based approach to healthcare that encoded a philosophy of aiding only the "deserving poor" (such as the blind, disabled, young children, and their

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

85. See *id.* at 75-77.

86. See STEVENS & STEVENS, *supra* note 57, at 46-49.

87. See *id.* at 48-51. For the current codification of Medicare, see 42 U.S.C. §§ 1395-1395lll.

88. See STEVENS & STEVENS, *supra* note 57, at 45-46.

89. See SMITH & MOORE, *supra* note 60, at 41 (noting that "many states were too poor or unwilling . . . to put up the matching funds" for Old Age Assistance and other medical welfare programs that predated Medicare); STEVENS & STEVENS, *supra* note 57, at 30-33 (arguing that although Kerr-Mills was a way to "shift[] the burden of [aid to the elderly] from others to the federal government," "the states responded slowly to the new program").

90. Medicare and Medicaid have always been linked for poor elderly who cannot pay out-of-pocket costs. STEVENS & STEVENS, *supra* note 57, at 49, 52. Thanks to Sara Rosenbaum for this insight.

parents)⁹¹—and keeping state control over those populations—that continued until the ACA.⁹² Thus, the distinction between social insurance and welfare that was encoded in the first Social Security Act was carried through into the statutory principles that underlie the differences between Medicare and Medicaid.⁹³

Medicare has been modified from time to time, for example to cover people with long-term disability in 1972⁹⁴ and to add a major drug benefit in 2003,⁹⁵ but it tends to avoid the same kind of frequent tinkering seen elsewhere in healthcare law. On the other hand, Medicaid has seen much more significant modification over time, often reflecting the larger pattern of federal incremental intervention where state governance is failing. For example, Medicaid has been amended to increase coverage categories and financial eligibility levels over time. In the 1980s, for instance, eligibility was expanded to cover all financially eligible children up to age eighteen and to increase the levels of financial eligibility for children younger than six.⁹⁶ And in 1989, the singular Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit (which ensures uniform, comprehensive medical benefits for children) was made mandatory for states.⁹⁷ In each instance, the federal government was stepping in where states failed to serve certain populations' medical needs. Medicaid was decoupled from welfare in the 1990s after President Clinton's healthcare reform failed and the Gingrich plan for block grants was defeated—a legislative change that unenrolled vulnerable people but that also set the stage

91. See Huberfeld, *supra* note 58, at 436-46; see also Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 26 and 42 U.S.C.) (enacting Medicare and Medicaid).

92. See Jost, *supra* note 82, at 1, 6-8 (discussing this progression and the link between state control of healthcare and continued limitations on serving all poor people).

93. See *id.* at 1, 5. For further discussion of the historically exclusionary approach to U.S. healthcare, see Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y L. & ETHICS 67 (2015).

94. See Social Security Amendments of 1972, Pub. L. No. 92-603, § 201(a)(3), 86 Stat. 1329, 1371 (codified as amended at 42 U.S.C. § 1395j (2016)); 42 C.F.R. § 406.5 (2017).

95. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101(a)(2), 117 Stat. 2066, 2071-150 (codified as amended at 42 U.S.C. §§ 1395w-101 to -154).

96. See SMITH & MOORE, *supra* note 60, at 133-36 (2d ed. 2015); Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 20-24 (2013) (detailing amendments to Medicaid that expanded eligibility, such as for pregnant women and children).

97. See S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 589-90 (5th Cir. 2004). The benefit had been optional since 1967. See *id.* at 589. Congress realized that states were bypassing the optional EPSDT benefit and created a highly detailed list of rules for screening children regularly. See *id.* at 589-90; see also 42 U.S.C. § 1396d(r) (defining the current EPSDT benefit).

for the ACA's expansion to all of the nation's poor in 2010.⁹⁸ Further, Medicaid both laid a foundation and acted as a foil for the creation in 1997 of the State Children's Health Insurance Program (then SCHIP, now CHIP), a federal block grant that allows states to subsidize coverage for children at higher financial eligibility levels than does Medicaid, after the Clinton health plan failed to create comprehensive coverage in 1994.⁹⁹

Every President from Franklin D. Roosevelt to Barack Obama tried to expand or improve healthcare access.¹⁰⁰ After Medicare and Medicaid, in the early 1970s, President Nixon promoted a new format for private insurance that was modeled on organizations like Kaiser Permanente.¹⁰¹ Nixon's Health Maintenance Organization Act of 1973 preempted conflicting state laws and offered funding to support the creation of health maintenance organizations, commonly known as HMOs.¹⁰² The Employee Retirement Income Security Act (ERISA) of 1974 was also negotiated by the Nixon Administration.¹⁰³ Although primarily conceived as a federal floor of rules addressing the problem of failed pensions, ERISA effectively (and mostly accidentally) nationalized the rules for a wide swath of health plans—those provided by employers who self-insure employee health benefits—immunizing them from

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98. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of the U.S. Code) (creating the Temporary Assistance for Needy Families program).
99. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901(a), 111 Stat. 251, 552-70 (codified as amended at 42 U.S.C. §§ 1397aa-1397mm). See generally Sara Rosenbaum et al., *The Children's Hour: The State Children's Health Insurance Program*, HEALTH AFF., Jan./Feb. 1998, at 75 (discussing features of CHIP).
100. See DAVID BLUMENTHAL & JAMES A. MORONE, *THE HEART OF POWER: HEALTH AND POLITICS IN THE OVAL OFFICE* 1-20 (2010); cf. PAUL STARR, *REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM* 4 (2011) [hereinafter STARR, *REMEDY AND REACTION*] (noting a century of effort in health reform, starting with Teddy Roosevelt's failed social insurance plan). See generally STARR, *supra* note 59, at 235-449 (describing the history of efforts in U.S. healthcare reform). President Trump campaigned on a universal access platform, see, e.g., Aaron Blake, *Trump's Forbidden Love: Single-Payer Health Care*, WASH. POST: THE FIX (May 5, 2017), <https://perma.cc/E8B9-EWDR> ("Everybody's got to be covered." (quoting Donald Trump's statement on *60 Minutes: Trump* (CBS television broadcast Sept. 27, 2015))), but quickly moved to undermine the ACA and repeal many of its most generous provisions, see, e.g., Robert Pear et al., *Trump to Scrap Critical Health Care Subsidies, Hitting Obamacare Again*, N.Y. TIMES (Oct. 12, 2017), <https://perma.cc/U7QD-VQFC>.
101. See STARR, *supra* note 59, at 394-405. President Obama embraced this format in the ACA. See Phil Galewitz, *Nixon's HMOs Hold Lessons for Obama's ACOs*, KAISER HEALTH NEWS (Oct. 21, 2011), <https://perma.cc/N3TR-QB75>.
102. See Pub. L. No. 93-222, 87 Stat. 914 (codified as amended in scattered sections of 12 and 42 U.S.C.); Marjorie Smith Mueller, *Health Maintenance Organization Act of 1973*, SOC. SECURITY BULL., Mar. 1974, at 35, 35, 38.
103. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of the U.S. Code).

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state regulations.¹⁰⁴ ERISA has remained a major obstacle to state-based health policy reform.¹⁰⁵

In the 1980s, Congress further expanded the federal baseline by enacting two important budget laws that transformed, in an effort to increase uniformity, Medicare physician payments¹⁰⁶ and the continuation of employer-sponsored health coverage at the termination of employment.¹⁰⁷ The second of these laws also contained a provision that prevents patient dumping and requires hospitals to treat patients who present with an emergency medical condition, commonly called the Emergency Medical Treatment and Labor Act (EMTALA).¹⁰⁸ President Reagan supported these federal interventions in traditionally state-based healthcare.¹⁰⁹

After the Clinton health reform effort of 1993 failed, prominent academics argued that states would have to take up the mantle of health reform.¹¹⁰ That largely did not occur. Instead, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 next addressed ongoing private insurance

104. See Randall R. Bovbjerg, *Alternative Models of Federalism: Health Insurance Regulation and Patient Protection Laws*, in *FEDERALISM & HEALTH POLICY*, *supra* note 15, at 361, 365 (describing ERISA's increased preemptive sweep as more employers turned to self-funded health benefits); Abbe R. Gluck et al., *ERISA: A Bipartisan Problem for the ACA and the AHCA*, HEALTH AFF. BLOG (June 2, 2017), <https://perma.cc/WN67-HZHM> (explaining that the Congress that passed ERISA did not foresee its major impact on healthcare and detailing impediments to state reform caused by the statute's reach).

105. See Gluck et al., *supra* note 104; see also, e.g., *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 940-41, 947 (2016) (holding that ERISA preempts Vermont's state all-payer claims database).

106. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6104, 103 Stat. 2106, 2208-09 (codified as amended at 42 U.S.C. § 1395u (2016)) (replacing the "reasonable charge" method of reimbursing physicians in Medicare with a relative value scale method of payment).

107. See Consolidated Omnibus Budget Reconciliation Act, Pub. L. No. 99-272, § 10002(a), 100 Stat. 82, 227-31 (1986) (codified as amended at 29 U.S.C. §§ 1161-1168 (2016)).

108. See *id.* § 9121(b), 100 Stat. at 164-67 (codified as amended at 42 U.S.C. § 1395dd).

109. See, e.g., Henry Olsen, *Reagan's Real Legacy: A Reply to Donald Devine*, NAT'L REV. (Nov. 10, 2014, 12:00 PM), <https://perma.cc/4XR7-PAZD> (noting that Reagan's signature on the Consolidated Omnibus Budget Reconciliation Act (COBRA) legislation that made EMTALA law was consistent with other views he held on healthcare). The finances of COBRA and EMTALA were consistent with President Reagan's desire to prevent any additional taxing or spending by the federal government. To wit: COBRA's cost was borne by a departed employee, who could be asked to pay up to 102% of the employer's cost of providing health insurance. See Consolidated Omnibus Budget Reconciliation Act sec. 10002(a), § 602(3), 100 Stat. at 228 (codified as amended at 29 U.S.C. § 1162(3)). EMTALA's cost was borne by hospitals accepting Medicare as reimbursement for services but was not separately or specifically funded. See *id.* § 9121(b), 100 Stat. at 164-67.

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

market failures.¹¹¹ HIPAA facilitated credit for insurance coverage when an employee moved from one job to another within a short period of time, offered incentives for creating medical savings accounts to try to address the continually growing problem of uninsurance, and facilitated the growth of high-risk pools in the states.¹¹² HIPAA did not preempt state laws regarding health insurance so long as they met the federal baseline of facilitating continued coverage for preexisting conditions, thereby allowing states to continue in their historic role of regulating insurance but with federal statutory guiderails.¹¹³ A number of the ACA's reforms are in fact amendments to these predecessor federal interventions, including ERISA and HIPAA, and in part respond to perceived failures in those statutes to improve healthcare markets and the difficulties for those with preexisting conditions.¹¹⁴

In 2003, Congress enacted the most noteworthy benefit amendment to Medicare since its creation—a prescription drug benefit, supported by the second President Bush.¹¹⁵ A few years later, the Health Information Technology for Economic and Clinical Health (HITECH) Act implemented a part of HIPAA pertaining to electronic health records by setting federal standards and offering grants to states for improved electronic records.¹¹⁶

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

112. *See id.* sec. 101(a), § 701, 110 Stat. at 1939-45 (codified as amended at 29 U.S.C. § 1181) (credit for coverage); *id.* sec. 102(a), § 2701, 110 Stat. at 1955-61 (codified as amended at 42 U.S.C. § 300gg-3) (credit for coverage); *id.* sec. 111(a), § 2744, 110 Stat. at 1984-86 (codified as amended at 42 U.S.C. § 300gg-44) (high-risk pools); JOST, *supra* note 53, at 188-89 (discussing some of HIPAA's features, including its interaction with employer-sponsored health insurance and attempts at regulating failing small-group markets).

113. *See* Bovbjerg, *supra* note 104, at 367 (describing HIPAA's structure).

114. *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1104, 124 Stat. 119, 146-54 (2010) (codified as amended at 42 U.S.C. §§ 1320d, 1320d-2, 1395y) (amending HIPAA); *id.* § 1562(e), 124 Stat. at 270 (codified at 29 U.S.C. § 1185d) (amending ERISA); *see also id.* sec. 1561, § 3021 (codified as amended at 42 U.S.C. § 300jj-51) (amending the Public Health Service Act, Pub. L. No. 78-410, 58 Stat. 682 (1944) (codified as amended at 42 U.S.C. §§ 201 to 300mm-61), to address health information technology).

115. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101(a)(2), 117 Stat. 2066, 2071-150 (codified as amended at 42 U.S.C. §§ 1395w-101 to -154); *Bush Signs Landmark Medicare Bill Into Law*, CNN (Dec. 8, 2003, 1:23 PM EST), <https://perma.cc/JKF8-64FP>.

116. *See* Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, div. A, tit. XIII, sec. 13101, § 3001, 123 Stat. 115, 230-34 (2009) (codified as amended at 42 U.S.C. § 300jj-11) (establishing the Office of the National Coordinator for Health Information Technology); *id.* sec. 13301, § 3013, 123 Stat. at 250-52 (codified at 42 U.S.C. § 300jj-33) (establishing standards for grants to states); Nicolas P. Terry, *Certification and Meaningful Use: Reframing Adoption of Electronic Health Records as a Quality Imperative*, 8 IND. HEALTH L. REV. 43, 46-49 (2011) [hereinafter Terry, *Certification and Meaningful Use*] (discussing the history of HITECH and its amendment of prior law); Nicolas P. Terry, *To HIPAA, a Son: Assessing the Technical, Conceptual, and Legal* footnote continued on next page

Promoting electronic records was long a priority of the second President Bush, and the HITECH Act was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009 at the beginning of the Obama Administration.¹¹⁷ The ARRA also included increased federal funding for Medicaid to help states overcome increased enrollment related to the Great Recession.¹¹⁸

This is a long history, and it does not even include the parallel development of federal intervention in and regulation of the terrain of pharmaceutical innovation and approval.¹¹⁹ Notably, although certain healthcare reform ideas tend to be floated from the right or the left, this history is not nearly as politicized as common understanding would have it. To be sure, Democrats supported programs such as the Social Security Act, Medicare, Medicaid, and the ACA, but Republicans supported the Health Maintenance Organization Act, ERISA, the Consolidated Omnibus Budget Reconciliation Act (COBRA), EMTALA, CHIP, and Medicare Part D. Pressure for healthcare intervention occurs on nearly every Congress's watch.

B. Patterns of National Intervention

Some notable patterns appear. First, the states' consistent need for federal support in times of economic stress underscores the importance of countercyclical spending in making some federal intervention almost inevitable.¹²⁰ During a recession, unemployment increases and health insurance coverage decreases, but income taxes decline at the same time, leading states to lose funding at the moment their citizenry most needs governmental support.¹²¹ Most state constitutions require balanced budgets,¹²² so states seek federal money to fill their gaps because the federal government can engage in deficit spending and respond to states' needs.

Frameworks for Patient Safety Information, 12 WIDENER L. REV. 133, 133 (2005) (discussing HIPAA's provisions regarding electronic records).

117. See Health Information Technology for Economic and Clinical Health Act § 13001(a), 123 Stat. at 226 (noting that the HITECH Act comprises two titles of the ARRA); Terry, *Certification and Meaningful Use*, *supra* note 116, at 48 (describing President Bush's drive to improve electronic records).

118. See American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5000(a), 123 Stat. 115, 496 (codified at 42 U.S.C. § 1396a app. at 3571-72).

119. See generally *Milestones in U.S. Food and Drug Law History*, U.S. FOOD & DRUG ADMIN., <https://perma.cc/V6EW-ML9N> (last updated Feb. 1, 2018) (detailing federal statutes regulating food, drugs, cosmetics, and devices since the nineteenth century).

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

121. See *id.* at 2629-39.

122. See Nat'l Conference of State Legislatures, NCSL Fiscal Brief: State Balanced Budget Provisions 4 (2010), <https://perma.cc/3X7C-MVHJ>; *id.* app. at 11-12.

Second, the same states do the same things over and over again.¹²³ Southern states and states with limited resources hold out; wealthier states like California, Massachusetts, and New York spend on social welfare programming while maximizing available federal money.¹²⁴ Discrimination based on race and class continues due to persistent echoes of welfare policy and stigmatization of the poor in healthcare reform efforts.¹²⁵ Even today, for example, we hear echoes of this history in calls to remove the so-called “able bodied” from Medicaid eligibility or to add work requirements when they are enrolled—even though most Medicaid-eligible households do contain workers.¹²⁶ The ACA rejected such castigatory thinking,¹²⁷ but new proposals aim to introduce work requirements and are being approved as this Article goes to print.¹²⁸

Third, most federal interventions have been incremental and fragmented. This is a key place where federalism and health policy intersect. Political scientists have consistently demonstrated that Congress legislates across all areas (not just healthcare) in piecemeal fashion.¹²⁹ Many reasons exist for policy incrementalism, including the numerous barriers to lawmaking of any sort in Congress and the difficulty of attaining consensus in a polity as diverse

123. See Huberfeld, *supra* note 58, at 436-49 (discussing path dependence in healthcare policy, especially in Medicaid).

124. For a fuller description of this phenomenon in the context of the Kerr-Mills regime, see notes 76-93 and accompanying text above.

125. See generally Huberfeld & Roberts, *supra* note 69, at 41-59 (discussing how, under the ACA as implemented, people who need public health insurance are subjected to “self-reliance scrutiny” while people who receive subsidies for purchasing private insurance are not).

126. See, e.g., Rachel Garfield et al., The Henry J. Kaiser Family Found., *Understanding the Intersection of Medicaid and Work 1-3* (2018), <https://perma.cc/KPV7-Z28J>; see also Phil Galewitz, *Medicaid Chief Says Feds Are Willing to Approve Work Requirements*, KAISER HEALTH NEWS (updated Nov. 7, 2017, 3:20 PM), <https://perma.cc/8RRB-2CMM>. The Centers for Medicare & Medicaid Services issued guidance for states interested in adding work requirements shortly before this Article went to print. See Letter from Brian Neale, Dir., Ctr. for Medicaid & CHIP Servs., U.S. Dep’t of Health & Human Servs., to State Medicaid Director (Jan. 11, 2018), <https://perma.cc/S246-FMN5>.

127. See Huberfeld, *supra* note 93, at 67-68 (contrasting the universality principle of the ACA with exclusionary practices in healthcare laws that predated it).

128. See Huberfeld & Roberts, *supra* note 69, at 5-6; Garfield et al., *supra* note 126, at 4 (discussing proposed work requirements); see also, e.g., Letter from Demetrios L. Kouzoukas, Principal Deputy Adm’r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., to Stephen P. Miller, Comm’r, Ky. Cabinet for Health & Family Servs. 1-2 (Jan. 12, 2018), <https://perma.cc/X57W-NQMV> (approving Kentucky’s application for a section 1115 waiver with work requirements for newly eligible beneficiaries).

129. For the classic statement of this point, see Charles E. Lindblom, *The Science of “Muddling Through,”* 19 PUB. ADMIN. REV. 79 (1959).

and populous as ours.¹³⁰ But as one of us has argued, a link exists between Congress's tendency toward policy incrementalism and the design of federal statutes that rely on state administration.¹³¹ The historical backdrop of state social policy regulation creates both political and pragmatic incentives for Congress to rely on, rather than to displace, the embedded state administrative apparatus.¹³² As a political matter, federalism-related concerns about big government and respect for traditional areas of state authority lead Congress to design federal schemes that give states large roles in administration.¹³³ Politically, it seems like less of a displacement, and like less of an expansion of government, to structure federal programs this way.¹³⁴ Pragmatically, in addition to the lack of sufficient federal personnel, established state bureaucracies provide ready experts to implement new federal legislation.¹³⁵

The result in healthcare is a policy design that has been criticized for being structurally fragmented in multiple ways.¹³⁶ All the federal interventions discussed above have different structures. The Veterans Health Administration is structured differently from Medicare, even though both are purely national programs;¹³⁷ Medicaid's state-federal partnership is uniquely structured in its open-ended match for state spending,¹³⁸ and block grants to states in programs such as HITECH, CHIP, and the ACA's exchanges are each differently designed.¹³⁹ A huge chunk of the private insurance market rests on the

130. *See id.* at 84-85.

131. *See* Gluck, *supra* note 1, at 572-74.

132. *See id.* at 572-73.

133. *See id.*

134. *See id.*

135. *See id.* at 572.

136. *See, e.g.,* Elhauge, *supra* note 51, at 1-10.

137. *See About VHA*, U.S. DEP'T VETERANS AFF., <https://perma.cc/9JRN-TUG9> (archived May 15, 2018) (describing the kinds of medical providers and facilities run by the Veterans Health Administration). Medicare offers financing but not facilities or special providers. *See Health Care Insurance*, U.S. DEP'T VETERANS AFF., <https://perma.cc/Q3ZG-F24F> (archived May 15, 2018) (noting that Veterans Affairs benefits are not a form of health insurance but that Medicare is); *see also* The Henry J. Kaiser Family Found., *An Overview of Medicare 5* (2017), <https://perma.cc/9QF4-MVBP> (describing Medicare's financing).

138. *See* 42 U.S.C. § 1396-1 (2016); *see also* Laura Snyder & Robin Rudowitz, The Henry J. Kaiser Family Found., *Medicaid Financing: How Does It Work and What Are the Implications?* 1 (2015), <https://perma.cc/AC9P-Z6PC> (explaining Medicaid's funding structure).

139. *Compare* 42 U.S.C. § 300jj-31 (providing HITECH funding for healthcare entities), *with id.* § 300jj-33 (offering grants to states to develop health information technology), *and id.* §§ 1397aa, 1397dd (establishing CHIP as a federal block grant offered annually to states). For discussion of the ACA's exchanges, see Part V below.

employer tax deduction—yet another entirely different structure of federal financing.¹⁴⁰

This fragmented structure leads different populations in our system to access healthcare in different ways, variation that fosters disparities and inefficiencies. Likewise, rather than wiping the slate clean to build a new, unified system from the ground up, the ACA's main components are drawn from these preexisting programs, each one the product of an incremental legislative moment. And because those earlier efforts also largely depended on state bureaucracies, the incremental way in which Congress has intervened in healthcare has reinforced the states' role, even within a more robust national framework.¹⁴¹

C. Theoretical Underpinnings of Healthcare Federalism

Before the enactment of the ACA, the most important works in healthcare federalism dated to the late 1990s and early 2000s and were largely autopsies of the Clinton health reform effort. That scholarship was marked by a then-new recognition that federalism in health policy could no longer be understood through the classic constitutional model: an either-or separate spheres model that asks *which* government (state or federal) has control over a particular facet of health policy.¹⁴² With failed national reform in the rearview mirror, a consensus among federalism scholars emerged that some kind of joint state-federal model would be necessary.¹⁴³ Although proposals' specifics varied, they coalesced around arguments for a system in which at least some minimum standards were set by the federal government and in which states could benefit from federal funds.¹⁴⁴ Being relatively new theoretical and policy terrain, the earlier scholarship did not go much further than that. Specifically, little if anything was written on the kind of negotiating relationships that mark

140. See Matthew Rae et al., *The Henry J. Kaiser Family Found., Tax Subsidies for Private Health Insurance 1* (2014), <https://perma.cc/2G32-DLVW> (“The largest tax subsidy for private health insurance—the exclusion from income and payroll taxes of employer and employee contributions for employer-sponsored insurance . . . —was estimated to cost approximately \$250 billion in lost federal tax revenue in 2013.”).

141. See Gluck, *supra* note 1, at 572-74.

142. See generally Bovbjerg, *supra* note 104 (describing states' and the federal government's roles in developing particular healthcare policies); Robert F. Rich & William D. White, *The American States, Federalism, and the Future of Health Care Policy*, in *HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES* 293, 293-96 (Robert F. Rich & William D. White eds., 1996) (arguing that “[c]hallenges to the . . . senior/junior paradigm of federalism in health care” point “toward a reduced federal role and an increased state role in setting [health] policy, as well as in administering and financing it”).

143. See, e.g., Holahan et al., *supra* note 15, at 6-7.

144. See Bovbjerg, *supra* note 104, at 380-83; Mashaw & Marmor, *supra* note 110, at 117-18; Rich & White, *supra* note 142, at 293-300.

collaborative federalism schemes or on other dynamics of implementation, including complications posed by intrastate politics or the salient role for Congress in any model in which the federalism is structured by an overarching national law.¹⁴⁵

Fast forward to the recent attempts at postmortems on the ACA and Republican proposals to replace it. Federalists critical of the ACA argue for a return to “states’ rights” in healthcare.¹⁴⁶ Some depict the ACA as an unconstitutional invasion of state authority.¹⁴⁷

These characterizations are deeply mistaken as a matter of both basic constitutional law and federalism theory, and they distract from the main questions. Federalism scholars who criticize the ACA in the name of the Constitution do not propose in its stead a wholesale return of insurance market governance or oversight of low-income populations (Medicaid) to states, nor do they advance a theory of why the federal government is legally restricted in so regulating. Instead, each counterproposal, in the name of constitutional “states’ rights,” would *retain* a supervisory, preemptive role for the federal government. For example, the bill that passed the House in May 2017, the American Health Care Act, would have made cuts but still would have retained the Medicaid program and the basic requirement that insurers cover all Americans without discriminating based on health risk.¹⁴⁸ The Graham-Cassidy proposal in the Senate, in many ways the most radical proposal offered, would have given the states more choices about how to spend federal dollars to satisfy federal policy floors but would still have funded state health policy and retained federal requirements in the form of continuing the federal Medicaid program and imposing federal requirements on state insurance markets.¹⁴⁹

145. This scholarship has only recently begun to emerge in other fields. *See, e.g.*, Ryan, *supra* note 5, at 1152-55 (discussing intergovernmental bargaining in modern environmental federalism).

146. *See* Bagley, *supra* note 48, at 2-3 (describing the states’ rights federalism narrative).

147. *See, e.g.*, Ilya Shapiro, *President Obama’s Top Ten Constitutional Violations of 2015*, NAT’L REV. (Dec. 23, 2015, 9:00 AM), <https://perma.cc/8RT6-YJYK> (arguing that the ACA is a “constitutional abuse[.]” and “a never-ending bonanza of lawlessness”). *See generally* Nathaniel Stewart, *Brief Observations: A Review of Obamacare Briefs and the Original Meaning of the Constitution* (2012), <https://perma.cc/C4J5-QTLS>.

148. *See* American Health Care Act of 2017, H.R. 1628, 115th Cong. §§ 111-117 (as passed by House, May 4, 2017); *Compare Proposals to Replace the Affordable Care Act*, *supra* note 3. The bill included more flexible waiver options with respect to what benefits must be covered. Anna Edgerton et al., *House Passes Obamacare Repeal in Razor-Thin GOP Victory*, BLOOMBERG POL. (updated May 4, 2017, 12:36 PM PDT), <https://perma.cc/CKX4-AG2N>.

149. *See* 163 CONG. REC. S5682-95 (daily ed. Sept. 13, 2017) (SA 1030) (proposing Graham-Cassidy); *see also* Sarah Kliff, *Graham-Cassidy: The Last GOP Health Plan Left Standing, Explained*, VOX (updated Sept. 13, 2017, 2:47 PM EDT), <https://perma.cc/7HRG-LC6S>.

This is *not* a different kind of federalism from the ACA. The difference lies only in the *policy choices*—whatever baseline Congress sets and how much discretion Congress gives states within the statutory framework—all made within a national superstructure with delegated state-led elements. That argument is not about constitutional federalism or any other fundamental structural difference.¹⁵⁰ It is, rather, about policy choices within the same structural paradigm we currently have: a federal-statute-based, state-federal cooperative regime.

In other words, the suggested models for federalism post-ACA *are the same models* as the ACA's federalism. Every proposal involves a federal superstructure that allows for state variation within a prescribed framework.¹⁵¹ Recognition of this point is key because it illustrates the irrelevance of classic dual sovereignty federalism theory in the healthcare sphere. Instead, we have a recognition dating to 1944 that Congress has the power, when it desires to use it, to regulate insurance markets.¹⁵² No constitutional barriers prevent Congress from so doing.¹⁵³ (This is not to say that Congress will always choose the right means. But structured correctly and legally, Congress can surely regulate.) The substance of the current Republican proposals reveals a consensus on that point. It also reveals an apparent consensus that some federal intervention is in fact warranted—or that at a minimum, once it is given it is hard to take away. The question now is what that intervention should be, not which governments should be involved.

This is where we see weaknesses in arguments of scholars like Nicholas Bagley, who argues in this vein that it would “spell[] the end of federalism” if a federal intervention in health policy such as the ACA were justified solely by virtue of unwise or unjust policymaking by the states.¹⁵⁴ In direct tension with such statements, commentators like Bagley himself *still* argue for Congress to set some baselines—precisely because those scholars disagree with some aspects of state policy, want some policy decisions nationalized, and wish to have and

150. For one example of this misunderstanding, see Bagley, *supra* note 48, at 17 (arguing that states “have some reason to complain” that the ACA’s prohibition against charging older people more than three times more for insurance than younger people violates federalism because it represents a “value judgment” that should be left to the states).

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

152. *See* United States v. Se. Underwriters Ass’n, 322 U.S. 533, 553 (1944) (upholding Congress’s power to regulate the business of insurance under the Commerce Clause, U.S. CONST. art. I, § 8, cl. 3), *superseded in other part by statute*, McCarran-Ferguson Act of 1945, Pub. L. No. 79-15, 59 Stat. 33 (codified as amended at 15 U.S.C. §§ 1011-1015 (2016)).

