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Safeguarding Federalism by Saving Health Reform: Implications of National Federation of Independent Business v. Sebelius

Brietta Clark

SAFEGUARDING FEDERALISM BY SAVING HEALTH REFORM: IMPLICATIONS OF *NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS*

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On June 28, 2012, the Supreme Court issued one of its most anticipated decisions in National Federation of Independent Business v. Sebelius *("*NFIB*")—the constitutional challenge to the Patient Protection and Affordable Care Act ("ACA"). The ACA is President Obama's signature accomplishment and creates a number of reforms intended to reduce cost, improve the quality of healthcare and health outcomes, and expand access to care. The main pillars of the ACA are the expansions of public and private insurance coverage. These expansions were the targets of a number of legal challenges by states, private individuals, and various organizations, with two reaching the Supreme Court in* NFIB. *The first, and the one that has received the most attention, was the challenge to the individual mandate as exceeding Congress's commerce and taxing powers. The second was a challenge to the structure of the Medicaid expansion as coercive in violation of the Tenth Amendment limit on Congress's spending power. These challenges were also significant because if either provision had been found unconstitutional, it might have been used to invalidate the entire heath reform law.*

The political and legal commentary about the challenges focused on the mandate as an exercise of the commerce power. Opponents of reform warned that upholding the mandate would lead to an unprecedented expansion of federal power in violation of our dual system of government. They shaped the dominant narrative that presented federal power as an inherent threat to state sovereignty and individual liberty. The mandate was seen as the beginning of a parade of other horrible intrusions into our personal lives, and state opposition as essential to protecting personal liberty. In this narrative, NFIB *presented the Court with a dichotomous choice: Would the conservative majority—Chief Justice Roberts, along with Justices Alito, Scalia,*

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Thomas, and Kennedy—take this opportunity to further limit federal power, or could the liberal wing of the Court sway one of the other Justices (most wrongly predicted Justice Kennedy) to uphold the mandate? The Court surprised many by answering "yes" to both.

The Court upheld the mandate as a constitutional exercise of the taxing power and preserved the Medicaid expansion as an option for states, but Chief Justice Roberts's approach defied the simplistic narrative that dominated commentary before the decision. By upholding the mandate and the ACA, the Court has preserved a powerful new version of cooperative federalism in healthcare—one that creates a federal platform for state experimentation, innovation, and regulation to facilitate meaningful choice in the private health-insurance market. At the same time, however, Chief Justice Roberts penned certain parts of the opinion that may advance more traditional federalist aims of limiting the commerce and spending powers. Most notable was the Court's unprecedented finding that the Medicaid expansion was structured in a coercive way and so could not be required as a condition of Medicaid participation generally. States now have the choice to opt in to the expansion or to refuse to participate, creating uncertainty for the poorest residents in states that opposed reform. More fundamentally, this holding suggests that the Spending Clause may now be a more viable site for federalism-based attacks and used to limit the federal government's ability to adapt its spending conditions to changing realities in longstanding healthcare programs like Medicaid and Medicare.

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I. INTRODUCTION

On June 28, 2012, the Supreme Court issued one of its most anticipated decisions in *National Federation of Independent Business v. Sebelius* ("*NFIB*")[1]—the constitutional challenge to the Patient Protection and Affordable Care Act ("ACA" or the "Act").[2] The ACA is President Obama's signature accomplishment. It relies on a host of reforms designed to reduce cost, improve the quality of healthcare and health outcomes, and expand access to care. But the linchpin of reform, and the piece receiving the overwhelming amount of attention, is its attempt to improve healthcare access by expanding public and private insurance coverage. Increased coverage should help improve health outcomes and reduce healthcare costs by ensuring that people can get access to the right kind of care at the right time to help prevent illness or avoidable hospitalizations.[3] Coverage also helps prevent the harmful cost shifting and rise in costs that result from uncompensated medical treatment.[4] The ACA is the most significant expansion of coverage since Medicare and Medicaid in 1965.