153. *See* Nat’l Fed’n of Indep. Bus. v. Sebelius (*NFIB*), 567 U.S. 519, 588 (2012) (opinion of Roberts, C.J.) (holding that Congress could pass the ACA’s individual insurance mandate as a tax rather than under its commerce power).

154. *See* Bagley, *supra* note 48, at 9.

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eat the cake alike.¹⁵⁵ The fact is that healthcare statutes today squarely align in their structure with other federal laws like the Clean Air Act and the Occupational Safety and Health Act of 1970, which set national baselines in the face of state regulatory failures but still preserve key roles for states as thought leaders.¹⁵⁶ That is modern federalism, and it is precisely how Congress now regulates in many areas once considered state domain.

A few other points need to be made here because they tend to be overlooked by formalist federalists writing about healthcare. One important reason healthcare reform tends to be driven from above, by federal law, is that state-level reform by either legislatures or courts is not likely, even though such local reforms have driven national reforms in other areas, such as same-sex marriage.¹⁵⁷ When it comes to legislative reform, it is very difficult for states to experiment in health policy without federal assistance both in funding and in standard setting. Experimenting is risky and expensive. In the case of demanding insurance standards, costs will rise and insurers may withdraw from state markets with such requirements.¹⁵⁸ (Remember that Massachusetts's experiment in universal coverage was funded and facilitated by a Medicaid demonstration waiver; it was not a solo state experiment.)¹⁵⁹ Indeed,

155. See, e.g., *id.* at 3, 19-20; see also Health Reform Roundtable, Convergence Ctr. for Policy Resolution, A Bipartisan Answer to "What Now?" for Health Reform 1-2 (2017), <https://perma.cc/Q4EM-WNLT> (publicizing a bipartisan group advocating for state flexibility and federal "guardrails").

156. See generally Occupational Safety and Health Act of 1970, Pub. L. No. 91-596, 84 Stat. 1590 (codified as amended at 29 U.S.C. §§ 651-678 (2016)); Clean Air Act, Pub. L. No. 84-159, 69 Stat. 322 (1955) (codified as amended at 42 U.S.C. §§ 7401-7671q (2016)).

157. See, e.g., Bagley, *supra* note 48, at 2-3 (suggesting that the same-sex marriage movement is an apt comparison).

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

159. See John Holahan & Linda Blumberg, *Massachusetts Health Care Reform: A Look at the Issues*, 25 HEALTH AFF. w432, w432, w436, w443 (2006) (discussing the technical and political elements that made Massachusetts's universal coverage possible). In an amicus brief supporting the national regulatory scheme of the ACA, Massachusetts offered data on the external costs imposed on its unique universal healthcare system by the residents of neighboring states:

During fiscal year 2009 alone, for example, Massachusetts hospitals provided inpatient care to more than 43,000 patients who were not residents of Massachusetts, at an estimated cost of \$910,000,000. Of these non-Massachusetts residents, approximately 1,200 did not have any health insurance. The number of out-of-state patients without insurance coverage was even greater at Massachusetts emergency departments where more than 12,900 uninsured individuals received care during fiscal year 2009. Massachusetts cannot regulate insurance coverage for non-Massachusetts residents, nor can it (or should it) restrict access to necessary and emergent care.

footnote continued on next page

those very facts are frequently cited in policy literature as a reason why states do not experiment in health policy at the level traditional federalism theory would predict.¹⁶⁰ State health policy is pushed, collectively, in a race to the bottom, not lifted to the top toward reform.¹⁶¹

With respect to recourse to state courts for state-level reform, no state constitution or state law offers a *positive* right to healthcare.¹⁶² By contrast, every state constitution contains other positive rights, which have helped to drive such social policy change as marriage equality.¹⁶³ Some state constitutions even contain other special welfare rights the U.S. Constitution does not, including the right to basic education.¹⁶⁴ Judicial remedy through state constitutional law therefore does not provide an alternative to federal statutory reform.¹⁶⁵

Brief of Amicus Curiae, Commonwealth of Massachusetts (Supporting Petitioners and Addressing Whether Enacting Minimum Coverage Provision of ACA Authorized by Article I) at 15, Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 567 U.S. 519 (2012) (No. 11-398), 2012 WL 160239 [hereinafter Massachusetts *NFIB* Amicus Brief] (footnotes omitted).

160. See, e.g., Gluck, *supra* note 43, at 1764; Rose-Ackerman, *supra* note 44, at 610-11; Rubin & Feeley, *supra* note 11, at 925-26; cf. Super, *supra* note 44, at 563 (“[T]he process of establishing democratic experimentalism in the first place may be problematic.”).
161. See, e.g., Thompson, *supra* note 158, at 80-81 (noting the view that states do not have the commitment or the capacity to experiment effectively in healthcare); Jonathan Chait, *The Health Care Regulatory Race to the Bottom*, NEW REPUBLIC (May 25, 2011), <https://perma.cc/X2UU-SB5H> (arguing that insurers will flock to states with less stringent regulations and concluding that “[f]or a small population state, the attractions of a major industry setting up shop within state laws almost invariably outweigh the costs it would incur in poor regulation”); Massachusetts *NFIB* Amicus Brief, *supra* note 159, at 1-6, 15-17. Bagley overlooks this argument in concluding that no collective action problem exists that supports a need for national regulatory standards in healthcare. See Bagley, *supra* note 48, at 5.
162. See, e.g., Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325, 1328, 1347, 1391-92 (2010).
163. See, e.g., Goodridge v. Dep’t of Pub. Health, 798 N.E.2d 941, 948-49, 969 (Mass. 2003) (“The Massachusetts Constitution is, if anything, more protective of individual liberty and equality than the Federal Constitution; it may demand broader protection for fundamental rights; and it is less tolerant of government intrusion into the protected spheres of private life.”).
164. Compare, e.g., Plyler v. Doe, 457 U.S. 202, 221 (1982) (“Public education is not a ‘right’ granted to individuals by the Constitution.”), with, e.g., Leandro v. State, 488 S.E.2d 249, 255 (N.C. 1997) (“We conclude that Article I, Section 15 and Article IX, Section 2 of the North Carolina Constitution combine to guarantee every child of this state an opportunity to receive a sound basic education in our public schools.”).
165. Bagley also argues that racism is not a reason to consider national regulatory standards. See Bagley, *supra* note 48, at 8 (“The case [for federal reform based on racism concerns] is harder to sustain than it may at first appear.”). U.S. healthcare has a long, deep history of discrimination that has infiltrated and stymied many efforts at universalism in healthcare reform—so much so that groups like the NAACP were even leery of the Clinton Administration’s health reform effort. See, e.g., Beatrix Hoffman, *Health Care* footnote continued on next page

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

III. Federalism Under the ACA

Like other federal interventions before it, the ACA responded to regulatory gaps and market failures in healthcare by focusing largely on weaknesses in (mostly state-run) insurance markets. Uninsurance had reached a record high of more than 16% during the first year of the Obama Administration, a trend exacerbated by the Great Recession, and the uninsured were concentrated among people earning less than 250% of the federal poverty level (FPL).¹⁶⁶

Reform and Social Movements in the United States, 93 AM. J. PUB. HEALTH 75, 75, 80 (2003) (exploring the complex relationship between segregation, other forms of racism, social movements, and healthcare reform in the United States). These historic patterns are still relevant. See Mark A. Hall, *States' Decisions Not to Expand Medicaid*, 92 N.C. L. REV. 1459, 1464-66 (2014) (suggesting that implicit racism may be a factor in the opposition to Medicaid expansion). Timothy Jost has documented the racism underlying resistance to Medicaid expansion, concluding that until Medicaid is federalized, "the original sin of racism will continue[] to infect" it. See Jost, *supra* note 82, at 6-8. Jost has explained:

If you look at the map today, it is many of the same states today that are rejecting Medicaid expansion whose senators blocked federal standards for public assistance almost 80 years ago, and, I would argue, for the same reason. They still want to keep control of determining which of the poor are eligible for assistance, and not to help those who are not worthy.

Id.

166. See CARMEN DENAVAS-WALT ET AL., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 22-28, 26 tbl.9 (2010), <https://perma.cc/Q9AH-GUBL> (reporting new Census Bureau data indicating a continued increase in the uninsurance rate and that the greatest number of uninsured individuals earned less than \$25,000 at the time the ACA was enacted); 2009 HHS Poverty Guidelines, OFF. ASSISTANT SECRETARY FOR PLAN. & EVALUATION (Dec. 1, 2009), <https://perma.cc/P5U2>
footnote continued on next page

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Fewer employers offered health insurance as an employment benefit, and those that did had increased employee cost sharing over time.¹⁶⁷ Additionally, individual and small group health insurance markets were inaccessible for many (especially the lower- and middle-income uninsured) because of high prices and exclusionary policies designed to prevent coverage of subscribers who were not “healthy.”¹⁶⁸ Though Medicaid had expanded since 1965 to include additional populations over time, it still offered an incomplete safety net, with many populations not covered in most states.¹⁶⁹ As of 2006, only about 45% of the nation’s poor uninsured were eligible for Medicaid.¹⁷⁰ Those excluded from insurance coverage often would seek care in emergency rooms¹⁷¹—a poor and increasingly expensive substitute for systematic care.

-TF28 (noting that the FPL in 2009 for one person was \$10,830); Andrew Villegas & Phil Galewitz, *Uninsured Rate Soars, 50+ Million Americans Without Coverage*, KAISER HEALTH NEWS (Sept. 16, 2010), <https://perma.cc/JN5U-2YZC> (reporting that the number of people uninsured was at “an all time high”); see also ROBIN A. COHEN ET AL., NAT’L CTR. FOR HEALTH STATISTICS, U.S. DEP’T OF HEALTH & HUMAN SERVS., HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY-MARCH 2016, at 1, 4, app. at A1 tbl.I, A7 tbl.IV (2016), <https://perma.cc/ML7N-N8TA> (reporting long-term trends in insurance coverage before and after the ACA); COMM. ON HEALTH INS. STATUS & ITS CONSEQUENCES, INST. OF MED., AMERICA’S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 25-44 (2009) (detailing trends of declining insurance coverage); RACHEL GARFIELD ET AL., THE HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER; KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED IN THE ERA OF HEALTH REFORM 3-4 (2016), <https://perma.cc/6LQU-KSWN> (discussing the landscape of uninsurance before the ACA).

167. See STARR, REMEDY AND REACTION, *supra* note 100, at 79-80, 155-56.

168. See Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1589 (2011) (describing ACA provisions designed to address pricing practices that made nongroup insurance too costly for most who did not fit in other insurance mechanisms). See generally Jessica L. Roberts & Elizabeth Weeks Leonard, *What Is (and Isn’t) Healthism?*, 50 GA. L. REV. 833, 837-38, 842-44 (2016) (considering which types of health-based distinctions are unjustifiable discrimination, deemed “healthism”).

169. See *supra* notes 94-99 and accompanying text.

170. See STAN DORN, AARP PUB. POLICY INST., MILLIONS OF LOW-INCOME AMERICANS CAN’T GET MEDICAID: WHAT CAN BE DONE? 5 (2008), <https://perma.cc/3UHF-SE7W>.

171. The practice was so common that President George W. Bush said, “[P]eople have access to health care in America. After all, you just go to an emergency room.” Remarks to the Greater Cleveland Partnership and a Question-and-Answer Session in Cleveland, Ohio, 43 WEEKLY COMP. PRES. DOC. 920, 922 (July 10, 2007); see also Rachel Weiner, *Romney: Uninsured Have Emergency Rooms*, WASH. POST (Sept. 24, 2012), <https://perma.cc/2ZPL-2VCJ> (recounting this statement and reporting that candidate Mitt Romney made a similar comment).

A. The ACA's Federalism as Drafted

The ACA responded to these gaps in coverage with an overarching philosophy one of us has called “universality”—universal access to healthcare through universal access to insurance coverage, even for most populations historically excluded due to health status or financial status.¹⁷² (Some populations were left out, notably millions of undocumented immigrants; legal immigrants were left out of Medicaid, too.)¹⁷³ The statute's two central mechanisms to accomplish this goal turned out to be its most federalism-oriented. First, it expanded Medicaid coverage to populations long excluded from categorical eligibility (namely, nonelderly childless adults, including men, with income up to 138% of the FPL).¹⁷⁴ Second, it facilitated individual access to insurance in the private market by subsidizing insurance purchases and creating individual insurance markets—the exchanges—to make options more transparent for consumers and to ensure that insurance so purchased met a minimum standard of coverage.¹⁷⁵

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

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

172. See Huberfeld, *supra* note 93, at 67-69.

173. See *id.* at 68 n.7 (noting the exclusion of undocumented immigrants); see also Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1312(f)(3), 124 Stat. 119, 184 (2010) (codified at 42 U.S.C. § 18032(f)(3) (2016)) (limiting access to ACA exchanges to lawful residents); *Coverage for Lawfully Present Immigrants*, HEALTHCARE.GOV, <https://perma.cc/Q58C-LXEG> (archived Apr. 23, 2018) (explaining that lawfully present immigrants can get coverage through ACA exchanges but that many must wait five years prior to receiving Medicaid coverage).

174. See Patient Protection and Affordable Care Act § 2001(a)(1), 124 Stat. at 271 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)) (creating a new Medicaid eligibility category). The Health Care and Education Reconciliation Act of 2010 immediately amended the ACA and created a 5% income disregard, raising eligibility for the new category to 138% of the FPL. See Pub. L. No. 111-152, § 1004(e)(2), 124 Stat. 1029, 1036 (codified at 42 U.S.C. § 1396a(e)(14)(I)).

175. See, e.g., Patient Protection and Affordable Care Act § 1321(a), 124 Stat. at 186 (codified at 42 U.S.C. § 18041(a)) (detailing exchange structure).

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The Medicaid expansion that the ACA enacted did not take Medicaid away from the states but did nationalize the program in the important sense that it mandated eligibility expansion to populations that prior to the ACA had been covered only at a state's option. The ACA ended Medicaid's limitation to the "deserving poor" by requiring that states expand eligibility to all adults under age sixty-five (when Medicare kicks in) with income up to 138% of the FPL.¹⁷⁶ The ACA funded the eligibility expansion completely from 2014 through 2016, after which it decreases the federal match slightly, paying for 90% of the expansion population's costs by 2020.¹⁷⁷ Even at 90%, the supermatch is more generous than the matching rates states have received historically, which are tied to per capita income and range from 50% to about 80%.¹⁷⁸ The ACA as enacted did not authorize partial expansion of eligibility, so states could not expand eligibility in a more limited fashion and still receive the supermatch.¹⁷⁹ The idea was to make more uniform and comprehensive the coverage that had become so distant for most of the nation's poor by the time of the 2008 election.

With respect to the insurance markets, the proposed bill originally considered in the House of Representatives would have created a nationally run ACA insurance market for the privately insured population. But the Senate insisted on a federalist structure.¹⁸⁰ The ACA as enacted therefore gave states the right of first refusal to run their own insurance exchanges.¹⁸¹ The exchanges were new marketplaces, creatures of federal law introduced by the ACA (but pioneered in Massachusetts).¹⁸² They not only aimed to increase insurance coverage through a baseline of coverage and information that would be delivered to subscribers but also enabled federal tax credits that subsidized the purchase of private health insurance for individuals earning between 100%

176. See *id.* § 2001(a)(1), 124 Stat. at 271; see also Health Care and Education Reconciliation Act § 1004(e)(2), 124 Stat. at 1036.

177. See 42 U.S.C. § 1396d(y).

178. See MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MACSTATS: MEDICAID AND CHIP DATA BOOK 17 exhibit 6 (2017), <https://perma.cc/D8X2-RWR8>.

179. See Patient Protection and Affordable Care Act § 2001(a)(1), (3), 124 Stat. at 271-74 (codified as amended at 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396d(b), (y)). Wisconsin has a Medicaid waiver for BadgerCare, which is equivalent to a partial expansion, but the waiver predated the ACA and has been renewed after the ACA, allowing coverage to continue despite noncompliance with the ACA. See Sara Rosenbaum, *Wisconsin's 1115 Medicaid Demonstration: What Will Policymakers Learn?*, COMMONWEALTH FUND: TO THE POINT (June 9, 2016), <https://perma.cc/8346-M738>.

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

181. See Patient Protection and Affordable Care Act § 1321, 124 Stat. at 186-87 (codified at 42 U.S.C. § 18041).

182. See JOHN E. McDONOUGH, *INSIDE NATIONAL HEALTH REFORM* 113, 128 (2011).

and 400% of the FPL.¹⁸³ Unlike the ACA's nationalized Medicaid eligibility provisions, the exchange provisions were written to put states in the driver's seat, giving states priority to create their own exchanges and broad discretion in how exchanges could be structured for a given state's existing insurance market.¹⁸⁴ The federal government would provide a fallback should the states decline (or fail) to run their own exchanges.¹⁸⁵

Less relevant to the federalism narrative but important to understanding these reforms and their political context is the ACA's minimum coverage requirement—the infamous individual mandate challenged in the Supreme Court in 2012.¹⁸⁶ The individual mandate required all individuals (with a few exceptions) to obtain insurance coverage or pay a tax.¹⁸⁷ The mandate was designed to bring more customers into the private insurance markets to sustain those markets in the face of the ACA's dramatic new requirements on the insurance industry.¹⁸⁸ The Republican tax bill of 2017 repealed the enforcement penalty.¹⁸⁹

B. The ACA's Flipped Federalism as Implemented

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

183. See Patient Protection and Affordable Care Act §§ 1401(a), 10105(a)-(c), 10108(h)(1), 124 Stat. at 213-19, 906, 914 (codified as amended at I.R.C. § 36B (2016)); *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015) (discussing the tax credits).

184. See Patient Protection and Affordable Care Act § 1321, 124 Stat. at 186-87.

185. See *id.* § 1321(c), 124 Stat. at 186-87 (codified at 42 U.S.C. § 18041(c)).

186. See *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 567 U.S. 519, 530-32 (2012) (opinion of Roberts, C.J.) (addressing challenges to the constitutionality of the individual mandate).

187. See Patient Protection and Affordable Care Act §§ 1501(a), 10106(a), 124 Stat. at 242-44, 907-09 (codified at 42 U.S.C. § 18091); *id.* §§ 1501(b), 10106(b)-(d), 125 Stat. at 244-49, 909-10 (codified as amended at I.R.C. § 5000A).

188. See *King*, 135 S. Ct. at 2486-87; Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REP. 130, 130-32 (2011); see also MCDONOUGH, *supra* note 182, at 121-22. The ACA requires insurers to cover everyone, regardless of health risk, at essentially equal prices with variation allowed in limited categories (e.g., age, tobacco use, and geography), a 180-degree deviation from the way the industry has traditionally measured risk and reaped profits. See, e.g., BlueCross BlueShield of N.C., *In the Spotlight: ACA Insurance Reforms* (2011), <https://perma.cc/8PC8-FZ43>.

189. See H.R. 1, 115th Cong. § 11081 (2017) (enacted) (to be codified at I.R.C. § 5000A).

statute's enactment.¹⁹⁰ But the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* (*NFIB*) was a game changer.¹⁹¹

NFIB was largely framed as a constitutional challenge to the ACA's insurance mandate.¹⁹² The Court, however, surprised many legal experts¹⁹³ by sustaining the mandate as a permissible exercise of Congress's taxing power but declaring the Medicaid expansion an unconstitutionally coercive exercise of the spending power.¹⁹⁴ The Court consequently interpreted the Medicaid expansion as optional for the states.¹⁹⁵ The result was to introduce a powerful element of state leverage—and with it state-federal bargaining—into ACA implementation.

Following *NFIB*, as we detail in Part IV below, many states—especially red states—stopped plans already in progress to expand Medicaid immediately. They later worked through both intrastate negotiations between governors and legislatures and through external negotiations with the U.S. Department of Health and Human Services (HHS) to create individualized deals for their expansions.¹⁹⁶ This change of events also gave Medicaid section 1115 demonstration waivers, which allow states to seek federal approval to deviate from statutory Medicaid requirements,¹⁹⁷ heightened significance under the ACA, as section 1115 became the primary vehicle for such negotiating. Congress did not write new Medicaid waivers into the ACA, and it did not

190. See Interview with Former Federal Executive Branch Healthcare Official 5 (Oct. 6, 2016) (on file with authors).

191. See *id.*; see also *NFIB*, 567 U.S. 519.

192. See, e.g., Brief for Private Respondents on the Individual Mandate at 1, 7-12, *NFIB*, 567 U.S. 519 (No. 11-398), 2012 WL 379586.

193. We each cautioned before oral argument that the government would be wise to pay attention to the Medicaid question. See Abbe R. Gluck, Opinion, *The 10th Amendment Question*, N.Y. TIMES: ROOM FOR DEBATE (Mar. 28, 2010, 7:00 PM), <https://perma.cc/H5S4-MYCB>; Nicole Huberfeld, *Jumping Ahead to Coercion*, CONCURRING OPINIONS (Dec. 9, 2011), <https://perma.cc/22VT-YZRZ>.

194. See *NFIB*, 567 U.S. at 574 (upholding the individual mandate); *id.* at 587-88 (opinion of Roberts, C.J.) (striking down the provision conditioning preexisting Medicaid funding on accepting the expansion).

195. See *id.* at 587-88 (opinion of Roberts, C.J.).

196. See *infra* Part IV.

197. Section 1115 allows HHS to approve a state waiver proposal that furthers the “objectives” of Medicaid while maintaining federal budget neutrality. See 42 U.S.C. § 1315 (2016). The provision was introduced as an amendment to the Social Security Act (in which Medicaid is codified) before Medicaid was created. See Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 122, 76 Stat. 172, 192 (enacting the first version of the waiver provision as a new section 1115 of the Social Security Act). Budget neutrality is not a statutory requirement but rather an informal policy that HHS applies. See MaryBeth Musumeci et al., *The Henry J. Kaiser Family Found., Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers 2* (2018), <https://perma.cc/HVG9-KVY4>.

need to: HHS has always had authority to allow deviation from Medicaid requirements by approving a section 1115 waiver.¹⁹⁸ But *NFIB*, in giving states more choices, opened the door to section 1115 waivers' becoming a central element of Medicaid expansion implementation and thus allowed states to negotiate for special programmatic features that embraced policies that deviated from the ACA's principle of universality.

NFIB also reinvigorated an atmosphere of state autonomy and sprouted acts of political resistance that bled outside Medicaid policy and into the realm of exchange implementation. Despite the fact that the states' rights faction in Congress had insisted on the state-run exchanges in the first place, it became an act of political loyalty for states to refuse to implement the ACA, including refusing to run an exchange.¹⁹⁹ The results of the 2010 state elections bolstered this effect, as Republicans scored a net gain of five governorships and eleven state legislatures.²⁰⁰

This political positioning ironically extended the federal enterprise in insurance much further than the ACA's drafters had envisioned because it required the *federal* government to run the exchanges in those states.²⁰¹ What we call "federalism for federalism's own sake" became the dominant approach as states paradoxically refused to run their own exchanges, even though state-based exchanges would have been the natural choice for states acting in their "autonomous" or "sovereign" interests.

This amplification of state resistance produced parallel state-federal negotiations in the exchange context. Unlike in the Medicaid context, no statutory provision facilitates an "exchange demonstration waiver,"²⁰² but HHS still worked closely with states, informally when necessary, on modifications to the ACA's envisioned exchange structure to bring as many

198. See SMITH & MOORE, *supra* note 60, at 332 (discussing the history of section 1115's waiver authority). The language in 42 U.S.C. § 1315(a) specifically refers to § 1396a, the provision delineating what a state's Medicaid plan must include to participate in the program.

199. See Anna Yukhananov, *U.S. State Officials in Stealth Mode on Health Exchanges*, REUTERS (Sept. 16, 2012, 2:10 PM), <https://perma.cc/EH2A-PVFP> (describing political opposition faced by Republican insurance administrators tasked with implementing the ACA).

200. Compare Nat'l Conference of State Legislatures, 2010 State and Legislative Partisan Composition (2010), <https://perma.cc/386J-UR9W> (reporting that as of January 31, 2010, Republicans held 24 governorships and controlled both chambers of 14 state legislatures), with Nat'l Conference of State Legislatures, 2011 State and Legislative Partisan Composition (2011), <https://perma.cc/BU85-TX52> (reporting that as of January 31, 2011, Republicans held 29 governorships and controlled both chambers of 25 state legislatures).

201. Cf. MCDONOUGH, *supra* note 182, at 128.

202. ACA section 1332, discussed in Part V below, is different. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1332, 124 Stat. 119, 203-06 (2010) (codified at 42 U.S.C. § 18052); *infra* text accompanying note 436.

states successfully into ACA implementation as possible.²⁰³ Choices included matters of exchange operation (eligibility and enrollment, health plan management, and consumer assistance), the platform of the consumer web portal (federal or state), the choice of benchmark plan for determining the essential health benefits to be provided by health plans in the exchange, the number and location of geographic rating areas, the choice of methods for reinsurance and risk adjustment, and the responsibility for reviewing health plan rates and compliance with the medical loss ratio requirements.²⁰⁴ HHS even gave states choices not envisioned by the statute: For instance, as detailed in Part V below, HHS allowed states to retain authority over certain key components of the exchanges, even as HHS ran some components itself. These developments led to significant variation across states, not just across states that chose to operate their own exchanges—where variation might be expected—but also in states that had a nationally run exchange. National has not meant uniform.

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

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

C. Study Methodology

The scale of the ACA and the fundamental changes it made in U.S. healthcare structure and finance are reasons enough to study it. The flipped

203. See *infra* Part V.

204. See Ctr. for Healthcare Research & Transformation, Guide to State Requirements and Policy Choices in the Affordable Care Act (2011), <https://perma.cc/6DYY-RN8G>; *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, KAISER FAM. FOUND. (Feb. 29, 2012), <https://perma.cc/9VQZ-5Y34>. For an overview of each state's decisions, see NAT'L CONFERENCE OF STATE LEGISLATURES, HEALTH INSURANCE EXCHANGES OR MARKETPLACES: STATE PROFILES AND ACTIONS (2017), <https://perma.cc/25S4-299Z>.

federalism of the ACA's implementation makes it all the more interesting. The detail in the following two Parts is both empirical and theoretical. By grounding our inquiry in real-world detail, our project responds to the frequent criticism that federalism scholarship is too abstract.²⁰⁵

Our data derive from three different research methods. First, beginning in July 2013, we collaborated with the HIX 2.0 Project at the University of Pennsylvania to systematically code and evaluate variations in states' implementation of the exchange and Medicaid expansion aspects of the ACA. The HIX 2.0 Project, which is no longer active, aimed to construct quantitatively coded datasets to support research on the impact of variations in state health law and policy choices on outcome measures of significance, such as the rate of uninsurance, the number of insurers active in a state market, and health insurance prices.²⁰⁶ We identified for the investigators categories to track that would be relevant for federalism in both the Medicaid and exchange contexts.

Second, we independently tracked state-federal activity in each state, using publicly available sources, including government materials. We tracked factors ranging from program design to political party in office to the legal means—such as statutes and executive orders—by which the new programs were implemented in each state.

Finally, we interviewed implementers themselves—current and former state and federal officials who ranged from state governors to insurance commissioners to high-ranking members of the Obama Administration. We also interviewed leaders in major healthcare nonprofit and trade groups that were known to be working closely with state and federal officials on implementation. The interviews are the subject of a separate article;²⁰⁷ for the purposes of this Article, their relevance is in corroborating the federalism story that emerged from the tracking data.

The initial goal of all of these methods was to measure the traditional federalism attributes—state autonomy, sovereignty, cooperation, experimentation, and variation—in the statute as well as what impact those attributes may have on health policymaking.

As noted, we ultimately were not able to quantitatively assess the federalism attributes as we had intended. The richness and complexity of the data, as detailed in the next two Parts, revealed aspects of autonomy, sovereignty, cooperation, experimentation, and variation occurring within all of the

205. *See supra* note 38 and accompanying text.

206. The project had a very long time horizon, so its dataset could not be put to use immediately. We built on the initial dataset with our own data collection and confirmation efforts.

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

different structural arrangements in the ACA—even structural arrangements perceived to be in opposition to one another. Assigning weights to measure these attributes relative to one another (for instance, whether an early Medicaid-expanding state was more or less autonomous than a late Medicaid waiver state) proved impossible, at least in this initial foray. Those observations changed our focus and gave rise to the theoretical analysis in this Article.

IV. The Medicaid Expansion

The Medicaid expansion is a story of dynamic, adaptive, horizontal, negotiated, and small-r republican federalism. Even though the Medicaid expansion became an option for the states after *NFIB*, it has not operated like an on-off switch. It has been in constant motion. Some opt-out states—even those that initially proclaimed resistance—have moved gradually to expansion, and many opt-in states have renegotiated deals with HHS even after flicking the on switch years before.²⁰⁸ Leaders among states emerged organically, creating horizontal state dynamics that changed implementation.²⁰⁹ For instance, states like Arkansas and Indiana became red-state thought leaders by pushing unconventional waiver elements and, in the process, taught other states how to negotiate and what could be gained.²¹⁰ A clear learn-and-response pattern materialized, resulting from these negotiations within states, among states, and between states and the federal government. Intrastate features pervaded the process, with governors and legislators of the same (typically Republican) party at odds on whether and how to expand.²¹¹

Classic federalism accounts, including the way in which the Court often describes federalism, tend to make zero-sum assumptions about federalism's sovereignty tradeoffs. The federal government's gain is portrayed as the states' loss, and vice versa.²¹² Our research illustrates that this has not been the case with the Medicaid expansion. Our interviews with high-level current and former state and former federal officials confirmed that largely because the Obama Administration adopted a very long time horizon—the administration's basic goal was to get the ACA entrenched and fix it later—states (often with

208. See *infra* Parts IV.A.3-4.

209. See *infra* Parts IV.A.3-4.

210. See *infra* Parts IV.A.3-4.

211. See *infra* Part IV.B.

212. See generally Stephen A. Gardbaum, *The Nature of Preemption*, 79 CORNELL L. REV. 767, 812-14 (1994) (exploring exclusivity through the lens of preemption); Theodore W. Ruger, *Preempting the People: The Judicial Role in Regulatory Concurrence and Its Implications for Popular Lawmaking*, 81 CHI.-KENT L. REV. 1029, 1038-46 (2006) (tracing the history of exclusive spheres of power in Supreme Court jurisprudence).

shorter-term goals) achieved significant victories in their federalism negotiations.²¹³ With the Obama Administration eager to get as many states to expand Medicaid as possible, states were able to negotiate special deals that enabled them to do so. Both sides viewed themselves victorious.

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

We found that the Medicaid expansion occurred in four discernible waves.

1. Early, generous implementers: the first wave

The first wave began in 2012, before the ACA's Medicaid implementation date of January 1, 2014. The ACA permitted early expansion, although at a state's usual federal funding match, rather than at the ACA's post-2014 supermatch.²¹⁴ The draw of early expansion was that it offered federal funds for the new expansion population, an economic boon for a handful of states that had already covered childless adults with no federal funds before the ACA.²¹⁵ Led by Minnesota, states including California, Colorado, Connecticut, New Jersey, and Washington, as well as the District of Columbia, expanded to childless adults by April 2012.²¹⁶ These early adopters largely aligned with the

213. See Interview with Former Federal Executive Branch Healthcare Official 1 (June 21, 2016) (on file with authors); Interview with Former Governor (Aug. 4, 2016) (on file with authors); Interview with State Policy Organization Officers 1, 2, 3, and 4 (June 6, 2016) (on file with authors).

214. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 2001(a)(4)(A), 10201(b), 124 Stat. 119, 274, 918 (2010) (codified at 42 U.S.C. § 1396a(k)(2)-(3) (2016)) (permitting states to expand via state plan amendments (SPAs) before 2014, when the supermatch kicked in).

215. Cf. Larisa Antonisse et al., Henry J. Kaiser Family Found., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review 1-2* (2018), <https://perma.cc/X8C6-QQV8> (reviewing literature “using data from 2014 or later” and concluding that “[a]nalyzes find positive effects of [Medicaid] expansion on numerous economic outcomes”).

216. See *States Getting a Jump Start on Health Reform's Medicaid Expansion*, KAISER FAM. FOUND. (Apr. 2, 2012), <https://perma.cc/8JRJ-VTVM>; see also Letter from Marilyn Tavenner, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Suzanne Brennan, State Medicaid Dir., Colo. Dep't of Health Care Policy & Fin. (Mar. 30, 2012), <https://perma.cc/5TMZ-URJM> (granting Colorado a section 1115 waiver allowing it to expand Medicaid to certain adults without dependent children beginning in April 2012). Some states implemented expansion through SPAs, and some amended existing demonstration waivers. See *States Getting a Jump Start on Health Reform's Medicaid Expansion*, *supra*. Some states sought section 1115 waivers to enroll individuals earning more than the ACA's baseline of 138% of the FPL. See *id.*

ACA's universal coverage goal, yet some first-wave states obtained section 1115 demonstration waivers to expand more generously beyond the ACA.²¹⁷

2. *NFIB* and the second wave

The *NFIB* decision, which came down on June 28, 2012,²¹⁸ initiated the second wave. Some states that had been waiting to see whether the ACA would be declared unconstitutional expanded almost as soon as the decision upheld the law. Due to the timing of the state budget cycle and a desire for consultant studies to prove the potential benefits of opting in, many others did not formally opt in until 2013. The second-wave states largely relied on state plan amendments (SPAs)—amendments to their existing Medicaid programs—for expansion and did not negotiate or seek special concessions from HHS, at least not at first.²¹⁹

Notably, during the second wave, governors were likely to take the lead, often at odds with their own legislatures or their states' national representatives in Congress. For example, Arizona Governor Jan Brewer,²²⁰ Kentucky

217. See, e.g., Letter from Donald M. Berwick, Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to John McCarthy, Medicaid Dir., D.C. Dep't of Health Care Fin. 1 (Oct. 28, 2010), <https://perma.cc/E96U-2TK9> (approving the District of Columbia's expansion of Medicaid to adults with incomes up to 200% of the FPL); Carol Backstrom, Minn. Dep't of Human Servs., Project No. 11-W-00039/5, Minnesota PMAP+ Section 1115 Waiver Renewal Request 1 (2013), <https://perma.cc/UST3-QFVC> (requesting approval to expand "to adults with children, 19- and 20-year[-]olds, and adults without children at incomes between 133% and 200% of the federal poverty level"); Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., U.S. Dep't of Health & Human Servs., to Lucinda E. Jesson, Comm'r, Minn. Dep't of Human Servs. 1 (Dec. 20, 2013), <https://perma.cc/HJN7-2EBA> (granting Minnesota's request); Ctrs. for Medicare & Medicaid Servs., No. 11-W-00194/1, Global Commitment to Health Section 1115 Demonstration: Waiver Authority (2012), <https://perma.cc/LWZ8-E2DU> (granting Vermont permission to expand financial eligibility for certain services).

218. Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 567 U.S. 519 (2012).

219. See generally *State Medicaid & CHIP Profiles*, MEDICAID.GOV, <https://perma.cc/HF2M-Y7PZ> (archived Apr. 23, 2018) (documenting each state's SPAs and waivers). SPAs are subject to less scrutiny than section 1115 demonstration waiver applications because they are merely a description of how the state is meeting the mandatory elements of Medicaid. See 42 U.S.C. § 1396a (establishing requirements for state plans); *State Plan, MEDICAID & CHIP PAYMENT & ACCESS COMMISSION*, <https://perma.cc/PF6K-2638> (archived Apr. 29, 2018) (providing background information on state plans and the SPA process). The Medicaid expansion was drafted in the ACA as a mandatory element. See Patient Protection and Affordable Care Act § 2001(a)(1), 124 Stat. at 271 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)).

220. Governor Brewer signed legislation expanding Arizona's Medicaid program on June 17, 2013 after calling a surprise emergency legislative session designed to force Medicaid expansion. See Mary K. Reinhart, *Brewer Signs Into Law Arizona's Medicaid Program*, ARIZ. REPUBLIC (June 18, 2013, 12:36 AM), <https://perma.cc/55MZ-HB64>.

Governor Steve Beshear,²²¹ and North Dakota Governor Jack Dalrymple²²² pushed—and in some cases explicitly defied and circumvented—their legislatures to achieve Medicaid expansion. We detail those intrastate dynamics in Part IV.B below.

At the same time, some states recognized that *NFIB* gave them leverage that the ACA as drafted did not originally contemplate. They began exploring what kinds of concessions they could extract in a world of now-optional Medicaid expansion that would look beyond a traditional, “cooperative,” SPA approach.²²³ The annual meeting of the National Governors Association held just one month after *NFIB* was crucial to this exploration; after state-to-state conversations at that meeting, holdout states started to investigate expansion options in earnest.²²⁴

HHS fed this interest. Although the HHS Secretary initially provided lean guidance after *NFIB*,²²⁵ within a few months HHS informed states that they could opt in at any time without being penalized or locked in.²²⁶ That meant states could opt in or opt out of expansion on a timeline and in a manner different from that initially envisioned by the ACA.²²⁷

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221. See Caroline Humer, *Kentucky Governor Announces Medicaid Expansion Under Obamacare*, REUTERS (May 9, 2013, 4:05 PM), <https://perma.cc/9N7F-XDXN>.
222. See Jeffrey Young, *North Dakota Medicaid Expansion Favored by Republican Governor*, HUFFPOST (updated Mar. 17, 2013), <https://perma.cc/8XDR-ZTTY> (reporting that Governor Dalrymple submitted a Medicaid expansion bill to the state legislature); see also Nick Smith, *Lawmakers Pan Medicaid Expansion*, BISMARCK TRIB. (Apr. 12, 2013), <https://perma.cc/97KH-5WUL> (reporting that the bill passed and discussing some state legislators’ opposition).
223. See Letter from Dan Crippen, Nat’l Governors Ass’n, to Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs. (July 2, 2012), <https://perma.cc/SE3A-LUFT>; see also *RGA Letter on Medicaid and Exchanges to President Obama*, REPUBLICAN GOVERNORS ASS’N (July 10, 2012), <https://perma.cc/G3N3-XVGL>.
224. See Michael Cooper, *Many Governors Are Still Unsure About Medicaid Expansion*, N.Y. TIMES (July 14, 2012, 10:07 AM), <https://perma.cc/BPX4-CDYZ>; Lisa Lambert, *At Annual Meeting, U.S. Governors Come Out Swinging over Medicaid*, REUTERS (July 14, 2012), <https://perma.cc/8H3V-WFXR>; see also Interview with Former Governor, *supra* note 213.
225. See Letter from Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs., to Governor (July 10, 2012), <https://perma.cc/72HV-XQ3F>.
226. See Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid 12* (2012), <https://perma.cc/GV5E-JP55>.
227. States that expand partially, such as by expanding only up to 100% of the FPL, are not eligible for the supermatch. See *id.* at 12.

3. Waivers, concessions, and the third wave

HHS's expressed flexibility stimulated the third wave, which was led by Arkansas, the first state to obtain a section 1115 demonstration waiver in September 2013 to implement Medicaid expansion.²²⁸ The Arkansas waiver included a pioneering concession that allowed Arkansas to move toward privatizing the Medicaid market by funneling the newly eligible Medicaid population into private insurance available through the exchange rather than enrolling beneficiaries in traditional Medicaid.²²⁹ Thus, this demonstration project made Arkansas Medicaid expansion beneficiaries the first to be enrolled in private coverage using federally funded premium assistance for purchasing private insurance with benchmark coverage in the exchange.²³⁰

Arkansas publicized its negotiations with HHS, generating intense curiosity among other states exploring expansion.²³¹ Some states strategically started to wait out other states' waiver negotiations, feeling that they could benefit from piggybacking on early moving states' efforts and get even more, as evidenced by the progression of states opting in to expansion. One high-level former federal official we interviewed noted that states perceived the Obama Administration as so eager to expand Medicaid that every state wanted to be

228. See Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Andy Allison, Dir., Ark. Dep't of Human Servs. 1 (Sept. 27, 2013), <https://perma.cc/MYJ9-LRPY> (approving the waiver for three years).

229. See *id.* For more details about Arkansas's waiver program, see Tracy Garber & Sara R. Collins, *The Affordable Care Act's Medicaid Expansion: Alternative State Approaches*, COMMONWEALTH FUND: TO THE POINT (Mar. 28, 2014), <https://perma.cc/WQ5U-MZV3>.

230. Premium assistance waivers were obtainable before the ACA, but the few that existed had low enrollment because no private insurance was *actually* available to low-income workers. See Teresa A. Coughlin & Stephen Zuckerman, *State Responses to New Flexibility in Medicaid*, 86 MILBANK Q. 209, 227-28 (2008) (discussing the minimal uptake for premium assistance waivers during the George W. Bush Administration); Sara Rosenbaum & Benjamin D. Sommers, Perspective, *Using Medicaid to Buy Private Health Insurance—The Great New Experiment?*, 369 NEW ENG. J. MED. 7, 8 (2013) (noting that employer-sponsored insurance was the only private insurance that could be purchased with premium assistance before the ACA and that such insurance was not accessible for most low-income workers). The ACA's exchanges made purchasing private insurance with premium assistance a realistic option for low-income populations by broadening the availability of small group and individual insurance and by offering financial assistance through premium tax credits. See Rosenbaum & Sommers, *supra*, at 8. Further, new rules such as the prohibition on excluding people with preexisting conditions, see Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201(2)(A), 124 Stat. 119, 154 (2010) (codified at 42 U.S.C. § 300gg-3(a) (2016)), and the establishment of adjusted community rating, *id.* sec. 1201(4), § 2701, 124 Stat. at 155-56 (codified as amended at 42 U.S.C. § 300gg), opened coverage to previously uninsurable populations.

231. See Robert Pear, *States Urged to Expand Medicaid with Private Insurance*, N.Y. TIMES (Mar. 21, 2013), <https://perma.cc/FD8X-T2SE>.

“last in line” to negotiate a waiver so that it could benefit from prior states’ successes and concessions won from the federal government.²³² The succession of waivers following Arkansas’s bears that out and shows that the strategy was effective.

Iowa announced its interest in a waiver around the time that Arkansas announced its deal with HHS.²³³ Iowa appeared to have benefited from Arkansas’s application by seeking to negotiate even more concessions, which HHS granted through two waivers. Beyond applying for a waiver for premium assistance (which applied to individuals earning more than 100% of the FPL), Iowa proposed enforceable premium payments for individuals earning more than 100% of the FPL (allowing it to deny coverage for failure to pay premiums), healthy behavior rewards (which could offset premium payments), a one-year waiver of the requirement to provide nonemergency transportation services, and copayments for nonemergency use of emergency departments.²³⁴ HHS approved each of these new features.²³⁵

Soon thereafter, in September 2013, Michigan initiated expansion waiver negotiations (before Arkansas’s waiver was formalized).²³⁶ Michigan did not seek a premium assistance waiver but, like Iowa, it sought and received concessions for cost sharing and healthy behavior incentives.²³⁷ In addition, Michigan wanted to create health savings accounts for enrollees’ cost sharing

232. See Interview with Former Federal Executive Branch Healthcare Official 5, *supra* note 190.

233. Iowa announced its intent to negotiate a waiver on February 26, 2013, see Rod Boshart, *Branstad to Seek Federal IowaCare Waiver*, SIOUX CITY J. (Feb. 26, 2013), <https://perma.cc/AZ7T-WVHN>, the same day Arkansas announced that it had reached an agreement with HHS, see David Ramsey, *Update: Medicaid Game-Changer*, ARK. TIMES: ARK. BLOG (Feb. 26, 2013), <https://perma.cc/GZ69-LWQ8> (reporting that HHS gave oral approval for Arkansas’s proposal on February 22, 2013). Iowa announced the details of its proposal on March 4, 2013. See Mike Wisner, *Branstad Releases Medicaid Expansion Alternative*, SIOUX CITY J. (Mar. 4, 2013), <https://perma.cc/85S6-UM4T>.

234. See The Henry J. Kaiser Family Found., *Medicaid Expansion in Iowa* (2015), <https://perma.cc/7DJW-TDJK>.

235. See *id.* Until 2014, Iowa required people earning 101-138% of the FPL to enroll in a Marketplace Qualified Health Plan in its exchange, but low insurer participation led the state to make this type of enrollment optional. See *id.*

236. See Jonathan Oosting, *Michigan Gov. Rick Snyder Signs Historic Medicaid Plan Into Law: This Is About “Family” Not “Politics,”* MLIVE.COM (updated Sept. 16, 2013, 2:51 PM), <https://perma.cc/5NK3-V9YG> (reporting that Michigan’s governor signed legislation allowing him to proceed with negotiating waivers).

237. See Letter from Marilyn Tavenner, Adm’r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., to Stephen Fitton, Dir., Mich. Med. Servs. Admin. 1 (Dec. 30, 2013), <https://perma.cc/S53V-BR7G> (approving Michigan’s waiver request and SPA for Medicaid expansion, including cost sharing for beneficiaries earning more than the FPL).

requirements,²³⁸ which Arkansas later proposed in an amendment to its original section 1115 waiver.²³⁹ HHS approved Michigan's waiver application a few weeks after Iowa's.²⁴⁰

Following Arkansas, Iowa, and Michigan, Pennsylvania's governor at the time, Tom Corbett, held protracted negotiations with HHS.²⁴¹ These were high profile, in part because the waiver application included contentious elements such as enforceable cost sharing and, more controversially, work search requirements, which were not approved by the Obama Administration.²⁴² Pennsylvania's original proposal called for Arkansas-style premium assistance, but in the end Pennsylvania chose—like Iowa—to use Medicaid managed care networks for the newly eligible population.²⁴³ (Under a new governor, Tom Wolf, Pennsylvania reversed course and abandoned its expansion waiver, opting instead for the kind of straightforward expansion envisioned by the ACA.)²⁴⁴

Additional states soon followed. Tennessee and South Dakota proposed partial expansion through premium assistance waivers.²⁴⁵ The ACA did not

238. See Ctrs. for Medicare & Medicaid Servs., No. 11-W-00245/5, *Healthy Michigan Section 1115 Demonstration: Special Terms and Conditions 13-16* (2013), <https://perma.cc/S53V-BR7G>.

239. See Michelle Andrews, *Arkansas Weighs Plan to Make Some Medicaid Enrollees Fund Savings Accounts*, KAISER HEALTH NEWS (July 22, 2014), <https://perma.cc/K64S-5S4L>.

240. Michigan's waiver was approved December 30, 2013. See Letter from Marilyn Tavenner to Stephen Fitton, *supra* note 237, at 1. Iowa's was approved December 10, 2013. See Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Jennifer Vermeer, Medicaid Dir., State of Iowa 1 (Dec. 30, 2013), <https://perma.cc/J6VJ-GXGC> (noting that Iowa's waiver was originally approved December 10, 2013 and approving amendments to that waiver).

241. See Greg Sargent, *Another Big Boost for Obamacare*, WASH. POST: PLUM LINE (Aug. 28, 2014), <https://perma.cc/8DFV-WF48> (noting that "months of jockeying between Corbett and the federal government" occurred before approval of Pennsylvania's plan).

242. See *id.*

243. See Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Beverly Mackereth, Sec'y, Pa. Dep't of Pub. Welfare 1-2 (Aug. 28, 2014), <https://perma.cc/UP7V-FLD5> (approving the program and noting that it would use managed care networks); see also Virgil Dickson, *Pennsylvania to Expand Medicaid, but with Strings Attached*, MOD. HEALTHCARE (Aug. 29, 2014), <https://perma.cc/6RMP-89B6> (discussing the terms of the waiver Pennsylvania negotiated with HHS); The Henry J. Kaiser Family Found., *supra* note 234 (noting Iowa's move to Medicaid managed care networks after insurers dropped out).

244. See John George, *Wolf Begins Dismantling Corbett's Healthy PA Plan*, PHILA. BUS. J. (updated Feb. 10, 2015, 3:46 PM EST), <https://perma.cc/9KAH-DQG4>.

245. See Dana Ferguson, *Daugaard Encourages Medicaid Expansion*, ARGUS LEADER (Sioux Falls, S.D.) (updated Dec. 8, 2015, 9:23 PM), <https://perma.cc/8WR2-E36D>; David Montgomery, *Feds Reject Daugaard's Partial Medicaid Plan*, ARGUS LEADER (Sioux Falls, S.D.) (Mar. 5, 2014, 12:09 AM CT), <https://perma.cc/X9ZF-C24J>; Andy Sher, *Tennessee GOP Skeptical of TennCare Expansion*, CHATTANOOGA TIMES FREE PRESS (Dec. 12, 2012),
footnote continued on next page

allow partial expansion—that is, expansion that does not include everyone earning up to 138% of the FPL—so Tennessee’s and South Dakota’s proposals were rejected by the Obama Administration but led to additional discussions.²⁴⁶

In sum, the third wave not only introduced premium assistance waivers and other red-state features into Medicaid expansion but also showcased HHS’s highly pragmatic approach to getting as many states to expand Medicaid eligibility as possible. Convincing a state to opt in, even with a waiver that deviated from the ACA as originally envisioned, was a critical step toward achieving the statute’s goal of near-universal coverage.

HHS also saw that it could more effectively get states to adopt the ACA’s policy through *individualized* state-by-state negotiations, rather than viewing the resisting states as a monolithic group. Our interviewees credited HHS Secretary Kathleen Sebelius’s background as the former governor of Kansas for her taking this highly effective approach, going state by state, even as it meant that HHS was in a near-constant state of negotiation.²⁴⁷

4. Renegotiated deals, political change, and the fourth wave

The fourth wave began with the ACA’s January 1, 2014 implementation date and has progressed at a more gradual pace than the first three waves. Notably, Medicaid was not implemented by all states immediately after its passage in 1965 either. Although many states embraced Medicaid’s promise of generous federal funding, others nearly missed the 1970 deadline for participation; Arizona did not implement Medicaid until 1982.²⁴⁸ This pattern of gradual—but ultimately widespread—uptake has been replicated to a degree in the ACA’s implementation, although the change in presidential administration disrupted implementation momentum and guiderails.

During the late Obama Administration years (2014-2016), New Hampshire, Indiana, Alaska, Montana, and Louisiana expanded Medicaid, each choosing different mechanisms of expansion and pulling different levers of policy and

<https://perma.cc/B5FJ-UGLH> (noting interest in expanding only for those with incomes up to the FPL); see also Alex Tolbert, *How Is New TN Medicaid Expansion Plan Different?*, TENNESSEAN (July 17, 2016, 8:02 AM CT), <https://perma.cc/B92F-TZ2X> (reporting on Tennessee’s 2015 and 2016 efforts to negotiate expansion, including through a premium assistance waiver).

246. See Montgomery, *supra* note 245 (reporting that the Obama Administration rejected South Dakota’s proposed partial expansion); see also Ctrs. for Medicare & Medicaid Servs., *supra* note 226, at 12 (“[HHS] will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016.”).

247. See Interview with Former Federal Executive Branch Healthcare Official 1, *supra* note 213; Interview with Former Governor, *supra* note 213.

248. See STEVENS & STEVENS, *supra* note 57, at 61; Erik Eckholm, *Late Starter in Medicaid, Arizona Shows the Way*, N.Y. TIMES (Aug. 7, 1991), <https://perma.cc/LQ2P-853R>.

power. For example, New Hampshire began expansion through its existing Medicaid program in the summer of 2014 but received a waiver in March 2015 that phased in Arkansas-style premium assistance through 2016 and beyond.²⁴⁹ In other words, New Hampshire began with a traditional Medicaid expansion through an SPA and later switched to follow the lead of Arkansas. Alaska and Louisiana both expanded through traditional SPAs, discussed more below.

The thought leader of the first part of the fourth wave was Indiana. Perhaps the most aggressively negotiated expansion to occur during the Obama Administration, Indiana's section 1115 waiver built on its existing Healthy Indiana Plan (HIP) Medicaid waiver as well as prior expansion states' waivers, and it sought more concessions than prior states had requested.²⁵⁰ Approved in January 2015, HIP 2.0 included elements from other states' waivers such as variation in benefit packages (Michigan and Pennsylvania), wellness incentives (Iowa and Michigan), nonemergency transportation payment exclusion (Iowa and Pennsylvania), and premium assistance for beneficiaries to purchase employer-sponsored insurance (Iowa).²⁵¹ HIP 2.0 also contained elements that were new to post-ACA section 1115 waivers, such as a complex cost sharing scheme that—for the first time ever—allowed Medicaid enrollees earning more than 100% of the FPL to be locked out of coverage for six months if they could not pay premiums; mandatory use of health savings accounts to pay for cost sharing; nonretroactive enrollment for certain beneficiaries; and graduated cost sharing for nonemergency use of emergency departments.²⁵² Work requirements were part of the original proposal but were publicly rejected by the Obama Administration.²⁵³

Notably, then-Governor Mike Pence (now Vice President of the United States) pursued HIP 2.0 with the aid of then-consultant Seema Verma (now

249. See Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Nicholas A. Toumpas, Comm'r, N.H. Dep't of Health & Human Servs. 1 (Mar. 4, 2015), <https://perma.cc/KV9Z-KBDQ>; see also Todd Bookman, *Hassan Holds Medicaid Expansion Kick-Off Event*, N.H. PUB. RADIO (June 30, 2014), <https://perma.cc/49VR-EL84> (reporting the initial expansion).

250. See Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Joseph Moser, Medicaid Dir., Ind. Family & Soc. Servs. Admin. 1-3 (Jan. 27, 2015), <https://perma.cc/9U6V-3BAF> (approving Indiana's HIP 2.0 waiver application).

251. See *id.*

252. See Ctrs. for Medicare & Medicaid Servs., No 11-W-00296/5, Waiver List: Healthy Indiana Plan (HIP) 2.0, at 1-3 (2015), <https://perma.cc/9U6V-3BAF>; see also Abby Goodnough, *Indiana Will Allow Entry to Medicaid for a Price*, N.Y. TIMES (Jan. 27, 2015), <https://perma.cc/2GRQ-MF35>.

253. See Phil Galewitz, *Kentucky and Feds Near Possible Collision on Altering Medicaid Expansion*, KAISER HEALTH NEWS (July 27, 2016), <https://perma.cc/W4LH-GMBM> (recounting that Indiana's plan was approved "only after [the state] gave up on requiring Medicaid recipients to hold jobs").

Administrator of the Centers for Medicare & Medicaid Services (CMS)), who was also paid to design section 1115 waivers for Iowa, Kentucky, Ohio, and Tennessee.²⁵⁴ (We see multistate consultants playing the same role in the horizontal dynamics of insurance exchange implementation, as detailed in Part V below.) Verma's participation surely facilitated the horizontal learning so prominent in the third and fourth waves of the Medicaid expansion, and HIP 2.0 quickly became a model for other states, including some that had already opted in and that sought modified or new waivers through the end of the Obama Administration and into the Trump Administration.²⁵⁵ New Hampshire's new Arkansas-style premium assistance waiver included some Indiana-style elements such as preventing retroactive coverage for newly eligible enrollees.²⁵⁶ Montana also mimicked parts of Indiana's successful negotiations, gaining approval for up to ninety-day disenrollment upon nonpayment of premiums for beneficiaries earning more than 100% of the FPL.²⁵⁷

The fourth wave also added a novel phenomenon: *existing* opt-in states reconsidering already-implemented SPAs or renegotiating existing waivers after witnessing new concessions being granted by HHS. Perhaps most notable among the existing opt-in states, Kentucky elected Republican Governor Matt Bevin in November 2015 after he campaigned on eliminating Kentucky's widely heralded implementation of the ACA, which included Medicaid expansion through a traditional SPA.²⁵⁸ Kentucky proposed a section 1115

254. See Seema Verma, U.S. DEP'T HEALTH & HUM. SERVS., <https://perma.cc/59XL-YUQV> (archived Apr. 23, 2018).

255. Verma's CMS expects states to learn from one another. For example, CMS issued guidance promoting the streamlining of section 1115 waivers. See Brian Neale, Ctr. for Medicaid & CHIP Servs., U.S. Dep't of Health & Human Servs., Section 1115 Demonstration Process Improvements 3 (2017), <https://perma.cc/E827-SK8N> ("CMS will develop parameters for expedited approval of certain waiver authorities under demonstrations . . . that are substantially similar to those approved in other states . . ."). Language in CMS's approval letter for Kentucky's demonstration project that includes work requirements is also telling. See Letter from Brian Neale, Deputy Adm'r, Ctr. for Medicaid & CHIP Servs., U.S. Dep't of Health & Human Servs., to Adam Meier, Deputy Chief of Staff, Office of Governor Matthew Bevin, State of Ky. 1 (Jan. 12, 2018), <https://perma.cc/X57W-NQMV> ("Your substantial work will help inform future state demonstrations seeking to draw on Kentucky's novel approaches to Medicaid reform . . .").

256. See Letter from Andrew M. Slavitt to Nicholas A. Toumpas, *supra* note 249, at 1.

257. See Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Mary E. Dalton, State Medicaid Dir., Mont. Dep't of Pub. Health & Human Servs. 1 (Nov. 2, 2015), <https://perma.cc/7CLR-H3XE>.

258. See Nora Kelly, *Can Kentucky's New Governor Undo Obamacare?*, ATLANTIC (Dec. 16, 2015), <https://perma.cc/GBC5-U225> (noting that Governor Bevin pledged to dismantle Kentucky's insurance exchange and alter its Medicaid expansion); see also The Henry J. Kaiser Family Found., Proposed Changes to Medicaid Expansion in Kentucky 2 (2017),
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waiver in the summer of 2016 that contained many of the same elements as the Indiana HIP 2.0 waiver but sought even more concessions.²⁵⁹ Like Indiana's, Pennsylvania's, and those of other states before it, Kentucky's waiver proposal included work requirements for the population Governor Bevin called the "able-bodied," which the Obama Administration consistently refused to allow.²⁶⁰

CMS approved Kentucky's waiver application—including the work requirements—shortly before this Article went to print,²⁶¹ signaling how the Trump Administration will proceed with fourth-wave renegotiations and new waiver applications. In addition to Kentucky, other states such as Arizona, Arkansas, Michigan, and Ohio have been attempting to renegotiate their expansions, seeking to win the same concessions other states received and, in most cases, pushing for even more.²⁶²

<https://perma.cc/K9LQ-BYYC> (noting the move from traditional expansion to waiver expansion).