On the public side, the ACA broadens Medicaid eligibility.[5] Traditionally, Medicaid only covered certain categories of the very poor: children, pregnant women, people with disabilities, and some parents of covered children. Though not explicitly labeled as such,

1. 132 S. Ct. 2566 (2012).

2. Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in various sections of 21, 25, 26, 29, and 42 U.S.C.).

3. *See, e.g.*, Katherine Brandon, *The President on Health Care: "We are Going to Get this Done"*, WHITE HOUSE BLOG (July 17, 2009, 5:42 PM), http://www.whitehouse.gov/blog/The-President-on-Health-Care-We-are-Going-to-Get-this-Done; *see also* Peter Orszag, *To Save Money, Save the Health Care Act*, N.Y. TIMES, Nov. 4, 2010, at A29 (arguing that the ACA will reduce healthcare costs); *The Right Care at the Right Time: Leveraging Innovation to Improve Health Care Quality for All Americans: Hearing Before the S. Comm. on Fin.*, 110th Cong. 57–69 (2008) (statement of Peter R. Orszag, Director, Congressional Budget Office) (same).

4. *See* 42 U.S.C. § 18091(2)(E) (2010) ("The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.").

5. For a comprehensive overview of the ACA, see HENRY J. KAISER FAMILY FOUND., SUMMARY OF NEW HEALTH REFORM LAW [hereinafter SUMMARY OF NEW HEALTH REFORM LAW], *available at* http://www.kff.org/healthreform/upload/8061.pdf (last modified Apr. 15, 2011), as well as Part II.A.1 of this Article.

this line drawing seemed to reflect assumptions about who was "deserving" of help, based in part on assumptions about the ability of the working poor to pay for insurance. After decades of criticism that Medicaid's categories did not accurately reflect the reality of access to employment-based or individual coverage in the private market, the ACA expanded Medicaid eligibility to cover all adults who fall below a certain income level.[6] States' responses were mixed: some eagerly anticipated the federal money they would get to expand care, and others decried the federal expansion as coercive of and financially untenable for the states.[7] As important as this expansion was seen for future beneficiaries and states, however, it did not receive nearly as much attention as the private insurance reforms.

Congress enacted a number of reforms designed to ensure access to affordable insurance coverage in the private market. These included the guaranteed-issue requirement, prohibition on pre-existing condition exclusions, and rate regulation of insurance premiums.[8] The ACA also authorized creation of health benefit exchanges, virtual-health-care markets used to facilitate consumer enrollment in, and government oversight over, health plans.[9] In general, there seemed to be a great deal of public support for these consumer protections.[10] But a critical component of this reform—the individual mandate—has been much less popular. The individual mandate is the requirement that citizens either obtain insurance coverage or make an annual "shared responsibility payment" to the federal government.[11] Policymakers considered the mandate necessary to ensure that enough healthy people would join the insurance pool to help spread the risk and keep insurance rates down.[12]

6. *See* SUMMARY OF NEW HEALTH REFORM LAW, *supra* note 5.

7. *See infra* Part III.

8. SUMMARY OF NEW HEALTH REFORM LAW, *supra* note 5, at 5–6.

9. *Id.* at 4–6.

10. There is widespread support for other ACA protections that have already taken effect, such as the under-twenty-six age requirement and the medical-loss ratio established to ensure that plans spend at least a certain percentage of premiums on medical care. *Id.* at 6.

11. Nat'l Fed'n of Indep. Bus. v. Sebelius , 132 S. Ct. 2566, 2580 (2012).

12. It does this by preventing adverse selection by consumers—that is, the process of waiting until one is sick and needs insurance before entering the pool. *See id.* at 2585. Requiring insurance companies to cover everyone regardless of risk at comparable pricing without a

Minutes after the law was signed, the first legal challenge to health reform was filed by Florida through its state attorney general,[13] joined thereafter by twelve other states' attorneys general or governors,[14] two individual plaintiffs, and the National Federation of Independent Business.[15] Within two months, another dozen lawsuits were filed by other states, businesses, individuals, and private associations.[16] Although various aspects of the reform law were challenged, the overwhelming focus of the challenges was the individual mandate: it proved to be a lightning rod for political and legal challenges to the ACA as a whole.[17]