259. See Kentucky HEALTH Waiver Application 7-14 (n.d.), <https://perma.cc/34C9-HREH>; see also Joseph Gerth, *Matt Bevin Calls for Unity at Inauguration*, COURIER-J. (Louisville, Ky.) (updated Dec. 8, 2015, 6:38 PM ET), <https://perma.cc/YQ74-PESB> (reporting that Governor Bevin said in his inaugural address that "he would model Kentucky's Medicaid policies after" Indiana's).

260. See Ryland Barton, *Federal Government Starting to Question Bevin's Medicaid Proposal*, 89.3 WFPL (Louisville, Ky.) (July 1, 2016), <https://perma.cc/44XR-LC5K>. In July 2017, Kentucky submitted an amendment to its application that made the work requirements more stringent by effectively shortening the clock for work requirements to kick in when enrollees churn out of and back into the program. See Kentucky HEALTH Operational Modification Request 3-6 (2017), <https://perma.cc/T83G-A5WM>; see also Deborah Yetter, *Bevin Revises Medicaid Plan, Seeks to Reduce Kentucky's Rolls by Another 9,000 People*, COURIER-J. (Louisville, Ky.) (updated July 8, 2017, 10:58 AM ET), <https://perma.cc/9E88-B5ZZ> (explaining the amended waiver application in plain English). This amendment was part of the approved section 1115 waiver. See Ctrs. for Medicare & Medicaid Servs., Nos. 11-W-00306/4 & 21-W-00067/4, KY HEALTH Section 1115 Demonstration 33 (2018), <https://perma.cc/JV3Q-SRXL>.

261. See Letter from Demetrios L. Kouzoukas to Stephen P. Miller, *supra* note 128, at 1-2.

262. Arizona pursued many of the concessions other states received in their waivers, including wellness incentives, exclusion of nonemergency medical transportation, varied benefit packages, and enforceable premiums and copayments with lockout periods. See Ariz. Health Care Cost Containment Sys., *Arizona's Application for a New Section 1115 Demonstration: Section I—Program Description 2-6* (n.d.), <https://perma.cc/PSF4-6RFB>.

Arkansas added cost sharing and limited nonemergency medical transportation by requiring prior approval, but its proposed work requirements and asset tests were rejected. See The Henry J. Kaiser Family Found., *Medicaid Expansion in Arkansas 1* (2015), <https://perma.cc/JZ9L-5Y3Z>; see also David Ramsey, *Governor Seeks New Concessions from CMS to Maintain Arkansas' Medicaid Expansion*, KAISER HEALTH NEWS (Feb. 1, 2016), <https://perma.cc/Q89V-WJWL>.

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Work requirements may be where the transition to the Trump Administration will make the most difference in the Medicaid expansion context. Former federal officials told us that in trying to make the ACA work during the end of the Obama Administration, HHS found new ways to compromise.²⁶³ Yet one place where President Obama's HHS consistently drew the line was work requirements.²⁶⁴ However, the new CMS Administrator Verma—who, as discussed above, crafted waiver applications with work requirements while working as a consultant—and then-HHS Secretary Tom Price issued a letter in March 2017 emphasizing their desire to protect “the most vulnerable populations” and stating that “[t]he best way to improve the long-term health of low-income Americans is to empower them with skills and employment.”²⁶⁵ The letter continued: “It is our intent to use existing Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment and independence.”²⁶⁶ Thus, the fourth wave is developing to include additional concessions that will motivate red states to opt in, and it appears that Kentucky's waiver

Michigan too sought new concessions. See Virgil Dickson, *GOP-Led Medicaid Expansion States Test Limits of CMS Flexibility on Waivers*, MOD. HEALTHCARE (May 7, 2015), <https://perma.cc/T2D6-3Y69>.

Ohio requested a waiver allowing it to require premium payments for all income levels; that request was denied along with other proposed features such as lockouts that would have “exclude[d] individuals from coverage indefinitely until they paid all arrears.” See Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dept. of Health & Human Servs., to John McCarthy, Medicaid Dir., Ohio Dep't of Medicaid 1 (Sept. 9, 2016), <https://perma.cc/EAU6-N78H>.

For a summary of states' waiver requests, see MaryBeth Musumeci et al., The Henry J. Kaiser Family Found., *Section 1115 Medicaid Expansion Waivers: A Look at Key Themes and State Specific Waiver Provisions* (2017), <https://perma.cc/Q8ZL-R26W> (comparing requests and flagging questionable application features such as work requirements and partial expansion). For additional resources tracking recent developments, see *Medicaid Waiver Tracker: Which States Have Approved and Pending Section 1115 Medicaid Waivers?*, KAISER FAM. FOUND. (Apr. 9, 2018), <https://perma.cc/W43Q-L8YG>; and Musumeci et al., *supra* note 197.

Third-wave demonstration waivers expire within five years, see *Waivers*, MEDICAID & CHIP PAYMENT & ACCESS COMMISSION, <https://perma.cc/T85C-KVLL> (archived Apr. 24, 2018), creating potential for further negotiation and adaptation as those waivers are reapproved, amended, or dropped.

263. See Interview with Former Federal Executive Branch Healthcare Official 1, *supra* note 213.

264. See Interview with Former Federal Executive Branch Healthcare Official 5, *supra* note 190; Interview with Health Policy Nonprofit Officers 1 (a Former State Official) and 2 (Aug. 1, 2016) (on file with authors).

265. See Letter from Thomas E. Price, Sec'y, and Seema Verma, CMS Adm'r, U.S. Dep't of Health & Human Servs., to Governor 1-2 (Mar. 14, 2017), <https://perma.cc/5Q6Q-3B79>.

266. *Id.* at 2.

could be the switch that flips other states in the post-Obama realm of ACA implementation,²⁶⁷ if it survives legal challenges.²⁶⁸

As this Article went to print, Indiana, Arkansas, and New Hampshire had work requirements approved by CMS in rapid succession.²⁶⁹ Other states are exploring section 1115 waivers that would include work requirements, cost sharing, and other novel limitations on Medicaid coverage and benefits.²⁷⁰

But as we have emphasized, movement in Medicaid goes both ways. In a mirror image to Kentucky's 2015 election, Democrat John Bel Edwards rejected prior Republican Governor Bobby Jindal's nonexpansion politics and expanded Medicaid eligibility in Louisiana.²⁷¹ His desire to enroll uninsured individuals as quickly as possible with a lean administrative staff led Louisiana to be first to take advantage of a rapid enrollment mechanism that allows states to use eligibility data for the Supplemental Nutrition Assistance Program (SNAP), the program commonly known as food stamps, to reach out to Medicaid-eligible individuals for enrollment.²⁷² By exercising this option, Louisiana swiftly added more than 300,000 new beneficiaries,²⁷³ Louisiana thus

267. See Nicole Huberfeld, Perspective, *Can Work Be Required in the Medicaid Program?*, 378 NEW ENG. J. MED. 788, 790 (Feb. 7, 2018) (predicting that new Medicaid expansions will be shaped by CMS's new policies permitting work requirements).

268. See, e.g., Class Action Complaint for Declaratory and Injunctive Relief, *Stewart v. Hargan*, No. 1:18-cv-00152 (D.D.C. Jan. 24, 2018), 2018 WL 525491.

269. Indiana's waiver application was approved three weeks after Kentucky's. See Letter from Demetrios Kouzoukas, Principal Deputy Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dept. of Health & Human Servs., to Allison Taylor, Medicaid Dir., Ind. Family & Soc. Servs. Admin. 1-2 (Feb. 2, 2018), <https://perma.cc/R8W2-536U>. For Arkansas's and New Hampshire's work requirements, respectively, see Letter from Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Cindy Gillespie, Dir., Ark. Dep't of Human Servs. 1-2 (Mar. 5, 2018), <https://perma.cc/G57C-Y8P4>; and Letter from Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to Henry D. Lipman, Medicaid Dir., N.H. Dep't of Health & Human Servs. 1-2 (May 7, 2018), <https://perma.cc/S3XE-PYLQ>.

270. See Musumeci et al., *supra* note 197.

271. See Elizabeth Crisp, *Louisiana Road to Medicaid Expansion Long, Winding but Finally Here*, ADVOCATE (Baton Rouge, La.) (July 5, 2016, 4:17 PM), <https://perma.cc/E3ED-92MT>.

272. See Kevin Litten, *Louisiana to Use Food Stamp Data for Medicaid Expansion*, TIMES-PICAYUNE (New Orleans, La.) (updated May 6, 2016, 2:53 PM), <https://perma.cc/3GM2-CL2S>. HHS had encouraged this approach. See Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., U.S. Dep't of Health & Human Servs., to State Health Official and State Medicaid Dir. 1-2, 4-5 (May 17, 2013), <https://perma.cc/H7VR-PEFE>.

273. See Elizabeth Crisp, *Medicaid Expansion Enrollment Tops 300K in Louisiana*, ADVOCATE (Baton Rouge, La.) (Sept. 19, 2016, 11:55 AM), <https://perma.cc/7NXY-6NN3>; Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., U.S. Dep't of Health & Human Servs., to State Health Official and State Medicaid Dir. 3 (Aug. 31, 2015), <https://perma.cc/23Z5-7JMC> (noting that CMS will allow targeted enrollment through SNAP).

offered a model for states that may experience political switches that lead to opting in with a desire to onboard newly eligible beneficiaries quickly, even in a post-Obama Administration environment.

One former governor told us that the topic of successful strategies for expansion is a popular one at governors' closed-door gatherings, especially at the National Governors Association.²⁷⁴ This is horizontal interaction to be sure, but it is not states acting in concert or using combined leverage to move HHS. Rather, states have experienced horizontal learning, leading to a sort of sibling rivalry, seeking what others acquired plus a little more.

The Medicaid implementation story illustrates our point that this is not a zero-sum game. Some states "won" concessions through individualized demonstration waivers. The Obama Administration arguably "lost" by conceding on the principle of universality in negotiations, allowing states to reintroduce exclusionary measures like lockout for failure to pay premiums. But President Obama's HHS "won" by bringing state after state into the ACA. States that have not yet negotiated their way to expansion have arguably "lost" because their uninsurance rates are higher on average than those in states that expanded.²⁷⁵ Consider Kentucky, which originally adopted an ACA-based Medicaid expansion but then sought an exclusionary demonstration waiver.²⁷⁶ Is Kentucky cooperative? Is it more sovereign to implement Medicaid expansion through an SPA or through a negotiated waiver? Each reserves power and allows choices for the state, and each involves federal standards the state must observe. Who has won?

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

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

It is ironic that federalism scholars often discuss "the states" as if they were a monolithic bloc, as one of the underpinnings of classic federalism theory is to recognize each state as a sovereign government—and thus distinguishable from

274. Interview with Former Governor, *supra* note 213.

275. See The Henry J. Kaiser Family Found., Key Facts About the Uninsured Population app. A at 8 (2017), <https://perma.cc/33L8-3JR3>; see also *id.* at 1-3 (discussing continued obstacles to coverage in states that have not expanded Medicaid).

276. See *supra* notes 221, 258-61 and accompanying text.

the next state. The Medicaid expansion highlights these differences and reinforces the important influence that intrastate politics—and the expression of state sovereignty that comes with it—has on state interaction with federal law. Medicaid expansion involved fifty-two different negotiating sovereigns—each state (plus the District of Columbia) individually and the federal government. It also involved politically fraught intrastate decisionmaking that both underscores the important differences among state governors, legislatures, and administrative agencies in state policymaking and undermines accounts of modern federalism as dominated by partisanship.

1. Intrastate differences as a countervailing force to partisanship

Not all states have the same legal or constitutional structure. These acknowledged differences affect how a state might go about implementing, or even deciding to implement, a federal program.²⁷⁷

One of our interviewees emphasized that “the lack of knowledge of how states function is rampant in Congress” and that Congress does not think about preexisting state regulatory structures when drafting.²⁷⁸ States had different laws regulating insurance and Medicaid going into the ACA, which affected the implementation choices they made.²⁷⁹

Internal state actors also diverge from one another in significant ways. In the Medicaid context, budget considerations, influential healthcare stakeholders (especially hospitals), and the needs of low-income and rural citizens turned some red-state governors into Medicaid supporters, even when they faced resistance from legislators in their own party. For example, Republican Governor Brewer announced that Arizona would expand, then faced opposition from legislators; she then called a surprise legislative session and refused to end it until expansion legislation passed.²⁸⁰ Similar (though less extreme) circumstances arose in North Dakota and Ohio, each of which also had a Republican governor supporting expansion over vociferous Republican legislative protests, but in which expansion ultimately occurred.²⁸¹

277. Cf., e.g., SHELLY TEN NAPEL ET AL., STATE HEALTH REFORM ASSISTANCE NETWORK, MANAGING STATE-LEVEL ACA IMPLEMENTATION THROUGH INTERAGENCY COLLABORATION 4-9 (2012), <https://perma.cc/5B8L-ARK4> (encouraging state actors that have historically had different goals in state policymaking to work together to implement the ACA).

278. See Interview with Former Governor, *supra* note 213.

279. See Interview with Health Policy Nonprofit Officers 1 (a Former State Official) and 2, *supra* note 264; see also Interview with Former Federal Executive Branch Healthcare Officials 2, 3, and 4, *supra* note 29.

280. See Reinhart, *supra* note 220.

281. See Smith, *supra* note 222; Young, *supra* note 222; Dan Zak, *Spurning the Party Line*, WASH. POST (Jan. 5, 2016), <https://perma.cc/RB8P-4GE7>.

Some governors tried working around legislatures altogether. For instance, Kentucky Governor Beshear (a Democrat) implemented Medicaid expansion using a longstanding Kentucky law that commanded Medicaid funds to be maximized.²⁸² He commissioned reports supporting his position, which then enabled him to instruct the Kentucky Cabinet for Health and Family Services to expand Medicaid pursuant to state law.²⁸³ A lawsuit argued that he could not expand in this manner—administratively and without legislative action—but state courts sided with the governor, allowing expansion to proceed.²⁸⁴ Similarly, Ohio Governor John Kasich (a Republican) asked the state Controlling Board (a commission that facilitates use of federal funds outside the legislative budgeting process) to approve the use of available federal funds for Medicaid expansion.²⁸⁵ This maneuver bypassed the legislature, which had refused to pass a budget that included expansion.²⁸⁶ In 2017, the legislature enacted a requirement that the state’s Department of Medicaid seek reapproval by the Controlling Board every six months so as to limit this kind of workaround.²⁸⁷

In Alaska, Governor Bill Walker (an independent) rejected the anti-expansion policy of Governor Sean Parnell (a Republican) and expanded through an existing state Medicaid law that automatically accepts federal eligibility categories labeled as mandatory.²⁸⁸ The Alaska Legislative Council challenged Governor Walker’s action to expand Medicaid, claiming that *NFIB*

282. See Sheila Lynch-Afryl, *Kentucky Court Rejects Constitutional Challenges to Medicaid Expansion, Insurance Exchanges*, HEALTH L. DAILY (Sept. 5, 2013), <https://perma.cc/N9G5-CJUA>; see also KY. REV. STAT. ANN. § 205.520(3) (West 2018) (“[I]t is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance.”).

283. See Press Release, State of Ky., Gov. Beshear Expands Health Coverage to over 300,000 Kentuckians (May 9, 2013), <https://perma.cc/P5XY-KMAQ>.

284. See Lynch-Afryl, *supra* note 282; The Henry J. Kaiser Family Found., *An Overview of Actions Taken by State Lawmakers Regarding Medicaid Expansion* 4-5 (2015), <https://perma.cc/JQX8-8XV9>.

285. See David Schleicher, *Federalism and State Democracy*, 95 TEX. L. REV. 763, 796-97 (2017) (detailing the history of Medicaid expansion in Ohio).

286. See *id.*

287. See Andy Chow, *Despite Complaints, Medicaid Expansion Funding Approved by Ohio Panel*, WOSU RADIO (Columbus, Ohio) (Oct. 31, 2017), <https://perma.cc/UT4U-5ELL>; Andy Chow, *House Budget Proposes a Tighter Grip on Medicaid Expansion Funds*, WKSU (Kent, Ohio) (May 1, 2017), <https://perma.cc/6PGG-KWUW>.

288. See Craig Tuten, *Legislature’s Medicaid Expansion Lawsuit Against State Dismissed*, ALASKA COMMONS (Mar. 2, 2016), <https://perma.cc/UCY4-HQ93> (discussing Governor Walker’s expansion strategy); Reid Wilson, *Alaska Says No to Medicaid Expansion*, WASH. POST: GOVBEAT (Nov. 18, 2013), <https://perma.cc/L335-T4KJ> (reporting that Governor Parnell refused to expand Medicaid); see also ALASKA STAT. § 47.07.020(a) (2017) (“All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance . . .”).

had converted the expansion into a Medicaid option that could be implemented only through affirmative legislative changes.²⁸⁹ A state court held that Alaska could sign on to the expansion over legislative objection.²⁹⁰ The Legislative Council lost steam and did not appeal the decision.²⁹¹

In other states, governors commissioned studies of expansion, which have supported ongoing intrastate negotiations regarding Medicaid expansion.²⁹² Movement toward expansion has continued, even after the Trump Administration took office.²⁹³

On the other hand, some governors who fought expansion were deeply opposed by their legislatures. For example, in Maine, Governor Paul LePage vetoed Medicaid expansion five times, leading to a 2017 ballot initiative that made Maine the first state to expand by referendum.²⁹⁴ And some governors have supported expansion but have been unable to work around their legislatures, such as North Carolina Governor Roy Cooper, a Democrat who attempted to reverse his Republican predecessor's decision to opt out of

289. See Memorandum in Support of Plaintiff's Motion for Summary Judgment at 3-5, *Alaska Legislative Council v. Walker*, No. 3AN-15-09208 CI, 2016 WL 4073651 (Alaska Super. Ct. Mar. 1, 2016), 2016 WL 1257541; see also Tuten, *supra* note 288 (discussing the litigation).

290. See *Alaska Legislative Council*, 2016 WL 4073651, at *9 (holding that "existing law required the Governor to provide Medicaid to the expansion group").

291. See Tegan Hanlon, *Legislative Council Drops Medicaid Lawsuit Against Gov. Walker*, ANCHORAGE DAILY NEWS (updated June 29, 2016), <https://perma.cc/7CFY-P2X4>. Thanks to Mark Regan for assistance in making the points in this paragraph.

292. See, e.g., Luke Ramseth, *Utah Governor Signs Medicaid Expansion Bill. Now, Utah Waits to See If the Feds Will Approve It*, SALT LAKE TRIB. (updated Mar. 28, 2018), <https://perma.cc/ZDU7-44RS> (reporting Utah's approval of expansion); Press Release, Utah Dep't of Health, Medicaid Expansion Options Community Workgroup to Hold First Meeting (Apr. 22, 2013), <https://perma.cc/4VW9-WVJ4>; *Utah Governor: Don't Rush to Judgment on Medicaid Expansion*, SALT LAKE TRIB. (Mar. 7, 2013, 5:02 PM), <https://perma.cc/PMR8-7DWK> (reporting on the Utah governor's commission); see also, e.g., Press Release, Office of the Governor of Idaho, Governor Appoints Working Groups to Study Obamacare Questions (July 13, 2012), <https://perma.cc/BZS6-4PHE>; Gary Rayno, *Governor's Commission Recommends Expanding State's Medicaid Program*, N.H. HOSP. ASS'N, <https://perma.cc/96XN-BGY9> (archived May 16, 2018).

293. See, e.g., Rose Hoban, *In First Budget, Cooper Pushes for Medicaid Expansion*, N.C. HEALTH NEWS (Mar. 2, 2017), <https://perma.cc/4TGK-AZHX> (reporting that North Carolina Governor Roy Cooper "remain[ed] at loggerheads" with legislators over his efforts to expand Medicaid); Bruce Japsen, *More States to Expand Medicaid Now That Obamacare Remains Law*, FORBES (Mar. 26, 2017, 9:19 AM), <https://perma.cc/Q28J-QBGW> (reporting Kansas's and North Carolina's continued efforts to expand).

294. See Patrick Whittle, *Maine OKs Medicaid Expansion in First-of-Its-Kind Referendum*, ASSOCIATED PRESS (Nov. 8, 2017), <https://perma.cc/J4GC-U9NU>.

Medicaid expansion,²⁹⁵ and Missouri Governor Jay Nixon, a Democrat who was thwarted by a Republican-dominated legislature.²⁹⁶

Of course, some governors and their legislatures have aligned. For example, Texas Governor Rick Perry submitted a letter to HHS Secretary Sebelius just days after *NFIB*, publicly proclaiming that Texas opted out of both the Medicaid expansion and the exchanges.²⁹⁷ The Texas legislature supported that letter with legislation preventing compliance.²⁹⁸

We surmise that the reason governors have diverged so much from legislatures of their own party has to do with governors' traditional accountability for state budgets and their longer time horizons.²⁹⁹ Governors are also likely to feel the heat from industry—such as the ire of the hospitals that suffered in nonexpansion states—in more focused fashion than any single legislator.³⁰⁰ It may be easier for legislators to take stands purely for political reasons.³⁰¹ Governors, on the other hand, must work with Medicaid commissioners and (sometimes elected) state insurance commissioners, get blamed for budget crises, answer to industry, and see benefits in shifting healthcare costs to the federal government while simultaneously creating more in-state medical sector jobs.³⁰²

295. See Anne Blythe, *NC Legislators Drop Lawsuit Challenging Cooper's Attempt to Expand Medicaid Under Obamacare*, NEWS & OBSERVER (Raleigh, N.C.) (updated July 20, 2017, 6:21 PM), <https://perma.cc/PU4T-RF4X>; David Ranii & Lynn Bonner, *Gov. Roy Cooper Wants to Expand Medicaid; Republicans Vow to Fight*, NEWS & OBSERVER (Raleigh, N.C.) (updated Jan. 5, 2017, 3:36 PM), <https://perma.cc/7D8C-VKK2>; Dan Way, *McCrory Announces Limited Medicaid Expansion*, CAROLINA J. (Apr. 12, 2016, 12:37 AM), <https://perma.cc/3QQW-E8FL>.

296. See Kyle Cheney, *Missouri Nixes Medicaid Expansion*, POLITICO (May 8, 2013, 5:19 AM EDT), <https://perma.cc/G4BV-C37P>. The newly elected Republican governor opposed expansion in early 2017. See Austin Huguelet, *Despite Failure of GOP Health Care Bill, Greitens Remains Opposed to Medicaid Expansion*, ST. LOUIS POST-DISPATCH (Mar. 28, 2017), <https://perma.cc/8JA6-2JEC>.

297. See Letter from Rick Perry, Governor of Tex., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (July 9, 2012) (on file with authors).

298. See James Jeffrey, *Texas Bill Thwarts Medicaid Expansion Here*, AUSTIN BUS. J. (May 28, 2013, 7:32 AM CDT), <https://perma.cc/G23R-5FTM>; see also Act of June 14, 2013, ch. 1310, § 6.09, 2013 Tex. Laws 3409, 3446.

299. See Interview with Former Governor, *supra* note 213.

300. See, e.g., Alexander Hertel-Fernandez et al., *Business Associations, Conservative Networks, and the Ongoing Republican War over Medicaid Expansion*, 41 J. HEALTH POL. POL'Y & L. 239, 244 (2016) (noting that hospitals have pressed states to expand Medicaid); Bruce Japsen, *Pressure on Governors to Expand Medicaid Under ObamaCare*, FORBES (Mar. 8, 2014, 10:01 AM), <https://perma.cc/3SR4-2WZX> (describing pressure on governors).

301. See, e.g., Hertel-Fernandez et al., *supra* note 300, at 259-61 (offering the example of Missouri legislators' rejection of expansion).

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

One former governor we interviewed put it this way: “The governor represents the entire state . . . [and] has to advance a statewide vision to move the state forward, whereas the legislature tends to be a more reactionary type body, drawing from small districts.”³⁰³ Indeed, as the most recent Republican efforts to repeal the ACA drew to a close, we saw this dynamic in play once again. Bipartisan groups of governors allied to protest the repeal legislation.³⁰⁴

Some recent federalism scholarship puts a heavy emphasis on partisan politics as the primary domain in which modern federalism issues play out. That narrative is a nationalist narrative to some extent, as inter- and intrastate differences matter less to it than national party affiliation. But as Rick Hills has observed, the ACA’s implementation calls this assumption into question.³⁰⁵ For instance, Jessica Bulman-Pozen argues that states are a proving ground in which national parties test their policies and claims that the resistance to the ACA’s implementation was “perfectly partisan.”³⁰⁶ David Schleicher likewise predicts, as Hills puts it, that state politicians will “march[] in lockstep with their national counterparts.”³⁰⁷ Schleicher also notes, however, that federalism theory that emphasizes partisanship may be less relevant when it comes to governors.³⁰⁸ Our findings substantiate that claim. Schleicher further suggests that state democracy itself—a key federalism attribute—is strengthened by these acts of differentiation from the national party.³⁰⁹

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

303. Interview with Former Governor, *supra* note 213.

304. See Letter from John Hickenlooper, Governor of Colo., et al., to Mitch McConnell, Majority Leader, and Charles E. Schumer, Minority Leader, U.S. Senate (Sept. 19, 2017), <https://perma.cc/6W6Q-DEUL>.

305. See Rick Hills, *Governors and the Failure of ACA Repeal: Federalism as Safeguard Against National Partisan Politics*, PRAWFSBLAWG (July 28, 2017, 11:46 AM), <https://perma.cc/KPU2-XLGM>.

306. See Jessica Bulman-Pozen, *Partisan Federalism*, 127 HARV. L. REV. 1077, 1081, 1098 (2014) (arguing that both political resistance and litigation against the ACA reflected partisanship).

307. See Hills, *supra* note 305; see also Schleicher, *supra* note 285, at 765 (“Elections where voters rely on party preferences developed in relation to another level of government are common enough worldwide that political scientists have developed a term for them: ‘second-order elections.’”).

308. See Schleicher, *supra* note 285, at 797-98.

309. See *id.* at 771.

2. Autonomy and local variation

Furthering the point about individual states acting as their own differentiated sovereigns, no state or federal official we interviewed told us that any states acted jointly in negotiations with HHS.³¹⁰ The Medicaid expansion did not play out as a battle between the national government and “the states” as a collective. Instead, the Obama Administration was a serial negotiator, inking distinct deals with individual states, all of which watched the others and then negotiated in their own interests.³¹¹

One influential critique of modern federalism theory—Malcolm Feeley and Edward Rubin’s argument that schemes like the ACA’s offer mere decentralization, not federalism—argues that two key criteria for federalism, even within a cooperative program, are at least “partial autonomy” and identity with the state.³¹² The leverage the states exerted in the ACA’s implementation and the extent to which they were able to shape their programs so individually seems to fit within the Feeley-Rubin model of federalism. To us, it is notable in this vein that state Medicaid programs typically adopt a state-centered identity. They have names like HIP 2.0, TennCare, and Husky Health, rather than Indiana Medicaid, Tennessee Medicaid, or Connecticut Medicaid.³¹³

With respect to the kind of variety federalist regimes are expected to demonstrate, these individual state negotiations produced enormous policy and legal diversity. Table 1 below offers a snapshot of the wide range of possible state decisions regarding Medicaid expansion. These decisions include not just whether to expand Medicaid but also how as a matter of law, when, and with which negotiated modifications to the ACA’s structure. The breadth of variations illustrates a classic federalism value in action—local decisionmaking—but with the modern twist of occurring *within* a national baseline established by federal law. At the same time, variability across states in Medicaid access conflicts with a common health policy goal of equality—the

310. See Interview with Former Federal Executive Branch Healthcare Official 1, *supra* note 213; Interview with Former Federal Executive Branch Healthcare Officials 2, 3, and 4, *supra* note 29; Interview with Former Federal Executive Branch Healthcare Official 5, *supra* note 190; Interview with Former Governor, *supra* note 213; Interview with State Policy Organization Officers 1, 2, 3, and 4, *supra* note 213.

311. One scholar of Canadian federalism wrote: “A common observation is that federal-provincial relations resemble international diplomacy, and often Ottawa’s only option is to negotiate separate bilateral deals with individual provinces.” JONATHAN A. RODDEN, *HAMILTON’S PARADOX: THE PROMISE AND PERIL OF FISCAL FEDERALISM* 263 (2006).

312. See FEELEY & RUBIN, *supra* note 9, at 16.

313. See Interview with Former Federal Executive Branch Healthcare Officials 2, 3, and 4, *supra* note 29; see also, e.g., HUSKY HEALTH CONN., <https://perma.cc/FF9M-4XJ6> (archived Apr. 30, 2018); *TennCare Medicaid*, DIVISION TENNCARE, <https://perma.cc/36J9-CPVS> (archived Apr. 30, 2018); *supra* text accompanying notes 250-51.

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very goal the ACA's universal Medicaid expansion was designed to address.³¹⁴ A preference for variety and state choices tends to undermine moral aims like this one in a federalist regime; but of course, this point is not unique to healthcare.

314. See Nicole Huberfeld & Jessica L. Roberts, Essay, *An Empirical Perspective on Medicaid as Social Insurance*, 46 U. TOL. L. REV. 545, 556 (2015) (exploring Medicaid expansion as social justice); *supra* Part III.A.

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Table 1
State Decisions Regarding Medicaid Expansion

State	HHS Approval	Method	Type of Waiver	Covered Childless Adults Before ACA	Exchange Design	Challenged Constitutionality of Expansion
Ala.					FFM	✓
Alaska	✓	SPA [†]			FFM	✓
Ariz.	✓	*			FFM	✓
Ark.	✓	Waiver	First prem. assist.; later work reqs.		SBM-FP	
Cal.	✓	SPA		✓	SBM	
Colo.	✓	SPA		✓	SBM	✓
Conn.	✓	SPA		✓	SBM	
Del.	✓	SPA			SPM	
D.C.	✓	Waiver	Beyond ACA	✓	SBM	
Fla.					FFM	✓
Ga.					FFM	✓
Haw.	✓	SPA			FFM	
Idaho					SBM	✓
Ill.	✓	SPA			SPM	
Ind.	✓	Waiver	Prem. assist.; later work requirements		FFM	✓
Iowa	✓	Waiver	Premium assistance		SPM	✓~
Kan.					FFM-PM	✓
Ky.	✓	Both [†]	First work requirements		SBM-FP	
La.	✓	SPA [†]			FFM	✓
Me.	◇	◇			FFM-PM	✓
Md.	✓	SPA			SBM	
Mass.	✓	Waiver	Universal coverage	∞	SBM	
Mich.	✓	Waiver			SPM	✓
Minn.	✓	Waiver	Beyond ACA	✓	SBM	
Miss.					FFM	✓
Mo.					FFM	
Mont.	✓	Waiver			FFM-PM	
Neb.					FFM-PM	✓
Nev.	✓	SPA			SBM-FP	✓
N.H.	✓	*	Prem. assist.; later work requirements		SPM	
N.J.	✓	SPA		✓	FFM	
N.M.	✓	SPA			SBM-FP	
N.Y.	✓	Waiver	Beyond ACA		SBM	
N.C.					FFM	

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State	HHS Approval	Method	Type of Waiver	Covered Childless Adults Before ACA	Exchange Design	Challenged Constitutionality of Expansion
N.D.	✓	SPA			FFM	✓
Ohio	✓	SPA [†]			FFM-PM	✓
Okla.				**	FFM	
Or.	✓	SPA			SBM-FP	
Pa.	✓	*			FFM	✓
R.I.	✓	SPA			SBM	
S.C.					FFM	✓
S.D.					FFM-PM	✓
Tenn.					FFM	
Tex.					FFM	✓
Utah					FFM	✓
Vt.	✓	Waiver	Beyond ACA		SBM	
Va.					FFM-PM	
Wash.	✓	SPA		✓	SBM	✓~
W. Va.	✓	SPA			SPM	
Wis.				**	FFM	✓
Wyo.					FFM	✓

FFM = federally facilitated marketplace; SBM = state-based marketplace; SPM = state partnership marketplace; SBM-FP = state-based marketplace on the federal platform; FFM-PM = federally facilitated marketplace with state plan management.

† Expansion initiated by executive action.

* Arizona began with expansion by SPA and obtained a waiver in 2016. New Hampshire started with an SPA but submitted an application for a waiver at the same time; its application was approved. Pennsylvania set aside its approved waiver after a gubernatorial election, instead expanding by SPA.

** Oklahoma has a state-funded program that helps to pay for the coverage of individuals earning up to 100% of the FPL and that relies in part on federal funds that were supposed to end with Medicaid expansion in 2013 but have been renewed on an annual basis due to Oklahoma's inability to expand. Wisconsin has a pre-ACA waiver that covers nonelderly adults up to 100% of the FPL; no super-match applies, but BadgerCare offers more coverage than nonparticipating states.

◇ Maine's electorate voted to expand Medicaid by ballot initiative in 2017, but the governor has objected, leading to neither an SPA nor a waiver for expansion at the time this Article went to print.

∞ Massachusetts created universal insurance coverage in 2006 that was a model for the ACA, but MassHealth put the childless nonelderly adult population in subsidized private insurance because Medicaid did not match coverage for this population until the ACA was enacted.

✓~ State attorney general and governor took opposite positions.

Table 1 shows that states have explored a variety of legal structures for implementing federalist policies. As discussed above, many first- and second-wave states complied with the ACA by using SPAs, the traditional mechanism for a state to indicate to HHS its strategy for complying with federal Medicaid law.³¹⁵ But as also discussed above, states have sought section 1115 demonstration waivers too, both to offer more than the ACA requires and to pursue variables that push on the baseline of universal coverage enacted in the ACA.³¹⁶ In states that have not yet expanded, negotiations are ongoing both intrastate and intergovernmentally with HHS, and another snapshot one year in the future would likely offer further variations.

To build on this narrative, Table 2 below offers a different snapshot, illustrating the variety of policy choices states have made after expanding Medicaid eligibility. For example, states have used section 1115 waivers to expand eligibility above the ACA's baseline; change the method of implementation, such as by providing benefits in the form of premium assistance; or adopt cost sharing, premiums, healthy behavior or wellness incentives, or work requirements. The states that have slowly opted in by negotiating their way to expansion have enjoyed the most policy discretion, seen in the chart by the numerous policy variations adopted by third- and fourth-wave expansion states. As discussed in Part IV.A above, each new section 1115 waiver involves more variation from the federal baseline, and fourth-wave states are leveraging the option not to expand eligibility that *NFIB* created and that HHS might not have been eager to grant if not for the Court's interference. Table 2 accounts for expansion waivers and submitted waiver applications but not informal negotiations.

315. *See supra* Parts IV.A.1-2.

316. *See supra* Part IV.A.

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Table 2
Policy Variations Through Waivers in Medicaid Expansion States

State	Eligibility Beyond ACA	Premium Assistance	Work Requirements	Premiums or Cost Sharing	Lockouts	Wellness Incentives	Limits on Nonemergency Transportation	Health Savings Accounts
Alaska								
Ariz.			Pending	✓		✓		
Ark.		✓	✓	✓				✓
Cal.								
Colo.								
Conn.								
Del.								
D.C.	✓							
Haw.								
Ill.								
Ind.			✓	✓	✓	✓	✓	✓
Iowa		✓*		✓		✓	✓	
Ky.			✓	✓	✓	✓	✓	
La.								
Md.								
Mass.							Pending	
Mich.		✓		✓		✓		✓
Minn.	✓							
Mont.				✓	✓			
Nev.								
N.H.		✓	✓					
N.J.								
N.M.				Pending	Pending	✓		
N.Y.	✓							
N.D.								
Ohio			Pending					
Or.								
Pa.				~		~	~	
R.I.								
Vt.	✓							
Wash.								
W. Va.								

States have waivers and pending waiver applications for existing Medicaid programs that echo the policies reflected in the waivers they seek for Medicaid expansion under the ACA, but nonexpansion waivers are beyond the scope of this Article, so we focus on expansion population waivers only.

* Iowa initially had approval for premium assistance; later, HHS approved an amendment to its waiver to enroll the newly eligible population in Medicaid managed care.

~ Pennsylvania began expansion by negotiating a section 1115 waiver but then switched to ACA-consistent expansion through an SPA.

V. Insurance Exchange Implementation

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

The exchange implementation story also turns many traditional federalism assumptions on their heads—or at least sideways. Traditional federalism characteristics like autonomy, sovereignty, cooperation, experimentation, and variation show up in unexpected ways in the context of the state-federal interchange over the exchanges. For instance, it is difficult to predict how cooperative, disobedient, autonomous, or experimental a state has been merely from that state's choice whether to implement its own exchange.

We also saw a recurrent desire in this context for some *middle ground* between traditional federalist and nationalist stances. Congress tends to draft statutes as nationalist or federalist in terms of architecture—with one or fifty options. But under the ACA, states worked with HHS to devise hybrid state-federal exchange structures that were not envisioned by the ACA's drafters but that allowed states to retain control with significant federal support. Some states preferred instead to model their exchanges on other states', with a general consensus emerging that while some variation of exchange structure may be useful, fifty different exchanges were too many. Some of these state moves were under the radar for political reasons and thus raise transparency concerns; hybrid structures obfuscated state cooperation with the national government while still allowing states to be in *de facto* control.

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

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

Like the Medicaid expansion, the exchange implementation rolled out with a first wave, but the states' exchange stances since then have been much more fluid and unpredictable. All of the states except Alaska applied for and received the initial, no-strings-attached exchange planning grants made available in the fall of 2010, shortly after the ACA was enacted.³¹⁷ Approximately three-fifths of the states also jumped in within months of the statute's enactment to exercise their option to operate their own transitional high-risk pools for those with preexisting conditions.³¹⁸ In February 2011, HHS also awarded "early innovator" grants to six states—Kansas, Maryland, New York, Oklahoma, Oregon, and Wisconsin—and to a consortium of New England states—Connecticut, Maine, Massachusetts, Rhode Island, and Vermont—all of which declared interest in developing exchange information technology that could be adapted and implemented by other states.³¹⁹ These states emerged early out of an apparent desire to position themselves as thought leaders. By mid-2013, forty-six states had received \$3.6 billion in planning, implementation, and early innovator grants.³²⁰

But politics quickly turned the tide firmly against working with HHS after the initial grant phase. The *NFIB* litigation both sowed uncertainty about the ACA's future—making states more reluctant to jump out in front and establish exchanges that might ultimately be struck down—and turned opposition to the statute into a Republican loyalty litmus test. Soon, Kansas, Oklahoma, and Wisconsin returned their early innovator grants, other states returned their exchange planning grants, and most red states declined to establish their own exchanges at all.³²¹

This resistance was unexpected. The most federalism-oriented states were expected to exercise their federally offered right of first refusal to

317. See ANNIE L. MACH & C. STEPHEN REDHEAD, CONG. RESEARCH SERV., R43066, FEDERAL FUNDING FOR HEALTH INSURANCE EXCHANGES 2 & n.6 (2014); *Establishing Health Insurance Marketplaces: An Overview of State Efforts*, KAISER FAM. FOUND. (updated Mar. 11, 2013), <https://perma.cc/K4RX-MCME>.

318. See Timothy Jost, *Implementing Health Reform: The Web Portal and Early Retiree Reinsurance*, HEALTH AFF. BLOG (May 6, 2010), <https://perma.cc/6MUU-ECWR>.

319. See MACH & REDHEAD, *supra* note 317, at 2-3, 4 tbl.I.

320. See *Establishing Health Insurance Marketplaces*, *supra* note 317.

321. See MACH & REDHEAD, *supra* note 317, at 2-3; Sarah Kliff, *It's Official: The Feds Will Run Most Obamacare Exchanges*, WASH. POST: WONKBLOG (Feb. 18, 2013), <https://perma.cc/FC89-A3AS>. Nevertheless, thirty-seven states and the District of Columbia applied for and received Level 1 exchange establishment grants, which provided funds for states to take steps toward establishing a state-based exchange without needing to meet the specific exchange structure and governance requirements for a Level 2 grant. See MACH & REDHEAD, *supra* note 317, at 2.

implement the federal program at the state level, as we see in other similarly structured schemes. It was expected that states would want the ability to tailor their own programs to their particular needs and that states would view the federal statute as encroaching less on state domains if states controlled implementation.³²² This was a key point in the original Medicaid statute's implementation and in those of predecessor programs.³²³ It was also emphasized by Republicans early in the ACA's implementation. One prominent Republican said that letting the federal government operate a state's insurance exchange would be a "Trojan horse" paving the way for a full-scale federal takeover.³²⁴ But the hot politics of the ACA trumped traditional federalism perspectives and reversed the usual course. Notably, states would have had this policy autonomy even without *NFIB*; the Court's holding had nothing to do with insurance exchanges. *NFIB*'s effect with respect to the exchanges was on the choices states made rather than on the existence of choice in the first place.

The paradoxical outcome was that the most anti-ACA states were the same states inviting the federal government to take over their insurance markets. The intention was to be seen as doing nothing to cooperate with "Obamacare."³²⁵ The result has been a much more robust role for the federal government in running state insurance markets than Congress and many states ever expected.³²⁶

There were surprises, too, even within the (typically blue) states that rushed to implement their own exchanges. As in our Medicaid account—indeed more so—extensive back-and-forth movement between state and federal structures emerged in the exchanges. Some states have moved back and forth between running their own exchanges and using federally operated exchanges. Oregon, which created its own exchange, defaulted to the federal exchange platform because of intractable technical issues.³²⁷ In the reverse direction, as further detailed below, some Republican states like Kansas worked out deals behind the scenes that effectively put their exchanges under state control,

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

323. See Huberfeld, *supra* note 58, at 441-45.

324. See Douglas Holtz-Eakin, *Yes to State Exchanges*, NAT'L REV. (Dec. 6, 2012, 5:00 PM), <https://perma.cc/FZQ4-TQHE>.

325. See Interview with Former Executive Branch Healthcare Officials 2, 3, and 4, *supra* note 29 ("Obamacare is a bad word."); Interview with State Policy Organization Officers 1, 2, 3, and 4, *supra* note 213.

326. See *supra* Part III.

327. See Jeff Manning, *Cover Oregon: \$248 Million State Exchange to Be Jettisoned in Favor of Federal System*, OREGONIAN (updated Apr. 25, 2014, 11:30 PM), <https://perma.cc/C9MB-4XNV>.

moving from red to blue in practice, even though they are still formally labeled federal exchanges for purposes of political cover (and simplicity of reporting and paperwork).³²⁸ Kentucky rhetorically opposed the ACA at the national political level but still adopted a highly successful state exchange under Governor Beshear—with the state-identified name Kynect.³²⁹ His successor dismantled Kynect in opposition to the ACA—not because it was failing; it was a “model” exchange by all accounts.³³⁰

These details bring to the surface questions about how useful it is, as federalism scholars are wont to do, to focus on cooperation, and even sovereignty, in complex state-federal schemes. For example, Texas used a federal exchange in protest against the ACA. Was Oregon more “cooperative” and Texas more “sovereign” merely because the latter resisted, the former didn’t, yet both wound up with the same structure? Was Kentucky or Kansas more “autonomous”? Both have been calling their own shots, but only Kentucky ever had its own exchange.

This kind of analysis also raises the very difficult question about how we could have a theory of federalism that turns on mere *motivation*. Taking the example above, Texas is only more federalist because of its *attitude*. Constitution-ists would shudder at the thought that federalism could be so malleable or subjective. Consider, for example, two states—New Mexico and Texas—both of which have exchanges operated by the federal government and so as a formal matter look identical from a structural federalism perspective. But each state’s control is very different across its exchange. As Table 3 below illustrates, New Mexico relies on the federal exchange platform but actually operates many aspects of its own exchange, including conducting plan management and consumer assistance; setting its own geographic rating areas, reinsurance, and risk adjustment formulas; and running rate reviews and medical loss ratio

328. See Christine H. Monahan, *Safeguarding State Interests in Health Insurance Exchange Establishment*, 21 CONN. INS. L.J. 375, 424 (2015) (“In February 2013, the Kansas Insurance Commissioner sent a letter to the director of [the Center for Consumer Information and Insurance Oversight (CCIIO)] explaining that while there was ‘no political support for a partnership arrangement,’ the state would like approval to perform plan management functions (such as certifying that health plans met state and federal statutory and regulatory requirements) on behalf of the federally run exchange.” (quoting Letter from Sandy Praeger, Comm’r of Ins., Kan. Ins. Dep’t, to Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight 1 (Feb. 15, 2013), <https://perma.cc/KE6E-ZJFQ>)).

329. See, e.g., Glenn Kessler, *What Did Mitch McConnell Mean When He Suggested the Kentucky State Exchange Was “Unconnected” to Obamacare?*, WASH. POST (May 29, 2014), <https://perma.cc/T29B-FDZ6>; see also Editorial, *Say Again, Senator, ACA Unkynected?*, LEXINGTON HERALD-LEADER (updated July 18, 2014, 9:52 PM), <https://perma.cc/6X54-X4DA>.

330. See Amber Phillips, *Kentucky, Once an Obamacare Exchange Success Story, Now Moves to Shut It Down*, WASH. POST: THE FIX (Jan. 14, 2016), <https://perma.cc/KHA5-ZWBP>.

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compliance. Texas has declined to operate an exchange, enforce any reform provisions like medical loss ratio compliance, or set its own geographic rating areas. Now who looks more federalist and autonomous? Is it sufficient to put all these categories aside and say that states got to make their own choices and that is enough for federalism?

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Table 3

Exchange Structure and Policy Control³³¹

State	Type of Individual Exchange	State Enforcing Compliance with Reform Provisions	State Set Geographic Rating Areas	State Sought Medical Loss Ratio Adjustment from Federal Standard	State Conducting Effective Rate Reviews
Ala.	FFM	✓			✓
Alaska	FFM	✓	✓		✓
Ariz.	FFM	✓	✓		✓
Ark.	SBM-FP	✓	✓		✓
Cal.	SBM	✓	✓		✓
Colo.	SBM	✓	✓		✓
Conn.	SBM	✓	✓		✓
Del.	SPM	✓	✓	✓	✓
D.C.	SBM	✓	✓		✓
Fla.	FFM	✓	✓	✓	✓
Ga.	FFM	✓	✓	✓	✓
Haw.	FFM	✓	✓		✓
Idaho	SBM	✓	✓		✓
Ill.	SPM	✓	✓		✓
Ind.	FFM	✓	✓	✓	✓
Iowa	SPM	✓	✓	✓	✓
Kan.	FFM-PM	✓	✓	✓	✓
Ky.	SBM-FP	✓	✓	✓	✓
La.	FFM	✓	✓	✓	✓
Me.	FFM-PM	✓	✓	✓	✓
Md.	SBM	✓	✓		✓
Mass.	SBM	✓	✓		✓
Mich.	SPM	✓	✓	✓	✓
Minn.	SBM	✓	✓		✓
Miss.	FFM	✓	✓		✓
Mo.	FFM		✓		✓

331. Data in this table were drawn from the following sources: *Compliance and Enforcement*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/UVT4-4WEA> (archived Apr. 23, 2018); *Market Rating Reforms*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/J2F9-QUB5> (last updated Apr. 20, 2018); *State Effective Rate Review Programs*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/N7KU-8P9Z> (last updated Mar. 17, 2017); *State Health Insurance Marketplace Types, 2018*, KAISER FAM. FOUND., <https://perma.cc/V5N8-PXMP> (archived Apr. 23, 2018); and *State Requests for MLR Adjustment*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/K5XP-Q36K> (archived Apr. 23, 2018).

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State	Type of Individual Exchange	State Enforcing Compliance with Reform Provisions	State Set Geographic Rating Areas	State Sought Medical Loss Ratio Adjustment from Federal Standard	State Conducting Effective Rate Reviews
Mont.	FFM-PM	✓	✓		✓
Neb.	FFM-PM	✓	✓		✓
Nev.	SBM-FP	✓	✓	✓	✓
N.H.	SPM	✓	✓	✓	✓
N.J.	FFM	✓	✓		✓
N.M.	SBM-FP	✓			✓
N.Y.	SBM	✓	✓		✓
N.C.	FFM	✓	✓	✓	✓
N.D.	FFM	✓		✓	✓
Ohio	FFM-PM	✓	✓		✓
Okla.	FFM			✓	
Or.	SBM-FP	✓	✓		✓
Pa.	FFM	✓	✓		✓
R.I.	SBM	✓	✓		✓
S.C.	FFM	✓	✓		✓
S.D.	FFM-PM	✓	✓		✓
Tenn.	FFM	✓	✓		✓
Tex.	FFM			✓	
Utah	FFM	✓	✓		✓
Vt.	SBM	✓	✓		✓
Va.	FFM-PM	✓			✓
Wash.	SBM	✓	✓		✓
W. Va.	SPM	✓	✓		✓
Wis.	FFM	✓	✓	✓	✓
Wyo.	FFM				

FFM = federally facilitated marketplace; SBM = state-based marketplace; SPM = state partnership marketplace; SBM-FP = state-based marketplace on the federal platform; FFM-PM = federally facilitated marketplace with state plan management.

We return to the subjects of autonomy and sovereignty in Part VI below. But the state and federal officials we interviewed consistently emphasized that states had “enormous autonomy” in developing their exchanges if they wished to participate—regardless whether the exchange structure was state or

federal.³³² Indeed, states that have engaged with implementation have retained much more control over their insurance markets' policy design than those that have resisted any role.

As Table 3 illustrates, the structure has been less important than the state's own involvement. States that ran their own exchanges did not necessarily exert more control over exchange policy than did states defaulting to the federal model. The key to policy control was *participation and engagement* within the federal statutory scheme regardless whether it was formally structured as state or federally implemented. For example, Kansas and Maine defaulted to federal exchanges but opted to maintain significant control over their health insurance markets. Both states conduct plan management, enforce compliance with reform provisions, sought adjustments to medical loss ratios, and conduct rate reviews.

* * *

The change of administration has added an important wrinkle to our account. Until recently, the experience of the exchanges was mostly interchangeable regardless of structural platform. But in 2017, some noticeable differences emerged between state- and federally operated exchanges. Whereas under the Obama Administration, states with federal exchanges received as much, if not more, federal support as states with their own exchanges, the Trump Administration has moved to strangle the exchanges as part of its larger effort to destabilize the ACA.³³³ Federally operated exchanges are more susceptible to these hostile efforts simply because the federal government has more control over them.

One salient example occurred in the context of open enrollment, the key period during which individuals must sign up for insurance. Whereas states with their own exchanges retain control over enrollment periods and advertising efforts, the Trump Administration slashed funding, canceled

332. See Interview with Health Policy Nonprofit Officers 1 (a Former State Official) and 2, *supra* note 264; see also Interview with Former Federal Executive Branch Healthcare Official 1, *supra* note 213.

333. See Exec. Order No. 13,813, 82 Fed. Reg. 48,385 (Oct. 12, 2017) (directing agencies to explore options to pull healthy individuals off of the exchanges); Market Stabilization, 82 Fed. Reg. 18,346, 18,381 (Apr. 18, 2017) (codified at 45 C.F.R. § 155.410(e) (2017)) (ending the open enrollment period on December 15, 2017, rather than January 31, 2018); Abbe Gluck, *President Trump Admits He's Trying to Kill Obamacare. That's Illegal*, VOX (Oct. 17, 2017, 1:40 PM EDT), <https://perma.cc/Q2P7-EQAE> (detailing the Trump Administration's efforts to stifle open enrollment, cut advertising and navigator funding, and cut off payments to the insurance industry); Shelby Gonzales, *Trump Administration Slashing Funding for Marketplace Enrollment Assistance and Outreach*, CTR. ON BUDGET & POL'Y PRIORITIES: OFF THE CHARTS (Sept. 1, 2017, 1:30 PM), <https://perma.cc/C8UY-3RZV> (discussing the Trump Administration's decision to cut funding for consumer outreach and navigator programs).

outreach events, and cut the 2017 enrollment period in half for those states on the federal exchange.³³⁴ The irony of course is that it is the red states that are suffering most—that have lost the most autonomy—because they refused to implement the statute in the first place.

In a further irony, this dynamic made state Republican officials some of the most important advocates for sustaining the ACA in 2017. A bipartisan governors' letter was a pivotal turning point in one of the failed attempts to repeal the ACA in the summer of 2017.³³⁵ Republican governors took to the media in the fall of 2017 to protest the Administration's moves to cut funding to insurers and destabilize the exchanges.³³⁶

But another twist was underway at the time this Article went to print. Idaho, one of the few red states that chose to run its own exchange,³³⁷ used that freedom in 2017 to try to create a parallel marketplace to allow for lower-cost, less-regulated off-exchange plans.³³⁸ The Trump Administration refused to allow that move³³⁹ but followed by proposing its own series of reforms, available to states with all kinds of exchanges, that would allow any state to move more people out of ACA plans and into different types of less-regulated plans.³⁴⁰ Critics argue that these proposals, if finalized, will destabilize the Act.³⁴¹

334. See, e.g., Timothy Jost, *CMS Cuts ACA Advertising by 90 Percent amid Other Cuts to Enrollment Outreach*, HEALTH AFF. BLOG (Aug. 31, 2017), <https://perma.cc/7XER-6LYL> (reporting 90% cuts in advertising and 40% cuts in funding to insurance navigator programs).

335. See Letter from John Hickenlooper et al. to Mitch McConnell and Charles E. Schumer, *supra* note 304; see also Jonathan Martin & Alexander Burns, *Governors from Both Parties Denounce Senate Obamacare Repeal Bill*, N.Y. TIMES (July 14, 2017), <https://perma.cc/P529-CPXH>.

336. See, e.g., Jeff Stein, *"It's Going to Hurt Everybody": Nevada's GOP Governor Rips Trump over ACA Sabotage*, VOX (Oct. 13, 2017, 2:40 PM EDT), <https://perma.cc/EVG6-T4M9>.

337. See *About*, IDAHO INS. MARKETPLACE, <https://perma.cc/BN4M-LRB8> (archived Apr. 23, 2018); see also Louise Norris, *Idaho and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Apr. 30, 2018), <https://perma.cc/5YRT-DBPD> (reporting that Idaho has not expanded Medicaid but that an effort to expand via ballot initiative is underway).

338. See Press Release, Office of the Governor of Idaho, *Governor Directs Development of Guidelines for More Affordable Health Coverage* (Jan. 5, 2018), <https://perma.cc/Z7N9-ZXZC>.

339. See Letter from Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to C.L. "Butch" Otter, Governor of Idaho, and Dean L. Cameron, Dir., State of Idaho Dep't of Ins. 1-2 (Mar. 8, 2018), <https://perma.cc/2G48-NJCG>.

340. See, e.g., Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 7437, 7438, 7445-47 (proposed Feb. 21, 2018) (to be codified in scattered sections of 26 and 45 C.F.R.) (expanding the possible duration of short-term, off-exchange plans from three to up to twelve months); Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 614, 615, 634-36 (proposed Jan. 5, 2018) (to be codified at 29 C.F.R. §§ 2510.3-3, -5) (expanding the definition of "employer" to allow more plans to qualify as association health plans that need not comply with all ACA requirements).

341. See Dylan Scott, *Trump's New Plan to Poke Holes in the Obamacare Markets, Explained*, VOX (Feb. 20, 2018, 10:10 AM EST), <https://perma.cc/2WC7-M9HD> (explaining these proposals and their risks).

On the one hand, then, the choice between a state-led and federal structure may be more significant than it initially appeared. With an administration pitted against the statute, states that do not go out on their own are suddenly less stable—and indeed less autonomous—than they were just months earlier, simply because a hostile caretaker is now in control. But on the other hand, the Administration is treating all states alike—regardless of exchange structure—when it comes to its new offers of flexibility of design. Again, national does not mean uniform, even when the federal government is running the exchange.

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

B. Under-the-Radar Adaptation and Engagement: Hybrid Federalism and the “Secret Boyfriend Model”

Extraordinary adaptivity also emerged in exchange implementation. Creative solutions developed in large part from the tension between the political pressure on state officials to publicly “resist” the ACA³⁴² and the practical view many of those same officials held that it was not in the long-term interests of the states—their sovereign interests—to cede full control of their insurance markets to the federal government.

Congress’s initial structural allocation turned out to be more of a starting point than the endpoint in terms of the exchange designs that emerged. New structures developed in part because Congress’s initial allocation was far too simplistic: Congress assumed that state choices would be of the either-or variety—state or federal. They turned out to be far more complex.

1. Split exchanges

Some states adapted through a kind of compromise—a purple-state solution of sorts—choosing to run their own state exchanges in part but

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

relying on the federal government for another part. For instance, Mississippi and Utah ran their own state-based exchanges for small businesses but carved out the individual insurance exchanges for the federal government to run.³⁴³ This move was mostly political. The ACA's highly controversial individual mandate was the focal point of political resistance and was closely associated with the individual market and its exchange. As a result, states like Utah refused to take any action that could be seen as supportive of the mandate, even as those states implemented other parts of the ACA and ceded power to the federal government in politically resisting the law.³⁴⁴

2. Hybrid exchanges: federalism born of necessity, federalism in secret

A more complex category of exchanges—and a salient example of pragmatic administration—comes in the context of the so-called hybrid exchanges, which blend state and federal management functions and come in many different forms. The hybrid exchange was a model developed by HHS in a guidance document early in the ACA's implementation, with the goal of attracting more states to engage.³⁴⁵ One high-level federal interviewee told us that it had become clear that many states did not want the binary choice Congress had laid out; they wanted to be able to rely on the federal government for as much as they individually needed but still wanted policy control.³⁴⁶

343. See Jeff Amy, *Mississippi to Create Small Business Health Insurance Exchange*, INS. J. (Sept. 9, 2013), <https://perma.cc/FM5R-ZZDE>; Louise Norris, *Utah Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (Mar. 29, 2018), <https://perma.cc/GPC9-73GG> (noting that Utah had been running its own small business exchange but is now moving to the federal platform).

344. Ironically, Utah was (along with Massachusetts) the state most often invoked as a "model" for the ACA's state-based exchanges during the statute's drafting process before politics drove its compromise solution. Utah, which had established an "open" exchange (essentially letting all insurers in without screening) prior to the ACA, was held up as an example of a state that had conducted a different kind of exchange experiment than Massachusetts in discussions of how capacious the states' options were in exchange design. See Gregg Girvan, *Consumer Power: Five Lessons from Utah's Health Care Reform*, BACKGROUND 2 (2010), <https://perma.cc/KVH4-467U> ("State lawmakers who want to maintain the independence of their state's health care system and fiscal future in the wake of the new federal law should consider Utah's recent experience with health care reform."); Robert Pear, *Health Care Overhaul Depends on States' Exchanges*, N.Y. TIMES (Oct. 23, 2010), <https://perma.cc/34L2-KYAB> ("Massachusetts and Utah provide a glimpse of the future, and they offer radically different models for other states.").

345. See Memorandum from Ctr. for Consumer Info. & Ins. Oversight, U.S. Dep't of Health & Human Servs., *Affordable Insurance Exchanges Guidance: Guidance on the State Partnership Exchange 1* (Jan. 3, 2013), <https://perma.cc/FZN6-6TD8>.

346. See Interview with Former Federal Executive Branch Healthcare Officials 2, 3, and 4, *supra* note 29.

Another official told us that some states wanted more control but needed political cover—a way to keep up appearances that the federal government was still in charge so as not to appear in betrayal of the red-state resistance.³⁴⁷

The hybrids were thus a type of blended entity born of necessity. Reacting to the changed landscape after *NFIB* and concerned that fewer states than expected were running their own exchanges, HHS helped design federally run exchanges that were heavily supported by the federal government but still directed on the policy front by states.³⁴⁸ Seven states took up this hybrid possibility: Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia.³⁴⁹ Those states were given a choice under the hybrid model of whether to conduct their own plan management activities, consumer assistance, outreach, and education.³⁵⁰ The federal government took on any remaining supportive and administrative responsibilities.³⁵¹

To our view, these hybrid exchanges may be the ultimate instantiation of cooperative federalism: a regime in which the federal government does what it does best, offering administrative support and maximizing the advantages of centralization and economies of scale, while giving states a platform to design and run their own programs. Arkansas switched to a state-based exchange for 2017, and the hybrid model provided the means for that transition to more state control.³⁵² But the idea of “cooperating” with the federal government in this way was still politically taboo for many state actors. One puerile problem was that the hybrid exchanges were called “partnership” exchanges, and some states did not want to appear to be in “partnership” with the Obama Administration.³⁵³

347. *See id.*; *see also* Interview with Former Federal Executive Branch Healthcare Official 1, *supra* note 213.

348. *See* Interview with Former Federal Executive Branch Healthcare Officials 2, 3, and 4, *supra* note 29.

349. *See Letters*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/A4GU-VN7D> (archived Apr. 23, 2018) (compiling approval letters for states’ exchanges, including seven that applied to adopt a partnership model).

350. *See* Memorandum from Ctr. for Consumer Info. & Ins. Oversight, *supra* note 345, at 1.

351. *See id.* at 17-18.

352. *See* Louise Norris, *Arkansas Health Insurance Marketplace: History and News of the State’s Exchange*, HEALTHINSURANCE.ORG (Mar. 5, 2018), <https://perma.cc/EAP9-CXMT> (“For the first three years of exchange implementation, Arkansas had a partnership exchange for individuals, but as of 2017 . . . , [it has] a state-based exchange using the federal enrollment platform . . .”).

353. *See* Monahan, *supra* note 328, at 423-24; Interview with Former Federal Executive Branch Healthcare Officials 2, 3, and 4, *supra* note 29; Interview with State Policy Organization Officers 1, 2, 3, and 4, *supra* note 213; *cf.* Leonard, *supra* note 342, at 162 (“[R]hetorical federalism acknowledges that federalism arguments have political salience aside from earnest concerns about the federal structure.”).

Another problem was the intrastate political arena. Some insurance commissioners and other lower-level state officials wanted to retain control over state insurance markets, even as governors and legislatures refused to run their own exchanges out of public resistance.³⁵⁴ For example, another seven states—Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia—did not opt in to the hybrid model for these political reasons, but they did not want full-scale federal exchanges either.³⁵⁵ As a result, these states actually took on significant exchange management functions, but they needed to keep these decisions *relatively secret*.

Sometimes state moves were so discreet that it appeared that one arm of the government was trying to hide its actions from another. Take Kansas as an example.³⁵⁶ Its state insurance department designed a plan for a hybrid exchange, desiring to retain control over its insurance markets rather than cede that power to the federal government.³⁵⁷ However, under HHS's hybrid exchange guidance, the governor was required to sign off on a state's hybrid exchange "blueprint."³⁵⁸ Kansas's governor refused to "partner" with the Obama Administration, even as the insurance commissioner pressured for that result.³⁵⁹

In response, HHS adapted again. Less than one week later, HHS announced a new hybrid option, this time called state "plan management."³⁶⁰ Plan management exchanges do not require formal gubernatorial approval but rather require only informal communications between the federal government and state insurance commissioners, thereby allowing state commissioners to get around resistant state capitols.³⁶¹

Thus, in these seven states, the state commissioners, sometimes at odds with the political interests of their own governors, were making decisions and quietly running important aspects of their exchanges even as governors

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

355. See Monahan, *supra* note 328, at 415-16.

356. This narrative largely is drawn from Christine Monahan's work. See *id.* at 415-16, 423-24.

357. See *id.*

358. See *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges—Frequently Asked Questions*, CTRS. FOR MEDICARE & MEDICAID SERVS. (May 16, 2012), <https://perma.cc/6ZLS-E6GE> (noting that a state pursuing a partnership exchange must submit an "Exchange Blueprint" containing an "Exchange Model Declaration Letter" from the governor).

359. See Monahan, *supra* note 328, at 423-24.

360. See *id.*

361. See *id.*

continued to publicly pledge their steadfast resistance to cooperating with the administration of the ACA. While there are a few states in which the insurance department has refused to implement the ACA, most state insurance departments are actively engaged, even in states with federally facilitated exchanges.³⁶²

These models raise transparency and accountability concerns, which we discuss further in Part VI below. One of our federal official interviewees colorfully dubbed these interactions the “secret boyfriend model”: states that wanted the assistance the federal government offered but were afraid to admit it to the public or even to other parts of state government.³⁶³ HHS even helped these states market their supposedly uncooperative exchange efforts to provide political cover.³⁶⁴

Another type of hybrid emerged to help states that tried to establish their own marketplaces but failed. Known as “State-Based Marketplace-Federal Platform” exchanges, these are exchanges in which the states make all of the policy decisions but rely on the federal government’s HealthCare.gov IT platform.³⁶⁵ Five states currently have this kind of exchange, including Oregon and New Mexico, which both had tried to operate fully state-based exchanges but failed for technical reasons.³⁶⁶ In 2015, this option allowed Arkansas to transition from a federal exchange to assuming full policy control over its marketplace without having to assume the risk of setting up a new technical platform.³⁶⁷ Hawaii, in contrast, transitioned in 2016 from this model to a full federal exchange.³⁶⁸

362. Only four states have refused to enforce compliance with insurance reform provisions. See *supra* Table 3.

363. See Interview with Former Federal Executive Branch Healthcare Officials 2, 3 and 4, *supra* note 29 (statement of Former Federal Executive Branch Healthcare Official 3).

364. See *id.*

365. See *State-Based Exchanges*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/92WD-RVMS> (last updated Sept. 15, 2017); *State Health Insurance Marketplace Types, 2018*, *supra* note 331. For further discussion of this model, see Christopher Koller, *Supported State-Based Marketplaces: The Point of Convergence?*, HEALTH AFF. BLOG (June 11, 2015), <https://perma.cc/C8UD-7WUM>.

366. See *State Health Insurance Marketplace Types, 2018*, *supra* note 331 (listing states by exchange type); see also Rosalie Rayburn, *Plans for State-Run Health Exchange Dropped*, ALBUQUERQUE J. (Apr. 8, 2015, 2:26 PM), <https://perma.cc/C5WE-6NDC>; Gosia Wozniacka, *Oregon Dropping Online Health Exchange for U.S. Site*, BELLINGHAM HERALD (Bellingham, Wash.) (updated Apr. 26, 2014, 12:07 AM), <https://perma.cc/X4NQ-2C6K>.

367. See *State Marketplace Profiles: Arkansas*, KAISER FAM. FOUND. (Oct. 8, 2013), <https://perma.cc/E52Q-N55Z>.

368. See Louise Norris, *Hawaii Health Insurance Marketplace: History and News of the State’s Exchange*, HEALTHINSURANCE.ORG (Mar. 10, 2018), <https://perma.cc/6KHQ-97WL>.

In short, HHS developed a wide continuum of structural options along the spectrum from state to federal to engage as many states as possible in implementation. In most cases the key to state autonomy was the level of engagement, not the formal structure.

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

The ACA included in its insurance reforms a formal mechanism for state-to-state cooperation: States could establish “regional” exchanges, combining insurance pools and regulations into a single market.³⁶⁹ As it turns out, the ACA’s stated vision of horizontal federalism did not materialize—no states established regional exchanges.³⁷⁰ But other forms of horizontal federalism developed on the ground, including robust state networks and an important role for quasi-official state organizations in coordinating implementation. Several thought-leader states also emerged and played important roles in disseminating information and experience to later-moving states.

1. Interstate cooperation

Interstate cooperation has been a dominant feature of exchange implementation. This is different from the Medicaid story, which has been more competitive across states.³⁷¹ Some of this cooperation was facilitated by formal networks states used to share information and coordinate efforts. These include the networks of “early innovator” states—states that took the lead in implementation and so served as a model for others.³⁷² Other interstate networks were supported by federal entities as well as quasi-governmental organizations, including the Center for Consumer Information and Insurance Oversight (CCIIO);³⁷³ the Health Care Reform Regulatory Alternatives Working Group of the National Association of Insurance Commissioners;³⁷⁴ the State Health Exchange Leadership Network of the National Academy for

369. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(f)(1), 124 Stat. 119, 179 (2010) (codified at 42 U.S.C. § 18031 (2016)).

370. See Sarah Dash et al., Health Insurance Exchanges and State Decisions 2 (2013), <https://perma.cc/VK28-U484>.

371. See *supra* Part IV.

372. See *States Leading the Way on Implementation: HHS Awards “Early Innovator” Grants to Seven States*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/3EK8-BNWD> (archived Apr. 23, 2018).

373. See *id.* (describing a CCIIO grant to “a multi-state consortium led by the University of Massachusetts Medical School”).

374. See *Health Care Reform Regulatory Alternatives (B) Working Group*, NAT’L ASS’N INS. COMMISSIONERS, <https://perma.cc/GJ3G-YU4H> (archived Apr. 23, 2018).

State Health Policy,³⁷⁵ the National Governors Association; and the National Conference of State Legislatures (NCSL).³⁷⁶ The ACA empowered and formalized some of these horizontal networks. The most salient example is that the ACA explicitly directed HHS to involve the National Association of Insurance Commissioners in implementation.³⁷⁷

Informal networks also emerged to trade information and coordinate efforts. These included technical assistance networks facilitated by the Robert Wood Johnson Foundation,³⁷⁸ the network of states that cooperated in the Enroll UX 2014 project to design user interfaces,³⁷⁹ informal networks of exchange officials who hired the same consultants and contractors,³⁸⁰ the informal network of states working in opposition to the ACA supported by the American Legislative Exchange Council,³⁸¹ and unofficial relationships that emerged out of formal networks, conferences, and workshops. One former federal official we interviewed recalled helping to organize regular meetings between state officials, so-called “learning collaboratives” facilitated by HHS, to enable state success in implementing exchanges and to share information between states for troubleshooting.³⁸²

Unlike in the Medicaid context, in creating exchanges, states did band together to exert leverage on the federal government for collective goals. For example, Christine Monahan has described how an informal group of states defaulting to federal exchanges cooperated to retain plan management functions: “Their collective advocacy ultimately resulted in the creation of the ‘marketplace plan management option’ by which states could conduct plan management on behalf of the federally run exchange”³⁸³ Similarly, a group

375. See *State Health Exchange Leadership Network*, NAT’L ACAD. FOR ST. HEALTH POL’Y, <https://perma.cc/3RR9-ESRP> (archived Apr. 23, 2018).

376. See Interview with Health Policy Nonprofit Officers 1 (a Former State Official) and 2, *supra* note 264 (detailing the support for state coordination from federal and other entities).

377. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1311(c)(1)(F), 1321(a)(2), 1333(a), 1341(b)(1), 124 Stat. 119, 174, 186, 206-07, 209 (2010) (codified in scattered sections of 42 U.S.C.); see also Monahan, *supra* note 328, at 409-14 (describing some of the efforts of the National Association of Insurance Commissioners).

378. See, e.g., *About Us*, ST. NETWORK, <https://perma.cc/9FYT-J5FB> (archived Apr. 23, 2018).

379. See *Who’s Involved*, ENROLL UX 2014, <https://perma.cc/U3A2-AYDK> (archived Apr. 23, 2018).

380. See *infra* notes 391-92 and accompanying text.

381. See, e.g., Christie Herrera, *Health Care Freedom Makes a Big Impact in 2012*, AM. LEGIS. EXCHANGE COUNCIL (Mar. 26, 2012), <https://perma.cc/2P3U-VLGE> (describing state efforts growing out of the organization’s initiative).

382. See Interview with Former Federal Executive Branch Healthcare Official 5, *supra* note 190.

383. Monahan, *supra* note 328, at 415-16.

of partnership exchange states coordinated efforts to persuade the CCIIO not to require them to enter into formal memoranda of understanding, thereby avoiding a potential political problem for state officials.³⁸⁴ While our sense from the interviews is that the advocacy was also coming from the other direction—from HHS and the White House—this is nevertheless a good example of how informal horizontal networks can be an effective method of federalism negotiation.

State networking efforts like these have received some recent attention in the new federalism literature. For example, political scientist John Nugent has argued that these organizations are critical players in “safeguarding federalism”—in the form of helping states leverage and interact with the federal government—in the context of a national scheme with key potential state roles.³⁸⁵ Our study lends support to that account.

2. Thought-leader states

Another dimension of horizontal federalism in the exchange context was visible in the emergence of thought-leader states. These states served as policy entrepreneurs and increased efficiency for states that were further behind in implementation. As in the Medicaid context, thought-leader states in ACA exchange implementation emerged organically; unlike in some statutes, leader states were not designated in advance in the ACA.³⁸⁶

Connecticut provides an example in its efforts to market its successful exchange platform to other states. As one of Connecticut’s entrepreneurial exchange officials put it: “We realized that we had invented a better mousetrap . . . We could package our services and expertise and make them available to other states, promoting collaboration and avoiding a duplication of effort.”³⁸⁷ The Connecticut exchange director, Kevin Counihan, even sought to market the state’s successful exchange platform to other states.³⁸⁸ He promoted

384. *Id.* at 415.

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

386. A classic example is the Clean Air Act, in which Congress designated California as the leader state and offered states the option to adopt federal pollution standards or the higher standards California had developed. See Gluck, *supra* note 43, at 1756 & n.23; see also 42 U.S.C. § 7543(e)(2) (2016).

387. Robert Pear, *Connecticut Plans to Market Health Exchange Expertise*, N.Y. TIMES (Feb. 24, 2014), <https://perma.cc/4MJP-SDNL> (quoting Robert E. Scalettar, member of the board of Access Health CT).

388. See Jeff Cohen, *Connecticut Looks to Sell Its Obamacare Exchange to Other States*, NPR (Feb. 28, 2014, 3:31 AM ET), <https://perma.cc/V9YN-HDXR>.

Connecticut's system as giving other states "the benefits of a state-based marketplace without the headaches of building or staffing it."³⁸⁹

At least four other states—including Maryland and Minnesota—used other states' exchange platforms as their own.³⁹⁰ In most cases, the sister-state-model option was an alternative to inviting the federal government to operate a federal exchange in the wake of a state's technical failures in operating its own. Even states that maintained their own exchanges following initial difficulties leveraged other states' experiences by using the same consulting firms that had successfully shepherded other states through similar transitions. Deloitte for instance was hired by Maryland and Minnesota following its successful oversight of exchange rollouts in Connecticut, Kentucky, Rhode Island, and Washington.³⁹¹ Vermont, on the heels of a botched attempted rollout using the same contractor as the federal exchange, hired the same consultant, Optum, that helped Massachusetts recover from a similar hiccup.³⁹²

389. Pear, *supra* note 387 (quoting Kevin Counihan, CEO of Access Health CT).

390. See Jenna Johnson, *Maryland Looks to Connecticut for Health Exchange Answers*, WASH. POST (May 31, 2014), <https://perma.cc/987K-56C5>; *MNSure Chooses Deloitte as Lead Vendor*, CBS MINN. (Apr. 16, 2014, 12:50 PM), <https://perma.cc/F3PC-HD32>.

391. See Johnson, *supra* note 390; *MNSure Chooses Deloitte as Lead Vendor*, *supra* note 390; Christine Vestal & Michael Ollove, *Why Some State Health Exchanges Worked*, KAISER HEALTH NEWS (Dec. 11, 2013), <https://perma.cc/Y7VK-577S>.

392. Lynnley Browning, *Thanks for Nothing: Obamacare Website Bunglers Fired*, NEWSWEEK (Aug. 6, 2014, 10:09 AM), <https://perma.cc/MT26-JR8P>.

hCentive operates exchanges in Massachusetts, New York, and Colorado. See Dan Mangan, *The "Policy Geek" Picked to Save Massachusetts' Obamacare Exchange*, CNBC (May 8, 2014, 4:14 PM ET), <https://perma.cc/EMY9-99C6>. Massachusetts hired hCentive after a failed rollout by CGI, the original contractor for HealthCare.gov, explicitly citing hCentive's record of success in other states. See Felice J. Freyer, *Mass. Sticking with Its Health Insurance Website*, BOS. GLOBE (Aug. 8, 2014), <https://perma.cc/8QN5-3SCC>; Mangan, *supra*; see also Lydia DePillis, *Meet CGI Federal, the Company Behind the Botched Launch of HealthCare.gov*, WASH. POST: WONKBLOG (Oct. 16, 2013), <https://perma.cc/8J4M-5V6W>.

Following difficulties with CGI, Vermont hired Optum, citing the fact that Optum oversaw the smooth transition for Massachusetts from CGI to hCentive. See Browning, *supra*. Optum owns a 24% stake in hCentive. See Mangan, *supra*.

For additional examples, see *Idaho's Health Insurance Exchange Awards \$40.8 Million in Contracts*, BOISE ST. PUB. RADIO (Feb. 21, 2014), <https://perma.cc/5JAV-LK97> (noting that when Idaho sought to transition from a federally facilitated marketplace model, it chose the same two companies California used, hiring GetInsured to build the exchange and Accenture to oversee the project); GetInsured, Corporate Fact Sheet 2 (n.d.), <https://perma.cc/YD4F-3ER3> (noting that GetInsured also built Mississippi's and New Mexico's small business exchanges).

3. A middle ground between one and fifty options

In this story of states modeling on and borrowing from one another, we see a parallel to our account of the hybrid exchanges. In both instances, there is recognition that a middle ground between fifty separate models and a single national model might be ideal as a matter of structural allocation. The ACA is not the first example of this. For instance, in the corporate law context, a few states' statutes have emerged as the basis for most states' choices; there are not fifty different options, and each state does not reinvent the wheel.³⁹³ Likewise, this middle ground in the ACA emerged organically, rather than as a result of the ACA's intentional design by Congress. States themselves may be adapting, but Congress still appears to be operating with outmoded design options. It continues to use the old either-or model of structural allocation in drafting.

A middle ground may capture efficiencies and economies of scale and may advance uniformity in ways inferior to a full national exchange but superior to fifty different ones. So understood, this horizontal movement, like the emergence of hybrids, might point toward a federalism sweet spot. As Access CT's CEO commented about the various exchange models: "We do not need fifty of these things, but we might need eight."³⁹⁴

D. Intrastate Differences, Redux

As we emphasized in the Medicaid discussion, one cannot understand the ACA's implementation without discarding the fiction that the states are a monolithic bloc. Divergences in state law and divergences among the internal state actors—in other words attributes of the state *sovereign* apparatuses—are critical to how federal-law implementation occurs on the ground. This is another response to those who would argue that what we saw was mere management or decentralization.³⁹⁵

Beginning with the law, states went into the ACA with different preexisting insurance laws.³⁹⁶ Some states already had generous insurance mandates—requirements that insurers cover specified services.³⁹⁷ A few states already had

393. See Roberta Romano, *The States as a Laboratory: Legal Innovation and State Competition for Corporate Charters*, 23 YALE J. ON REG. 209, 215 tbl.1, 216 (2006) (cataloging states' adoption of statutory innovations in corporate law).

394. See Email from Kevin Coughlin to authors (May 18, 2018) (on file with authors) (recounting remarks made in February 2014 at the Yale Law School Conference on Insurance Exchange Implementation).

395. Cf. FEELEY & RUBIN, *supra* note 9, at ix.

396. See Katherine Swartz et al., *How Insurers Competed in the Affordable Care Act's First Year* exhibit 2, 7-8 (2015), <https://perma.cc/D5CA-V8YJ>.

397. See, e.g., *Pre-ACA State Mandated Benefits in the Individual Health Insurance Market: Mandated Coverage in Mental Health*, KAISER FAM. FOUND., <https://perma.cc/DT5L-ZHEF> (archived Apr. 24, 2018); *Pre-ACA State Maternity Coverage Mandates: Individual* footnote continued on next page

community rating requirements—meaning insurers could not price according to health risk by especially wide margins.³⁹⁸ New York had a particularly stringent community rating requirement that it continued even after the ACA was passed with a looser one.³⁹⁹ There is some evidence that having those preexisting legal structures influenced states to run their own exchanges rather than defaulting to the federal platform.⁴⁰⁰

Some states also passed laws to give their insurance commissioners power to buck federal requirements.⁴⁰¹ President Obama’s famous “if you like your health plan, you can keep it” statement destabilized many exchanges by allowing healthy customers, expected to join the new insurance pools, to remain outside them.⁴⁰² States that bucked the President and decided not to allow individuals to keep their old plans had healthier exchange markets in the end, according to at least one study.⁴⁰³

Looking next to differences among internal state actors, as with Medicaid, we saw governors’ interests diverging from those of their legislatures. Some states, including Michigan and New Jersey, were unable to create their own exchanges because of the objections of one of the elected branches necessary to pass the required implementing legislation.⁴⁰⁴ Executives in three states—Kentucky, New York, and Rhode Island—made an end-run around recalcitrant legislatures by creating state-based exchanges through purely executive

and Small Group Markets, KAISER FAM. FOUND., <https://perma.cc/T7WZ-92ZN> (archived Apr. 24, 2018).

398. See Anthony T. Lo Sasso, *Community Rating and Guaranteed Issue in the Individual Health Insurance Market*, EXPERT VOICES 1 (2011), <https://perma.cc/LL5R-N76B> (describing community rating and state policies before the ACA).

399. See N.Y. INS. LAW § 3231 (McKinney 2018) (mandating one-to-one community rating); *Obama’s New York Model: How the State Destroyed Its Insurance Market Using ObamaCare Rules*, WALL ST. J. (July 23, 2013, 7:28 PM ET), <https://perma.cc/X6GF-Q838>.

400. *Compare Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)*, KAISER FAM. FOUND., <https://perma.cc/XPM4-F4LD> (archived Apr. 24, 2018) (showing limits on rating by state), with *State Health Insurance Marketplace Types, 2018*, *supra* note 331 (showing marketplace type by state). A simpler explanation might be that these states were largely Democratic and so were sympathetic toward the ACA from the start.

401. See Richard Cauchi, *State Laws and Actions Challenging Certain Health Reforms*, NAT’L CONF. ST. LEGISLATURES (Feb. 27, 2018), <https://perma.cc/VB9L-YKUQ>.

402. See Robb Mandelbaum, *How Holdover Health Plans Help Some Businesses but Hurt Obamacare*, FORBES (Feb. 28, 2017, 9:30 AM), <https://perma.cc/HSG9-A6AQ>.

403. See Kevin Lucia et al., *The Extended “Fix” for Canceled Health Insurance Policies: Latest State Action*, COMMONWEALTH FUND: TO THE POINT (Nov. 21, 2014), <https://perma.cc/F8N5-Q4GE>; cf. *West Virginia ex rel. Morrissey v. U.S. Dep’t of Health & Human Servs.*, 827 F.3d 81, 82, 84 (D.C. Cir. 2016) (rejecting for lack of standing a state challenge to the transitional policy permitting certain insurers to temporarily continue policies that did not comply with the ACA), *cert. denied*, 137 S. Ct. 1614 (2017).

404. See NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 204, at 23, 31.

authority.⁴⁰⁵ Four of the seven states that adopted the hybrid partnership exchange model also used purely executive authority to adopt their exchanges.⁴⁰⁶ In at least one state, the fact that a partnership exchange could be launched by the executive without legislative action was the very reason it was used.⁴⁰⁷

We also saw conflicts between insurance commissioners eager to retain control of state insurance policy and governors in the same states resistant to engage with the exchanges or appear cooperative with the ACA. These intrastate struggles played out differently in each state—precisely because each state is a unique local democracy. Not all of these efforts were successful. Mississippi’s elected insurance commissioner, for instance, applied to HHS—unsuccessfully—for approval to create a state-based exchange, without the approval of either the governor or the legislature.⁴⁰⁸ But many workarounds that did emerge succeeded largely because of cooperation between state and federal insurance officials.

E. “Picket Fence Federalism”

Federalism scholars will undoubtedly see in some of these stories—especially in the case of the hybrid exchanges—the concept of “picket fence federalism.” That term is used to describe when administrators across governments working in the same policy area more closely identify with one another in furtherance of shared goals than they do with other members of their own government.⁴⁰⁹

The formal and informal networks that we have already described among implementers facilitated these picket fence relationships between state insurance experts and their federal counterparts. Another contributing factor was that many key Obama Administration officials were former insurance

405. See *id.* at 18, 33, 40; see also Kelly, *supra* note 258; Kevin J. Mooney, *Gov. Chafee’s Use of Executive Orders Is Viewed as Anti-democratic*, CURRENT (Aug. 14, 2012), <https://perma.cc/P3SS-7C6V>; Casey Seiler, *Cuomo Uses Clout to Sidestep GOP on “Obamacare,”* TIMES UNION (Albany, N.Y.) (updated Apr. 12, 2012, 10:10 PM), <https://perma.cc/98T9-NWHZ>.

406. See NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 204, at 5, 9, 16, 23.

407. See *State Marketplace Profiles: Michigan*, KAISER FAM. FOUND. (updated Nov. 26, 2013), <https://perma.cc/XYG2-83PY>.

408. See Jeffrey Hess, *HHS Denies Mississippi’s Bid to Run Its Own Exchange*, KAISER HEALTH NEWS (updated Feb. 8, 2013, 10:15 AM), <https://perma.cc/LGD6-7ZFS> (reporting that an HHS spokesman said that “[w]ith the Governor’s refusal to work with us or the insurance commissioner, there is no way to coordinate strategy with other agencies that he’s in charge of”).

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

commissioners or had held similar roles in various states. These included HHS Secretary Kathleen Sebelius (Kansas);⁴¹⁰ Joel Ario, the first director of the Office of Health Insurance Exchanges (Oregon and Pennsylvania);⁴¹¹ Teresa Miller, an acting director of the State Exchanges Group, the Oversight Group, and the Insurance Programs Group (Oregon and Pennsylvania);⁴¹² CCIIO Director Steve Larsen (Maryland);⁴¹³ Jay Angoff, the director of HHS's Office of Consumer Information and Insurance Oversight (which became the CCIIO) (Missouri);⁴¹⁴ and Kevin Counihan, the first CEO of HealthCare.gov (Connecticut).⁴¹⁵ States also engaged directly with the federal government in the ACA implementation process. States actively participated in the notice and comment rulemaking process and, even more frequently, weighed in through informal channels.⁴¹⁶ All forty-nine states that received any kind of exchange grant were assigned a designated officer who served as the state's point person at HHS and was available to interact "on a daily or weekly basis."⁴¹⁷ State insurance departments were in regular contact with the CCIIO regarding technical implementation issues.⁴¹⁸ Consistent with their historical roles as the "intergovernmental lobby,"⁴¹⁹ the National Governors Association and the NCSL also actively engaged with federal officials regarding exchange implementation.⁴²⁰ The State Health Exchange Leadership Network also engaged vertically, albeit on a less formal basis than the others.⁴²¹

410. See Peter Baker & Robert Pear, *Kansas Governor Seen as Top Choice in Health Post*, N.Y. TIMES (Feb. 18, 2009), <https://perma.cc/9R9L-ZWMP>.

411. See Joel Ario, COMMONWEALTH FUND, <https://perma.cc/KTR8-LC2M> (archived Apr. 24, 2018).

412. See *Pennsylvania Selects Commissioner Miller to Lead Department of Human Services*, INS. J. (Aug. 18, 2017), <https://perma.cc/P5ZU-MA7Y>.

413. See Sara Hansard, *CCIIO Director Steve Larsen Leaving for UnitedHealth Unit Optum in Mid-July*, BLOOMBERG BNA (June 20, 2012), <https://perma.cc/GMM9-8SU2>.

414. See Christopher Weaver, *HHS Insurance Oversight Office to Become Part of Medicare Agency*, NPR (Jan. 5, 2011, 5:08 PM ET), <https://perma.cc/ERN3-CYQA>; *Executive Profile: Jay Angoff*, BLOOMBERG, <https://perma.cc/22FC-W38C> (archived Apr. 24, 2018).

415. See Dan Diamond, *Kevin Counihan, the New "Obamacare CEO," Faces Four Key Challenges*, FORBES (Aug. 26, 2014, 12:25 PM), <https://perma.cc/HMT3-TK8W>.

416. See Monahan, *supra* note 328, at 398-409, 400 tbl.3 (listing the frequency with which each state submitted a comment).

417. See *id.* at 403-04.

418. See Email from Brian Webb, Assistant Dir., Life & Health Policy & Legislation, Nat'l Ass'n of Ins. Comm'rs, to authors (May. 17, 2018) (on file with authors) (confirming that state regulators have always had and continue to have "regular contact with CMS/CCIIO staff on a variety of implementation issues").

419. NUGENT, *supra* note 385, at 31.

420. See Monahan, *supra* note 328, at 409-14.

421. See *id.* at 14-15. State legislatures did not have formal institutional connections to HHS, making direct vertical connections with legislatures harder to document and assess, but

footnote continued on next page

F. Deconstructing “Federalism” Attributes

The traditional federalism account contends that certain attributes—autonomy, sovereignty, local policy variation, and experimentation—are most attainable for states separate from federal law. That account also argues that federalism’s attributes produce particular democracy benefits, including accountability and checks against the federal government. Modern federalism scholars diminish the importance of some attributes, such as sovereignty, and find others in centralization rather than separation. Our account pushes back against both perspectives.

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

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

Variation and experimentation are two of the most commonly touted federalism attributes, yet they seem much less linked to federalism structures than most accounts assume. The variation-in-exchange-implementation story has two intersecting vectors. On the one hand, the ACA homogenized insurance law and policy to an important extent. Before the statute was passed, wide inequities and variation existed across states in the number of uninsured people and the generosity of insurance plans.⁴²² After the ACA, inequities decreased in virtually every state, although some interstate differences remained.⁴²³ The ACA also established national network adequacy standards for the first time.⁴²⁴ Prior to the ACA, almost all states had at least some measures in place to ensure network adequacy, but states varied widely in their

the potential for such connections exists given how state officials move from one branch to another somewhat fluidly.

422. See CATHY SCHOEN ET AL., *AMERICA’S UNDERINSURED: A STATE-BY-STATE LOOK AT HEALTH INSURANCE AFFORDABILITY PRIOR TO THE NEW COVERAGE EXPANSIONS*, at ix-x, 3-5 (2014), <https://perma.cc/923N-SV95> (reporting wide variations between states in the number of individuals with access to adequate insurance); The Henry J. Kaiser Family Found., *supra* note 275, app. A at 8 (reporting uninsurance rates).

423. See The Henry J. Kaiser Family Found., *supra* note 275, app. A at 8.

424. See JANE B. WISHNER & JEREMY MARKS, *URBAN INST., ENSURING COMPLIANCE WITH NETWORK ADEQUACY STANDARDS: LESSONS FROM FOUR STATES* 4 (2017), <https://perma.cc/W6BJ-FJFP>.

approaches.⁴²⁵ The ACA required the HHS Secretary to ensure that plans offered on marketplaces had “a sufficient choice of providers . . . and provide[d] information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.”⁴²⁶

On the other hand, we still see significant variation across exchange models, but those differences do not stem from the choice between state and federal exchanges. The ACA explicitly leaves to state discretion many of the important details regarding the structure and operation of the exchanges, and regulations promulgated under the ACA expand that discretion.⁴²⁷ As Table 3 above illustrates, state discretion under the ACA created the possibility of vast differences in insurance markets even within exchange types. For example, some states used their authority to conduct rate review to deviate significantly from the federal rating standards, limiting insurers’ ability to impose surcharges for tobacco use or increase premiums based on age.⁴²⁸ Other states

425. See Justin Giovannelli et al., Regulation of Health Plan Provider Networks 3 (2016), <https://perma.cc/6JGQ-X9M5>.

426. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(c)(1)(B), 124 Stat. 119, 174 (2010) (codified at 42 U.S.C. § 18031(c)(1)(B) (2016)).

427. Most importantly, the regulations gave states a choice of the health insurance policy that would serve as the benchmark plan to determine the essential health benefits that must be offered by plans in the individual and small group markets. See Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,866 (Feb. 25, 2013) (codified as amended at 45 C.F.R. § 156.100 (2017)); see also *Essential Health Benefit (EHB) Benchmark Plans, 2017*, KAISER FAM. FOUND., <https://perma.cc/AWK2-EMHS> (archived May 16, 2018).

For federal-exchange states, CMS did impose quantitative standards, but the standards varied further by county composition. See CTR. FOR CONSUMER INFO. & OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., 2017 LETTER TO ISSUERS IN THE FEDERALLY-FACILITATED MARKETPLACES 23-24, 24 tbl.2.1 (2016), <https://perma.cc/292Y-7NLA> (setting time and distance maximums for different types of providers, such as primary care physicians).

Federal-exchange states conducting plan management were allowed to accept the federal standard or implement their own, subject to the time and distance caps. For example, in a “large” county, a network would have to cover a primary care physician at most 10 minutes or 5 miles away from 90% of enrollees. See CTR. FOR CONSUMER INFO. & OVERSIGHT, *supra*, at 24 & tbl.2.1. In a “rural” county, a network would have to include a primary care physician at most 40 minutes or 30 miles away for 90% of enrollees. See *id.*; see also Timothy Jost, *CMS Releases Final 2017 Letter to Issuers in the Federally Facilitated Marketplaces*, HEALTH AFF. BLOG (updated Mar. 3, 2016), <https://perma.cc/R9PY-UEQM>.

CMS proposed, but ultimately declined to adopt, quantitative standards for plans in all states regardless of exchange type. See HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,204, 12,205 (Mar. 8, 2016).

428. See Justin Giovannelli et al., Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market 2-7 (2014), <https://perma.cc/BV68-84SL>; *supra* Table 3.

prohibited insurers on their marketplaces from providing coverage for abortions.⁴²⁹

As is evident, there has been enormous variety—even within a particular category of exchange model—in how the exchanges look depending on states’ levels of involvement. Critically, although the federal government is nominally operating exchanges in about three dozen states, not all states’ federally run exchanges look the same—precisely because the federal government was eager to give states input even within the federal model, whether through a hybrid structure or just through a federal exchange in which the state had a voice in directing policy.

In total, twenty-nine states and the District of Columbia are making plan management decisions, including eighteen states using the federal IT platform (the six partnership states, seven plan management states, and five states with state-based exchanges using HealthCare.gov’s technology).⁴³⁰ In forty-seven states and the District of Columbia, the state insurance departments are managing health plan rate reviews.⁴³¹ Seventeen states and Guam sought adjustments to the federal medical loss ratio.⁴³² Forty-six states oversee compliance with the ACA’s market reform standards.⁴³³ The majority of states have chosen to set their own geographic rating areas, including fifteen states with federally run exchanges, seven plan management states, six partnership states, four states with state-based exchanges on the federal IT platform, and all eleven states (plus the District of Columbia) with fully state-run exchanges.⁴³⁴

For those federalism theorists who embrace federalism for policy variety, these details should give pause. They offer examples of locally driven experimentation that comes through a *national* program with a flexible, state-centered component. Pure separation of state and federal is not necessary—indeed, perhaps not even ideal—for the states to fulfill their role as policy “laboratories.” States may not even be necessary! At the same time, the nationalism in the exchange design did have something of a smoothing effect at

429. See Alina Salganicoff et al., The Henry J. Kaiser Family Found., Coverage for Abortion Services and the ACA 4 & fig.1 (2014), <https://perma.cc/TS8U-WJWN>.

430. See *State Health Insurance Marketplace Types, 2018*, *supra* note 331.

431. See *State Effective Rate Review Programs*, *supra* note 331. Only Oklahoma, Texas, and Wyoming do not have effective state-run rate review programs. See *id.*

432. See *State Requests for MLR Adjustment*, *supra* note 331. Nine of the states seeking adjustment had federally run exchanges, two were plan management states, four were partnership states, and two ran federally supported state-based marketplaces. See *State Health Insurance Marketplace Types, 2018*, *supra* note 331.

433. See *Compliance and Enforcement*, *supra* note 331. Only Missouri, Oklahoma, Texas, and Wyoming “have notified CMS that they do not have the authority to enforce or are not otherwise enforcing the Affordable Care Act market reform provisions.” *Id.*

434. See *Market Rating Reforms*, *supra* note 331; *State Health Insurance Marketplace Types, 2018*, *supra* note 331.

least on the equity front, in the sense that it set a floor that lessened some of the basic differences in coverage in the individual insurance markets across states.⁴³⁵ In other words, even where there has been policy autonomy, it has not been complete.

* * *

Another form of market variation could come in the form of waivers. The ACA includes a provision—section 1332—that allows a state to seek a waiver from the statute’s insurance requirements if the state can propose a program that would provide essentially the same coverage at the same cost.⁴³⁶ The statute did not permit waivers until 2017, so details about them were not included in our study. We might expect to see aggressive use of this provision under the Trump Administration.

Early information on waivers is mixed. In 2017, the Trump Administration approved waivers for Alaska, Minnesota, and Oregon, allowing those states to take on the healthcare costs of certain higher-cost individuals, taking them out of the market’s risk pools and thereby lowering premiums overall.⁴³⁷ Ohio, Maine, and Wisconsin now have similar proposals pending, with more states getting in line with draft proposals.⁴³⁸ At the same time, states have expressed frustration with the slow pace of review by CMS.⁴³⁹ The Administration recently also did not act on waiver proposals from two red states—Iowa and Oklahoma—that included many conservative reforms.⁴⁴⁰

435. See *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., <https://perma.cc/WHG4-PK6Z> (archived Apr. 24, 2018) (to locate, select “View the live page,” then select “Trend Graph,” and then select all locations and the “Uninsured” distribution) (showing a trend toward less variation in uninsurance rates across states).

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

437. See Richard Cauchi, *State Roles Using 1332 Health Waivers*, NAT’L CONF. ST. LEGISLATURES (Apr. 13, 2018), <https://perma.cc/8774-2K3H> (summarizing state requests for section 1332 waivers and their goals). On December 30, 2016, when Obama was still President, Hawaii received a waiver related to the ACA’s requirement that it operate a small business insurance marketplace. See *id.*

438. See *The ACA’s Innovation Waiver Program: A State-by-State Look*, COMMONWEALTH FUND (May 7, 2018), <https://perma.cc/XVN5-4F9U>; Heather Howard, *More States Looking to Section 1332 Waivers*, ST. HEALTH & VALUE STRATEGIES (May 10, 2018), <https://perma.cc/5WNH-C882>.

439. See Susannah Luthi, *Senate Republicans in Talks with Verma to Expedite States’ 1332 Waivers*, MOD. HEALTHCARE (May 9, 2018), <https://perma.cc/8DJQ-ERE9>.

440. See *id.*; see also Timothy Jost, *ACA Round-Up: 1332 Waiver News from Iowa and Minnesota; Big Blow to Graham Cassidy*, HEALTH AFF. BLOG (updated Sept. 24, 2017), <https://perma.cc/TJ8G-KBRA>; Leslie Small, *Waiver Weirdness: What the Oklahoma and Iowa Cases Could Mean for Other States Seeking ACA Exemptions*, FIERCEHEALTHCARE (Oct. 10, 2017, 12:52 PM), <https://perma.cc/ZUA6-UYL9>.

Some media reports suggested that the Administration, hostile to the law, did not want to approve any programs that would *strengthen* healthcare markets in those states.⁴⁴¹ In other words, this may mark a 180-degree turn from the Medicaid strategy of the Obama Administration, which was generous in granting waivers the Administration perceived as suboptimal from a policy perspective to further the long-term goal of entrenching the law in as many states as possible.

VI. Federalism Values, Old and New

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

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

A. Federalism and Democracy Goals

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

The big question concerns how to think about sovereignty and autonomy when are we not talking about separate spheres of power. We might say that the ACA enhanced state sovereignty because the alternative—excluding states from any role in the federal scheme—would have dramatically reduced state control over healthcare. But couching an absolute concept like sovereignty in

⁴⁴¹ See, e.g., Eric Levitz, *Trump Personally Tried to Sabotage Obamacare in Iowa*, NEW YORK: DAILY INTELLIGENCER (Oct. 6, 2017, 10:59 AM), <https://perma.cc/MDE5-6JWX>.

relative terms is conceptually challenging. It is easier, and maybe more apt, to talk about *control*. The ACA did offer states policy control—power that was enhanced by the ability to leverage the possibility of opting out to extract concessions from the federal government.

Another way to think about questions of sovereignty and autonomy is to ask whether the ACA's implementation helped to strengthen or to diminish state local democracy. State governments are their own democracies and make their own state law—and that is indeed a hallmark of being sovereign. Perhaps counterintuitively, the ACA did not necessarily diminish this aspect of state sovereignty. The ACA preempts some areas of health law traditionally considered reserved for states, so by that measure, state sovereignty is lost. But the statute itself also has generated an enormous amount of new state law. We found hundreds of state laws and state administrative acts issued in Medicaid and exchange implementation alone.⁴⁴² Like any major federal law that relies on state implementation, the ACA depends on the healthy functioning of *the state sovereign lawmaking apparatus*.⁴⁴³ As one of us has argued, this very fact—the fact that major national schemes rely on functioning state legal and legislative regimes—also gives these aspects of state sovereign governance enduring relevance, even in an era dominated by national law.⁴⁴⁴ Had Congress designed the ACA with no role for the states, we would not have had any of these intrastate government debates or this volume of state lawmaking on health policy. Health policy would be mostly federal all the way down, as in Medicare.

Accountability is another central democracy value and one often mentioned in the context of federalism. Conservative members of the Court, including the dissenters in *NFIB* and going back at least to Justice O'Connor's opinion in *New York v. United States*, have expressed concern that cooperative federalism schemes obfuscate accountability, leading voters to blame states for what are actually federal policies.⁴⁴⁵

442. For a helpful catalog of the vast amounts of state legislative and regulatory action taken by the end of 2013, see KATIE KEITH & KEVIN W. LUCIA, IMPLEMENTING THE AFFORDABLE CARE ACT: THE STATE OF THE STATES (2014), <https://perma.cc/6BFM-9M9M>.

443. For elaboration of this point, see Gluck, *supra* note 23, at 1999.

444. *See id.* at 2000, 2007.

445. *See Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 567 U.S. 519, 678 (2012) (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) ("When Congress compels the States to do its bidding, it blurs the lines of political accountability."); *New York v. United States*, 505 U.S. 144, 168-69 (1992) (expressing concern that if the federal government could commandeer states to carry out federal regulatory schemes, then state politicians might bear the brunt of unpopular policies because voters might be ignorant as to whether policy choices were made by the state or the federal government).

On the one hand, the ACA's story substantiates this concern. The federal government certainly tried to punt some decisions to the states. One example comes in the form of the ACA's essential health benefits—the baseline benefit package the statute guarantees for all exchange plans. Although the ACA itself directs federal agencies to determine which benefits should be counted as essential, this decision proved so controversial that HHS outsourced it to the states.⁴⁴⁶ A similar example comes from the more recent Republican repeal proposals. Those bills nominally would have left the ACA's essential health benefits and other generous insurance reforms in place—because they are politically popular—while at the same time inserting waiver provisions allowing the states to remove them.⁴⁴⁷

But our findings also flip some of these accountability concerns on their heads. The kind of hybrid federalism structures that HHS pursued to facilitate implementation of the ACA—including the “secret boyfriend model”—helped state politicians blur responsibility. These structures gave the state actors *cover* to participate in a scheme that they viewed as valuable but politically risky. When the ACA was later successful, some state electorates were largely unaware that their state was benefiting from cooperating with the federal administrative scheme.⁴⁴⁸ Since the 2016 presidential election, we have seen evidence that the citizenry is deeply confused about the implications of repealing the ACA, what it accomplished, whether it even exists, and who is accountable for what.⁴⁴⁹

446. See Sabrina Corlette et al., *Urban Inst., Cross-Cutting Issues: Moving to High Quality, Adequate Coverage; State Implementation of New Essential Health Benefits Requirements 3-5* (2013), <https://perma.cc/3WDS-6KE5> (“[T]he ACA calls for the [HHS] Secretary . . . to define a set of essential health benefits to be offered by all new fully insured individual and small-group health plans, beginning January 1, 2014. . . . Rather than define a uniform, national set of essential health benefits, HHS provided that each state could choose a benchmark plan on which to base [its] EHB package.”).

447. See *Compare Proposals to Replace the Affordable Care Act*, *supra* note 3.

448. See, e.g., Kyle Dropp & Brendan Nyhan, *One-Third Don't Know Obamacare and Affordable Care Act Are the Same*, N.Y. TIMES (Feb. 7, 2017), <https://perma.cc/UV9Q-KCM4> (reporting that a survey found that “only 61 percent of adults knew that many people would lose coverage through Medicaid or subsidies for private health insurance if the A.C.A. were repealed and no replacement enacted”). *But see* Sarah Kliff, *Why Obamacare Enrollees Voted for Trump*, VOX (Dec. 13, 2016, 8:10 AM EST), <https://perma.cc/TXV4-GDA6> (questioning whether Kentuckians in fact failed to understand what benefits came from the ACA).

449. See, e.g., Dropp & Nyhan, *supra* note 448 (“35 percent of respondents said either they thought Obamacare and the Affordable Care Act were different policies (17 percent) or didn't know if they were the same or different (18 percent). . . . When respondents were asked what would happen if Obamacare were repealed, even more people were stumped.”); Ilya Somin, *Public Ignorance About Obamacare*, VOLOKH CONSPIRACY (May 1, 2013, 1:27 PM), <https://perma.cc/ZS9S-ZCBB> (“42% of Americans are unaware that the Affordable Care Act is still the law of the land.”).

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

B. Federalism and Policy Goals

The political and judicial arenas tend to give more attention to federalism for federalism’s own sake—for the political and constitutional values it advances—than for policy goals. That theme has certainly been dominant in the ACA’s implementation. But this has not always been the case. The Federalist Papers themselves contain a well-known statement in the other direction, putting “the public good” above “the sovereignty of the States” in the event the two were to conflict.⁴⁵⁰ So understood, federalism is a means to an end, not the end in itself.⁴⁵¹

But even this narrower slice of federalism as means still stands in for many things. One way to think about federalism as a tool for policy is that it generates a particular *kind* of policy solution. As discussed above, local variation and experimentation are the kinds of policy values typically associated with federalism. But a different way to think about federalism as a tool for policy is that federalism may generate the best specific policy outcomes on a particular substantive question. In the context of the ACA’s drafting, there were indeed numerous suggestions that health policy is better when it is closer to the people as justifications for the statute’s state-led structure.

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

451. Compare, e.g., Gerken, *Federalism and Nationalism*, *supra* note 5, at 1039 (“Gluck sees state power as an ‘end worth achieving itself.’ . . . I understand both decentralization and centralization to be means to an end.” (quoting Abbe R. Gluck, *Nationalism as the New Federalism (and Federalism as the New Nationalism): A Complementary Account (and Some Challenges) to the Nationalist School*, 59 ST. LOUIS U. L.J. 1045, 1050 (2015))), with Gluck, *supra*, at 1046-47 (critiquing Gerken’s view of federalism as a means to ends unrelated to federalism).

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

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

1. ACA federalism and Medicaid outcomes

It is almost certain that the ACA's Medicaid expansion as drafted—which would have mandated a nationwide expansion—would have increased access to care simply by covering more than 3 million more lives than were covered after the Supreme Court in *NFIB* gave states a choice.⁴⁵² But that figure is not the only salient outcome measure for what the state-led model that *NFIB* created actually delivered, as it does not take into account other factors that are constants in any health policy conversation, such as cost and quality of care.

Empirical studies of the ACA's implementation have begun to document that especially in Medicaid expansion states, those who have become insured through the ACA have better access to care.⁴⁵³ Studies also show that access does not occur at the expense of individuals who were already insured—they are not being crowded out, as some feared would occur.⁴⁵⁴ Medicaid beneficiaries experience better access to care and better health,⁴⁵⁵ better ability

452. See Kevin Quealy & Margot Sanger-Katz, *Who Would Have Health Insurance if Medicaid Expansion Weren't Optional*, N.Y. TIMES (Nov. 3, 2014), <https://perma.cc/2MZW-N5BF>.

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

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

455. See, e.g., Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA INTERNAL *footnote continued on next page*

to take medications consistently,⁴⁵⁶ and less trouble paying medical bills.⁴⁵⁷ Medicaid coverage is better than uninsurance⁴⁵⁸ (which sounds like a low baseline, but the notion that it would not be was a tenacious trope around the time the ACA was being drafted), for example, in that it increases the probability that a patient will present earlier with an illness or injury, which contributes to better management of a medical issue.⁴⁵⁹

With respect to the cost of healthcare, Medicaid expansion costs both states and the federal government more than pre-ACA Medicaid.⁴⁶⁰ Yet studies show that those states that expanded Medicaid eligibility are better off

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

456. See Benjamin D. Sommers et al., *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586, 588 (2017).

457. See DELOITTE, COMMONWEALTH OF KENTUCKY: MEDICAID EXPANSION REPORT, 2014, at 35-36 (2015), <https://perma.cc/3RSK-E485>; The Henry J. Kaiser Family Found., *What’s at Stake in the Future of the Kentucky Medicaid Expansion?* 2 (2016), <https://perma.cc/964T-LXCA>; see also Antonisse et al., *supra* note 215, at 1.

458. See Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year* 29 (Nat’l Bureau of Econ. Research, Working Paper No. 17190, 2011), <https://perma.cc/UQL2-STG2> (“Using a randomized controlled experiment design, we examined the approximately one year impact of extending access to Medicaid among a low-income, uninsured adult population. We found evidence of increases in hospital, outpatient, and drug utilization, increases in compliance with recommended preventive care, and declines in exposure to substantial out-of-pocket medical expenses and medical debts. There is also evidence of improvement of self-reported mental and physical health measures, perceived access to and quality of care, and overall well-being.”); see also, e.g., Benjamin D. Sommers et al., *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, 36 HEALTH AFF. 1119, 1124-25, 1125 exhibit 3 (2017) (“Our four years of data indicate that the ACA’s coverage expansion to low-income adults was associated with significant improvements in access to primary care and medications, affordability of care, preventive visits, screening tests, and self-reported health.”). Amy Finkelstein and colleagues found no statistical difference in emergency room usage. See Finkelstein et al., *supra*, at 3.

459. See Andrew P. Loehrer et al., *Association of the Affordable Care Act Medical Expansion with Access to and Quality of Care for Surgical Conditions*, JAMA SURGERY E6 (2018), <https://perma.cc/9KAY-ALPR> (“In this study of surgical patients in 42 states (including Washington, DC), the ACA’s Medicaid expansion was associated with higher coverage rates, earlier presentation, and improved probability of optimal care for common and serious surgical conditions. Our data reinforce that insurance coverage is an important contributor to earlier presentation with less severe disease at the time of diagnosis.”). Research indicates, however, that the newly eligible may experience longer wait times for appointments with specialists than with primary care providers. See Sommers et al., *supra* note 458, at 1126.

460. See *State and Federal Spending Under the ACA, MEDICAID & CHIP PAYMENT & ACCESS COMMISSION*, <https://perma.cc/H74Z-NTFE> (archived Apr. 24, 2018).

economically than states that have not.⁴⁶¹ The costs of expansion largely are borne by the federal government, even when the supermatch phases down to 90%, and states are able to offset costs (such as for uncompensated care) that were the state's responsibility before Medicaid expansion.⁴⁶² Insurance marketplace premiums are lower in states that expanded Medicaid.⁴⁶³ Hospitals have had fewer uninsured patients requiring treatment in emergency departments,⁴⁶⁴ and one study reported that hospitals—especially rural hospitals—were less likely to close in expansion states.⁴⁶⁵ Evidence indicates that people do not leave employment due to Medicaid expansion, countering fears that Medicaid somehow causes joblessness (a different kind of economic effect).⁴⁶⁶

Not much data is available yet to assess the economic impact of demonstration waivers in the ACA's implementation.⁴⁶⁷ Section 1115 demonstration

461. See, e.g., Deborah Bachrach et al., State Health Reform Assistance Network, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains* 1 (2016), <https://perma.cc/L7Y3-EXN6> ("Data regarding Medicaid expansion in 11 states—Arkansas, California, Colorado, Kentucky, Michigan, New Mexico, Oregon, Maryland, Pennsylvania, Washington state, and West Virginia—and the District of Columbia confirm that states continue to realize savings and revenue gains as a result of expanding Medicaid."); Stan Dorn et al., *What Is the Result of States Not Expanding Medicaid?* 1 (2014), <https://perma.cc/NC9H-6CEC> ("A review of state-level fiscal studies found comprehensive analyses from 16 diverse states. Each analysis concluded that expansion helps state budgets.")

462. See Benjamin D. Sommers & Jonathan Gruber, *Federal Funding Insulated State Budgets from Increased Spending Related to Medicaid Expansion*, 36 HEALTH AFF. 938, 941-43 (2017) (studying the state-federal budgetary balance in Medicaid expansion states and concluding that costs were borne primarily by the federal government); see also *State and Federal Spending Under the ACA*, *supra* note 460.

463. See Aditi P. Sen & Thomas DeLeire, U.S. Dep't of Health & Human Servs., *The Effect of Medicaid Expansion on Marketplace Premiums* 2 (2016), <https://perma.cc/8QQW-4Q9F> ("We estimate that Marketplace premiums are about 7 percent lower in expansion states, controlling for differences across states . . ." (emphasis omitted)).

464. See Antonisse et al., *supra* note 215, at 1, 5-7.

465. See Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFF. 111, 117 (2018).

466. See Antonisse et al., *supra* note 215, at 11 ("Studies examining employment rates and other measures such as transitions from employment to non-employment, the rate of job switches, transitions from full- to part-time employment, labor force participation, and usual hours worked per week have not found significant effects of Medicaid expansion.")

467. To fill the gap, the Kaiser Family Foundation conducted interviews and focus groups in Michigan and Indiana to learn about implementation of those states' waivers. See MaryBeth Musumeci et al., The Henry J. Kaiser Family Found., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana* 3 (2017), <https://perma.cc/F4Q9-G4WT> (noting, among five key findings, some indication that administration of these states' programs is costly and complex and that "[h]ealth accounts can be confusing for beneficiaries").

waivers are supposed to be budget neutral to the federal government, but HHS gauges budget neutrality in a number of ways that facilitate rather than impede waiver approvals.⁴⁶⁸ In the Medicaid expansion context, negotiating a waiver takes time, and HHS's evaluation and approval of a waiver usually takes anywhere from several months to more than a year.⁴⁶⁹ This extended negotiation and approval process is not cost-free; people who are uninsured have no consistent means of care and thus are more costly when they arrive in hospitals that must treat them under federal law, resulting in expensive and inefficient emergency care.⁴⁷⁰ In addition, demonstration waivers have specific timing and reporting that make immediate, quantifiable evaluation tricky; they were typically approved for five years and renewed for three, though some provisions had a one-year timeline.⁴⁷¹

Historically, waivers' successes or failures were not evaluated until a state applied to renew or amend a waiver, and section 1115 waivers have a long history of implementation without supervision or reflection.⁴⁷² The ACA modified the section 1115 waiver process to increase transparency.⁴⁷³ Regulations now require states to report annually, regardless of the duration of the initial waiver approval.⁴⁷⁴ Indiana's HIP 2.0 waiver has been criticized based on its first interim report, which indicated that enrollment was low due to the

468. See *Waivers*, *supra* note 262 (detailing each type of waiver and how states obtain waivers).

469. See *id.*

470. This is due to EMTALA, discussed briefly in Part II.A above, which requires hospitals that have emergency departments to treat or stabilize and transfer all individuals who present with an emergency condition regardless of their ability to pay. See 42 U.S.C. § 1395dd(b) (2016); *supra* text accompanying note 108.

471. See *About Section 1115 Demonstrations*, MEDICAID.GOV, <https://perma.cc/4T2G-ULNZ> (archived Apr. 24, 2018). For examples of one-year section 1115 waivers and extensions, see Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Florida: Section 1115 Demonstration Fact Sheet 5 (n.d.), <https://perma.cc/PX38-NBMF>; and Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Iowa Wellness Plan Section 1115 Demonstration Fact Sheet 1 (2016), <https://perma.cc/99VF-748U>. CMS announced in late 2017 that it would adjust some waiver approval and renewal features, allowing for "fast track" approval of waiver provisions already approved in other states and allowing waiver approvals to last longer (ten years, in some instances). See Neale, *supra* note 255, at 3-4 (emphasis omitted).

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

473. See Watson, *supra* note 472, at 214-15.

474. See 42 C.F.R. § 431.428 (2017).

exclusionary measures in the state's waiver.⁴⁷⁵ Although the waiver was in effect for only about one year, the commissioned study of its implementation showed that the state had trouble managing enrollee compliance with rules for premium payments, wellness programs, and other measures designed to decrease enrollment in Medicaid.⁴⁷⁶ Another example comes from Iowa, which applied for an extension of a one-year waiver that allowed charging for nonemergency medical transportation. The little evidence collected indicated that Medicaid beneficiaries' access to care was *decreased* by this "experiment" (especially for individuals earning less than the FPL).⁴⁷⁷ Overall, many elements common in Medicaid expansion waivers are likely to be costlier for states to administer than traditional Medicaid.⁴⁷⁸

As a different example, waiver provisions that are designed to prevent continuous enrollment will decrease costs to the state (and therefore also the federal government under Medicaid's matching funding) but will curtail the extent of coverage. In part to reduce costs, states now are seeking to implement waivers that will drive the newly eligible population out of Medicaid. Consider, for example, Kentucky's section 1115 waiver approved early in 2018, which is designed to decrease state Medicaid costs through work requirements, cost sharing, and other features. According to the state's own evaluation, enrollment will drop by nearly 100,000.⁴⁷⁹

475. See, e.g., Letter from Am. Congress of Obstetricians & Gynecologists et al. to Thomas Price, Sec'y, U.S. Dep't of Health & Human Servs. 2 (Mar. 17, 2017), <https://perma.cc/FRX6-U2AV> ("Findings in the HIP 2.0 interim evaluation report show [that Indiana's] policies are affecting participation in the program and making it harder for people to obtain care . . .").

476. See THE LEWIN GRP., INC., INDIANA HEALTHY INDIANA PLAN 2.0: INTERIM EVALUATION REPORT 3, 20-21 (2016), <https://perma.cc/3ZNW-Z237> (revealing that one-third of "conditionally enrolled" members—individuals who have applied and are eligible for Medicaid but have not yet started coverage—never complete enrollment because they fail to make the required premium payments and contributions to their Personal Wellness and Responsibility (POWER) accounts); see also *id.* at 3 (noting that only 66% of enrollees required to make contributions to their POWER accounts reported ever hearing of the POWER account). HHS required this interim evaluation as well as a final evaluation at the end of the three-year waiver. See *id.* at 1.

477. See Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., U.S. Dep't of Health & Human Servs., to Julie Lovelady, Interim Medicaid Dir., Iowa Dep't of Human Servs. 1 (Dec. 30, 2014), <https://perma.cc/8MDH-8MBE>.

478. See Melissa Burroughs, *The High Administrative Costs of Common Medicaid Expansion Waiver Elements*, FAMS. USA (Oct. 20, 2015), <https://perma.cc/Q77M-LF8N>.

479. See Deborah Yetter, *Bevin Unveils Plan to Reshape Medicaid in Ky.*, COURIER-J. (Louisville, Ky.) (updated June 22, 2016, 6:26 PM ET), <https://perma.cc/XM92-QTFJ> (reporting the waiver application's indication that Medicaid enrollment will decline by nearly 86,000 people by 2021); see also Jason Bailey, *What's in the Governor's Proposed Medicaid Changes*, KY. CTR. FOR ECON. POL'Y: KY. POL'Y BLOG (June 22, 2016), <https://perma.cc/HZ9U-KMZR>. The waiver proposes a number of mechanisms that are likely to block, discourage, or cause sporadic enrollment; for example, beneficiaries who cannot pay

footnote continued on next page

As discussed in Part IV above, some states have gone further than the ACA's Medicaid expansion, offering more generous coverage. Those efforts have the predictable effect of costing the federal government more money in matching payments.

In sum, *NFIB's* enhancement of state policy control over Medicaid expansion unquestionably served the structural ends sometimes advanced by federalists, including state leverage and policy autonomy. So too for federalist policy ends like variation and experimentation—although section 1115 waivers would have been possible even within a full nationwide Medicaid expansion had *NFIB* never been decided. But it is far less clear that as a tool to improve health policy outcomes—along the most common metrics of access, cost, and quality—*NFIB's* state-led structure of the Medicaid expansion was successful. But then, Congress never assumed that it would be, which is why Congress did not draft the Medicaid expansion that way in the first place.

2. ACA federalism and exchange outcomes

In contrast, Congress did assume that exchanges would benefit from a state-led structure. The data thus far are equivocal, and no firm conclusion can be drawn as to whether the structure of the exchanges, in terms of being state or federally run, made a difference.⁴⁸⁰ Most states lost insurers between 2014 and 2018 regardless of exchange type,⁴⁸¹ but some of these losses were due to

premiums or who do not meet work requirements would be “locked out” for months. See Yetter, *supra*; see also Yetter, *supra* note 260; *supra* notes 258–61 and accompanying text.

480. See, e.g., Sabrina Guilbeault et al., *Making the Grade: Evaluating the Performance of State Health Insurance Marketplaces*, COLLABORATIVE (May 26, 2016), <https://perma.cc/N6FH-ZCP3> (finding that federally run exchanges performed as well as or better than state-based exchanges and hybrids); *Marketplace Enrollment as a Share of Potential Marketplace Participation*, KAISER FAM. FOUND., <https://perma.cc/BQ7H-WAEX> (archived Apr. 24, 2018) (compiling data on marketplace enrollment as a percentage of total eligible individuals, with a difference of less than two percentage points between federally facilitated and state-based exchanges and a difference of less than three percentage points among all kinds of exchanges, including hybrids).

481. Partnership-model states fared the best, increasing the average number of issuers slightly from 3.7 in 2014 to 4.3 in 2017, although the bulk of this increase is attributable to New Hampshire, which went from 1 to 4 issuers while four partnership-model states saw no change. See *Number of Issuers Participating in the Individual Health Insurance Marketplaces*, KAISER FAM. FOUND., <https://perma.cc/SF2H-C895> (archived Apr. 24, 2018) (listing the number of issuers by state, from which we calculated these averages). Other exchange types lost roughly one or fewer issuers over the three-year period on average. See *id.* Federally supported state-based marketplaces fared the worst, losing 1.2 issuers on average, a drop largely attributable to Oregon, which went from 11 to 6 issuers while three other states saw no change. See *id.*

others' acts of political resistance⁴⁸²—including the shutting off of critical insurance stabilization funding by the Republican-controlled Congress.⁴⁸³

Average premiums increased in forty-six states and the District of Columbia from 2016 to 2017, more than doubling in one state, although premium tax credits have largely insulated consumers from the increases.⁴⁸⁴ On the other hand, approximately 16.9 million more Americans received healthcare coverage in the first two years of the ACA,⁴⁸⁵ and 11.8 million Americans received insurance through the exchanges in the most recent open enrollment period.⁴⁸⁶

Data from a few years before the ACA's passage also reveal wide variation among the number of uninsured people across states.⁴⁸⁷ The ACA has reduced that number in each state, but differences across states remain.⁴⁸⁸

The data are even more equivocal as to whether state-based exchanges performed better across the typical variables of market penetration, premium levels, and number of insurers. States with federally run exchanges had lower enrollment relative to projections than did states with state-based marketplaces.⁴⁸⁹

482. See Bob Bryan, *Insurance Companies Are Freaking Out About Trump's Obamacare Threats*, BUS. INSIDER (Apr. 28, 2017, 9:28 AM), <https://perma.cc/UZG2-7HG2>; Olga Khazan, *Why So Many Insurers Are Leaving Obamacare*, ATLANTIC (May 11, 2017), <https://perma.cc/3WMW-4K3G>.

483. See *Number of Issuers Participating in the Individual Health Insurance Marketplaces*, *supra* note 481.

484. See Cynthia Cox et al., *2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces*, KAISER FAM. FOUND. (updated Nov. 1, 2016), <https://perma.cc/J29T-PS5Z>. For example, the second most expensive silver plan in Phoenix, Arizona cost \$300 more per month in 2017 than in 2016 for a 40-year-old nonsmoker earning \$30,000 per year. See *id.* After tax subsidies, though, the price remained steady at \$207 per month. See *id.* Preliminary data from the 2018 open enrollment period suggest that this trend will continue to hold true. See Rabah Kamal et al., *The Henry J. Kaiser Family Found., An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges 2*, 3 tbl.1 (2017), <https://perma.cc/KHN2-M3XN>. Some analysts view the rate increases in 2017 as a necessary market correction as the health profile of the pool of insured individuals became clear. See Ashley Semanskee & Larry Levitt, *The Henry J. Kaiser Family Found., Individual Insurance Market Performance in Mid 2017*, at 5 (2017), <https://perma.cc/33GE-PABP>.

485. See Katherine G. Carman et al., *Trends in Health Insurance Enrollment, 2013-15*, 34 HEALTH AFF. 1044, 1044, 1046 (2015).

486. See *Total Marketplace Enrollment*, KAISER FAM. FOUND., <https://perma.cc/VMP8-9FGF> (archived Apr. 24, 2018).

487. See generally John Holahan, *Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?*, in *FEDERALISM & HEALTH POLICY*, *supra* note 15, at 111.

488. See *The Henry J. Kaiser Family Found.*, *supra* note 275, at 2, 4; see also *Health Insurance Coverage of the Total Population*, *supra* note 435.

489. See *Marketplaces Make Significant Progress in 2015*, URB. INST. (updated Apr. 8, 2015), <https://perma.cc/99KH-QZJG>.

This trend reversed in 2015, and federally run exchanges had higher enrollment growth than state-based exchanges.⁴⁹⁰ The federal government has doled out billions of dollars in exchange development grants, but states that have received the most grants have not necessarily been the most successful.⁴⁹¹ In terms of both enrollment and cost, at least some data reveal that contrary to expectations, state-based exchanges did not outperform either federal or hybrid marketplaces.⁴⁹²

C. Federalism, Regulation, and Law

Our study also has implications for federalism's doctrinal landscape.⁴⁹³ First and foremost, we need to know what we are talking about to know what law is protecting or whether law can even protect it. Courts are generally ill suited to address one important segment of federalism questions: questions about policy, such as whether federalist structures produce better health outcomes. We doubt courts are even the appropriate place to address other federalism attributes, like autonomy, cooperation, experimentation, and variation, because they are so context-specific and dynamic. Frankly, based on our findings, we would eliminate those factors entirely as irrelevant to any deep analysis of federalism.

Courts are far better at policing clear boundaries, which we do not have here, and at focusing on process, which we do. We can envision, for instance, courts intervening in cases to be sure that the policy control a statute gives to

490. *See id.*

491. *See* Robert B. Hackey & Erika L. May, Viewpoint, *Measuring the Performance of Health Insurance Marketplaces*, 314 JAMA 667, 667 (2015) (“Hawaii’s [state-based exchange], the nation’s most expensive marketplace in terms of per enrollee costs, received more than \$205 million in federal funding, but as of February 2015 had only enrolled 12,625 individuals In contrast, Florida accepted no federal funding for ACA planning and implementation, but its [federally facilitated marketplace] enrolled more subscribers than any other state in 2015 (1,596,296 individuals).”).

492. *See id.* at 668 (“This is a counter-intuitive outcome because [state-based exchanges] retained a larger role in regulating insurance premiums. In such states, insurance commissioners were expected to use their rate review powers to exert downward pressure on insurers’ premium requests.”). Evidence suggests that insurers in state-based exchanges performed better financially than insurers in federal exchanges. *See* Mark A. Hall et al., *Financial Performance of Health Insurers: State-Run Versus Federal-Run Exchanges*, MED. CARE RES. & REV. 7 (2017), <https://perma.cc/HGM5-W2JG>. However, this effect may be attributable to states’ decisions on Medicaid expansion. *See id.* (“[S]tate-run exchange states . . . tended to be the ones that expanded Medicaid, and doing that takes some of the higher risk people out of the exchange market . . .”).

493. The arguments in this Subpart benefited tremendously from the thoughts of one of our initial colleagues in researching the ACA, Dean Ted Ruger at the University of Pennsylvania Law School.

states remains with the states.⁴⁹⁴ Our study corroborates the focus of much of the new federalism literature on the role of vertical and interagency bargaining as the central feature of modern, intrastatutory federalism relationships.⁴⁹⁵ The former federal officials we interviewed told us that their daily interactions with each state individually were all-consuming and complex.⁴⁹⁶ These vertical negotiations have been the core dynamic of the ACA's implementation.

We also saw that the federal government exerts power—but not hegemonically. The dance between the federal government and each state is not a zero-sum negotiation over policy optimization between a federal executive and state actors who might disagree on a single dimension. The federal government has at least two negotiating levers, regulatory policy and budget generosity, and it can switch between them (or use both) to implement its policy goals. Extending this two-lever bargaining dynamic is a temporal and vision mismatch between national and state policy ends. If the Obama Administration was typical, the federal executive operates on a longer time horizon than most state officials, a point confirmed by several of our interviewees.⁴⁹⁷ States likely care more about Medicaid implementation specifics given their primary role in delivering healthcare and the budgetary consequences they face every year. The federal executive tends to aim at a higher level of generality.

These factors combine to give states a lot more leverage than most newer federalism scholars assume, and we doubt this observation is unique to the ACA. Much of the new scholarship has portrayed the states as *victims* in these negotiations, calling for new legal doctrines as a way to level the bargaining playing field between states and the federal government.⁴⁹⁸ Our findings cast

494. Cf. Ernest A. Young, *Two Cheers for Process Federalism*, 46 VILL. L. REV. 1349, 1351 (2001) (“[W]hat judicial review we have should be directed toward maintaining a vital system of political and institutional checks on federal power, not on policing some absolute sphere of state autonomy.”).

495. See, e.g., ERIN RYAN, *FEDERALISM AND THE TUG OF WAR WITHIN 350* (2011) (recognizing “the important interpretive roles by political actors in vertical federalism bargaining”); Gerken, *Federalism and Nationalism*, *supra* note 5, at 1010 (discussing states’ powers as those “of the servant” (quoting Heather K. Gerken, Commentary, *Of Sovereigns and Servants*, 115 YALE L.J. 2633, 2635 (2006))); Gluck, *supra* note 1, at 570 (discussing “important vertical and horizontal implementation networks” that arise in the context of the ACA); Theodore W. Ruger, *Of Icebergs and Glaciers: The Submerged Constitution of American Healthcare*, 75 LAW & CONTEMP. PROBS., no. 3, 2012, at 215, 224-26 (emphasizing state leverage under the ACA).

496. See Interview with Former Federal Executive Branch Healthcare Official 1, *supra* note 213; Interview with Former Federal Executive Branch Healthcare Official 5, *supra* note 190.

497. See Interview with Former Federal Executive Branch Healthcare Official 1, *supra* note 213; Interview with Former Federal Executive Branch Healthcare Official 5, *supra* note 190; Interview with State Policy Organization Officers 1, 2, 3 and 4, *supra* note 213.

498. Cf., e.g., Ilya Somin, *Federalism and the Roberts Court*, 46 PUBLIUS: J. FEDERALISM 441, 442 (2016) (praising the Roberts Court’s “strengthen[ing of] judicial enforcement of limits
footnote continued on next page”).

doubt on whether the states need more protection or power at all. At least in the context of the ACA, states have proved themselves quite adept at leveraging available options to their benefit.⁴⁹⁹ We suspect that this leverage was due to more than just *NFIB*, although that decision undoubtedly helped. States still had the lever of refusing to establish their own exchanges. As we have seen, that was a powerful tool to bring HHS to the table to adapt. The Medicaid waiver provisions also were available before *NFIB*.

Central to the negotiating power we observed are several features that appear not to be limited to the ACA: state choice to implement, a context in which the federal government does not wish to or lacks capacity to itself implement a program nationwide, and the executive branch's commitment to the program's success. Of course, other kinds of statutes exist too—including ones with less political salience—in which an administering agency might be able to step in more easily or be more willing to stake out firmer negotiating positions at the expense of entrenching the law.

It also is notable that Congress and federal courts remain largely on the sidelines when it comes to these intergovernmental negotiations.⁵⁰⁰ We saw little of those institutions after Congress set the ACA in motion and the Court effectively amended it in *NFIB*. Part of the reason is that almost no legal doctrine applies to these new vertical interactions, and so courts have had little role to play.⁵⁰¹ As noted, we can imagine doctrines that would recognize the federalism features within national statutory implementation and seek to effectuate them. We might, for instance, recognize rights for state implementers to challenge executive action that undermines a law's effectiveness—at the moment, those kinds of challenges are exceedingly difficult to bring.⁵⁰² We have mentioned one important legal advance that already has occurred, perhaps in recognition of the growing importance of bargaining relationships: the ACA's amendment of the Medicaid section 1115 waiver process to bring more transparency to waiver negotiations.⁵⁰³ Waivers were notorious legal

on federal power . . . for the purpose of leaving greater scope for state and local authority"). See generally Erin Ryan, *Negotiating Federalism*, 52 B.C. L. REV. 1, 24-73 (2011).

499. See *supra* Parts IV.A, V.B.

500. Cf. Bulman-Pozen, *supra* note 2, at 954 (arguing that Congress has been sidelined because of polarization, not the lack of legal doctrine, and seeing an enhanced role for executive negotiations as a result).

501. See Gluck, *supra* note 23, at 1997-98 ("This push-pull of nation and state—both from *inside* the landscape of federal statutes—is more than just an interesting theoretical observation. It is a 'law' problem. When it comes to legal doctrines to deal with this new world of statutory federalism, ours is a sorry state of affairs.").

502. The Take Care Clause provides a means of suing the executive but imposes an extraordinarily high hurdle. See Gluck, *supra* note 333; see also U.S. CONST. art. II, § 3.

503. See Watson, *supra* note 472, at 215.

black boxes across all areas of law, and this new transparency has facilitated state copying in Medicaid.

Another problem is that current legal doctrine does not recognize and so cannot capture the blended entities that modern federalism statutes like the ACA produce.⁵⁰⁴ These institutions are neither “state” nor “national.” Ask any health law scholar if an insurance exchange—whether state-run, federally run, or hybrid—is a state or federal entity, and a variety of conflicting answers will follow. These are mixed entities of the sort that—because they retain some features of state sovereignty and yet are the brainchildren of federal law—have puzzled constitutional and federal courts scholars when it comes to categorizing them as state or federal.⁵⁰⁵

In years to come, courts will certainly be asked whether challenges to aspects of insurance exchange operation are federal or state law questions for purposes of jurisdiction and applicable law, just as courts have been asked—and have unevenly answered—such questions regarding state implementation of the Clean Air Act.⁵⁰⁶ Questions are also likely to arise concerning the extent to which Congress can direct state officials in the implementation of federal law. For instance, the ACA required state insurance commissioners to engage in rate review that some states did not already allow those officials to perform.⁵⁰⁷ Courts have not answered whether federal law may authorize this otherwise ultra vires state-official behavior, or whether state law first must authorize state officials to act as federal law requires. The Court narrowly skirted this question in 2011—a Term before it skirted the difficult question of when individuals can challenge states for lax implementation of federal law.⁵⁰⁸

504. See generally Gluck, *supra* note 23 (detailing the lack of doctrine).

505. Cf. *id.* at 2007, 2027, 2033 (illustrating confusion about similar entities, such as the implementation tools of the Clean Air Act, a state-led federal statute).

506. See Ernest A. Young, *Stalking the Yeti: Protective Jurisdiction, Foreign Affairs Removal, and Complete Preemption*, 95 CALIF. L. REV. 1775, 1787-88 (2007) (discussing cases evincing confusion under the Clean Air Act).

507. See *Premium Rate Reviews*, NAT'L CONF. ST. LEGISLATURES (Dec. 2010), <https://perma.cc/875G-NRXX> (“Under federal law, states (usually insurance departments) will review rates and determine whether they are unreasonable. . . . [Only t]wenty-four states give the state insurance department or commissioner legal power of prior approval or disapproval of certain rate changes.”).

508. See *Va. Office for Prot. & Advocacy v. Stewart*, 563 U.S. 247, 255, 257-58 (2011); see also *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 565 U.S. 606, 610, 616 (2012) (declining to decide “whether the Ninth Circuit properly recognized a Supremacy Clause action to enforce” a Medicaid provision against the states). The Court returned to a similar question in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015). In that case, the Court held that doctors could not sue state officials for underenforcing federal Medicaid laws. See *id.* at 1382, 1384-85, 1387.

This blurring of state and national contributes to the conceptual difficulties for federalism outlined above. It also undermines the assumptions made by federalism legal doctrines, which still rest on a separate spheres conception.

D. Federalism and Healthcare

Federalism as a tool of health policy in particular remains theoretically muddy. On the one hand, an attachment to retaining localism in healthcare persists and clearly relates to federalism. Nationalization of healthcare has been something Americans have strongly supported only when circumstances are dire for a particular group, such as when Medicare was enacted in 1965,⁵⁰⁹ or when populations Congress views as especially vulnerable—such as mothers and children in the case of Medicaid—need help.⁵¹⁰ The tradition has been to place trust in state-run programs to control quality, bring down healthcare costs, enhance competition, and promote innovation—in other words, federalism has been assumed to be the means to improve policy outcomes.⁵¹¹

It is well established that healthcare varies across geographic markets.⁵¹² Some of this variation is driven by the kinds of differences typically discussed in federalism literature. Medicine historically has a very local culture, and provider practices may vary substantially even across communities within the same state.⁵¹³ Even Medicare, the national health insurance program for the

509. See STARR, *supra* note 59, at 368-69; Robert J. Blendon & John M. Benson, *Americans' Views on Health Policy: A Fifty-Year Historical Perspective*, HEALTH AFF., Mar./Apr. 2001, at 33, 34 (“Shortly before Medicare was enacted, 75 percent of the public said that the federal government should pass a law to provide medical care for seniors.”).

510. See, e.g., Lisa Shapiro, First Focus, *The Children’s Health Insurance Program: Why CHIP Is Still the Best Deal for Kids 1* (2017), <https://perma.cc/B6UD-GRL5> (“The American people overwhelmingly support CHIP’s continuation. In a May 2014 poll conducted by American Viewpoint, voters favored extending funding for CHIP by a 74-14% margin, including 66-19% among Republicans.”).

511. See Holahan et al., *supra* note 15, at 6-7.

512. See, e.g., John Wennberg & Alan Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCIENCE 1102, 1107 (1973).

513. See, e.g., *Hall v. Hilbun*, 466 So. 2d 856, 872 (Miss. 1985) (“Because of . . . differences in facilities, equipment, etc., what a physician may reasonably be expected to do in the treatment of a patient in rural Humphreys County or Greene County may vary from what a physician in Jackson may be able to do. A physician practicing in Noxubee County, for example, may hardly be faulted for failure to perform a CAT scan when the necessary facilities and equipment are not reasonably available.”), *superseded in other part by statute*, Act of Mar. 2, 1989, ch. 311, 1989 Miss. Laws 19 (codified as amended in scattered sections of the Mississippi Code), as recognized in *Narkeeta Timber Co. v. Jenkins*, 777 So. 2d 39 (Miss. 2000); James N. Weinstein et al., *Trends and Geographic Variations in Major Surgery for Degenerative Diseases of the Hip, Knee, and Spine*, 23 HEALTH AFF. VAR-81, VAR-82 (2004) (“In a given region, local physicians tend to apply their rules of practice consistently, which results in the ‘surgical signature’ phenome-
footnote continued on next page

elderly and disabled, still relies on local coverage determinations.⁵¹⁴ Geographic variations in diseases and local health behaviors also drive differences.⁵¹⁵

Other differences are driven by inequality, including disparities when it comes to local resources and social determinants of health.⁵¹⁶ Moral considerations may outweigh a preference for localism in these circumstances, depending on whether the policy goal of healthcare federalism is outcomes or structure. Those moral considerations were part of Congress's motivation to nationalize the Medicaid expansion in drafting the ACA.⁵¹⁷

In this vein, a particularly fascinating outgrowth of the ACA from a healthcare federalism perspective is that the threat of its repeal has done more to advance a *nationalized* vision of healthcare than ever before. Calls for a fully national "single payer" system were politically impossible before the Trump Administration. But the threat to the ACA's efforts to expand healthcare access has led many to place moral concerns above structural ones and has brought arguments for single payer healthcare into the mainstream.⁵¹⁸

But whichever side of the line one is on, our key point is that little evidence supports the claim that any of the structural options is best. Little data exists showing that states acting alone actually achieve better health outcomes than do states working within federal guidelines. Even less evidence exists comparing outcomes when states work alone, when states work inside federal guidelines, and when the federal government acts alone.

non: rates for specific surgical procedures that are idiosyncratic to a region, sometimes differing dramatically among neighboring regions.").

514. See 42 U.S.C. § 1395ff(f)(2)(B) (2016) ("For purposes of this section, the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with [42 U.S.C.] § 1395y(a)(1)(A) . . .").

515. See, e.g., Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States, 2001-2014*, 315 JAMA 1750, 1756 (2016) (describing the importance of local trends in health behaviors in creating geographic differences in health outcomes).

516. See Harry J. Heiman & Samantha Artiga, The Henry J. Kaiser Family Found., *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity 2* (2015), <https://perma.cc/8X88-3K45>; see also, e.g., Jennifer Weisent et al., *Socioeconomic Determinants of Geographic Disparities in Campylobacteriosis Risk: A Comparison of Global and Local Modeling Approaches*, INT'L J. HEALTH GEOGRAPHICS 2 (2012), <https://perma.cc/BN4M-582G> (describing the socioeconomic factors influencing rates of campylobacteriosis, a common cause of gastroenteritis).

517. See Remarks on Signing the Patient Protection and Affordable Care Act, 2010 DAILY COMP. PRES. DOC. NO. 00196, at 3 (Mar. 23, 2010), <https://perma.cc/DR5A-LNPY> ("And we have now just enshrined . . . the core principle that everybody should have some basic security when it comes to their health care.").

518. See Abbe Gluck, *Obamacare as Superstatute*, BALKINIZATION (July 29, 2017, 10:18 AM), <https://perma.cc/25MX-658G>.

The ACA is the ultimate compromise. It retains and strengthens the preexisting landscape of fragmented and structurally diverse healthcare programs. It straddles the systemic philosophical options, incorporating components of both individual responsibility and solidarity/universality into one statute. And when it comes to federalist structures, the statute embraces a federalist model with a nationalized baseline, even as the healthcare goals it aims to accomplish may be better suited to a fully nationalized structure, at least when it comes to Medicaid. But that is why we can say with more certainty that the ACA's implementation structure serves state power than we can say that the implementation proves that federalism results in the best health policies.

Some newer federalists might take a third way. Heather Gerken, for instance, might focus less on state power and more on how the ACA creates a structure that accommodates policy differences or leads to beneficial policy churn.⁵¹⁹ Even so, saying that healthcare federalism is merely a vehicle to allow for a variety of policy solutions does not ring completely true to us, in large part because we have shown that we can have that policy churn without state-led programs at all. Moreover, even if healthcare federalism is mostly understood as a vehicle for policy diversity, that does not amount to a normative defense of it. Either that variety itself produces benefits—such as in the form of health outcomes—or it should be justified on different terms, whether in terms of democracy benefits from federalist structures or in terms of the benefits of such policy diversity even in the face of moral concerns about unequal access to healthcare across the country.

None of this is to suggest that federalism is not real in healthcare. Our story makes the salience of the state role, including the importance of state sovereignty, clear. But federalism's normative justifications require more serious clarification and evaluation. More empirical examination of benefits and drawbacks of different federalist structures across classic health policy metrics such as coverage, quality, and cost is needed. Additional data could provide information about whether federalism *should be* a key *policy* move. If it turns out that federalist structures do not make for better policy outcomes in a particular area, then we need to ask whether there is instead a normative justification for suboptimal policy choices in exchange for the other structural, political, or constitutional benefits we think healthcare federalism would offer as an end unto itself.

519. See Gerken, *Federalism and Nationalism*, *supra* note 5, at 1026.

Conclusion

The ACA's implementation offers a window into modern American federalism—and modern American nationalism—in action. The implementation process baked into the statute's structure, despite being flipped by *NFIB* and the ensuing political resistance, invites participation from a wide range of state and federal actors and extends that iterative process forward through time. The process is both vertical and horizontal as well as exceedingly adaptive, as state and federal actors respond not just to federal regulators but also to internal state dynamics, other states' experiences, and complex policy goals. States move back and forth between different structural arrangements vis-à-vis the federal government, and negotiation with federal counterparts is a near constant.

The story is not one of separate-spheres federalism. But neither is it one of states as subservient entities lacking sovereignty. Rather, the ACA's structure has given the states a great deal of policy autonomy and leverage. It has relied on the gears of state sovereign democracy to work and so strengthens those democracies in the process. At the same time, the state-federal blur that the ACA produces has sometimes obfuscated accountability—notably by sometimes masking state cooperation with the federal program when it would be politically unpopular to engage. The features we detail have endured, including after the election and arrival of an administration hostile to the law.

In work describing our study at an earlier stage, we labeled our findings “The New Health Care Federalism.”⁵²⁰ We have moved away from this label here, in part because we suspect our story is not unique to healthcare. The ACA's scale simply makes the features we describe particularly salient.

We also are not certain whether the features we identify mark differences in kind or in degree from what came before. States have negotiated with the federal government for decades; internal state politics have always mattered; Congress has used states as lead implementers of federal law for many years. But the ACA showcases these features in extreme fashion, and it deconstructs “federalism” in ways we have not seen before. This does not mean that no other statute does it; just that the ACA makes it impossible to ignore.

Federalism scholars spend most of their time arguing for a particular structural arrangement based on prior goals and values. The ACA's architecture challenges whether any of these goals and values are unique to federalism or any particular expression of it. It illustrates how federalism is a proxy for many ideas and challenges us to ask what we are really fighting over, or seeking, when we invoke the concept. Underneath it all is a modern system

520. Gluck & Huberfeld, *supra* note 207.

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of governance that blends state and federal in ways legal doctrine has not recognized.

And when it comes to healthcare, conceptual difficulties multiply, largely because first principles are wanting. Without settling on the overarching goals of a healthcare system in the first place, no one can determine whether the kinds of state-federal arrangements built into the ACA serve those goals. And without deciding whether structural separation of state and federal is an end in itself or a means to a policy end—or both—we cannot say much that is meaningful about it. As a result, we cannot determine whether federalism is serving its ostensible purposes, how strongly it is entrenched, or how vigorously it is worth defending.