A key legal question that surfaced early in litigation was whether the mandate was unconstitutional because Congress had exceeded the scope of one of its enumerated powers under the Constitution.[18] The mandate was justified as an exercise of two powers: Congress's power to regulate interstate commerce and its power to tax and spend for the general welfare.[19] Very quickly, however, the focus of the constitutional question sharpened around the commerce power issue: every court hearing the issue rejected the taxing power justification, while a split emerged among the circuits on the commerce question, making Supreme Court review inevitable.[20] This focus was also evident in much of the legal scholarship, which viewed the mandate as reviving a longstanding debate about federalism and the proper balance of federal–state

mandate would expose insurers to potentially exorbitant costs, which would lead to a "death-spiral" of insurers fleeing the market, undermining access goals. *Id.* at 2626 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

13. Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1263 (N.D. Fla. 2011), *aff'd in part, rev'd in part sub nom.* Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom.* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

14. *Nat'l Fed'n of Indep. Bus*, 132 S. Ct. at 2580. Eventually the number of state plaintiffs rose to twenty-six. They included Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. *Id.*; Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1240 n.2 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom.* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

15. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2580.

16. *Id.*

17. Andrew Koppelman, *Bad News for Mail Robbers: The Obvious Constitutionality of Health Care Reform*, 121 YALE L.J. ONLINE 1, 1–2 (2011).

18. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2577.

19. *Id.* at 2584.

20. *See infra* Part II.B.2.

power in the Commerce Clause.[21] Reform opponents criticized the ACA as a federal takeover that undermined states' rights and the mandate as a compelling example of how federal power threatened individual liberties. "What's next?" they asked, "Can the government force us to eat broccoli, buy American-made cars, join a health club?"[22]

In contrast to the mandate, the states' challenge to the Medicaid expansion received less attention. They claimed that requiring participation in the expansion as a condition of existing Medicaid funding was a coercive use of the federal government's spending power, which violated the Tenth Amendment's prohibition on federal usurpation of state authority or commandeering of state legislative functions.[23] This claim likely did not receive as much attention because Medicaid is voluntary for states, courts have routinely upheld amendments expanding eligibility, and the challenge was not faring well in lower courts. Moreover, most scholars seemed to agree that the spending power was incredibly expansive and not a viable means through which to narrow federal power.[24] Consequently, many people were surprised when the Supreme Court also granted certiorari on this issue.

Even after the Supreme Court agreed to hear both challenges, commentary continued to focus the constitutional question and federalism debate on the mandate as an exercise of the commerce power.[25] Reform proponents and opponents wondered whether the Roberts Court would continue the trend of the Rehnquist Court in narrowing federal power to strike down the mandate in the name of

21. *See infra* Part III.

22. *See* Plaintiff's Motion for a Preliminary Injunction & Brief in Support at 17–18, Thomas More Law Center v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010) (No. 2:10-cv-11156) (claiming that upholding the mandate under the Commerce Clause would give the government "unfettered power" to require private citizens "to engage in affirmative acts, . . . such as joining health clubs, buying a GMC truck, or purchasing an AIG insurance policy"); *see also* James B. Stewart, *How Broccoli Landed on Supreme Court Menu*, N.Y. TIMES, June 13, 2012, at A1 (describing Justice Scalia's question in oral arguments to the government's counsel asking whether requiring Americans to buy health insurance could allow the government to force people to buy other things that are good for them, such as broccoli).

23. *Nat'l Fed'n of Indep. Bus.,* 132 S. Ct. at 2601 (quoting New York v. United States, 505 U.S. 144, 188 (1992).

24. *See infra* Part III.B.

25. *See infra* Part III.

federalism. The dominant narrative suggested a dichotomous choice: Would the conservative majority—Chief Justice Roberts with Justices Alito, Scalia, Thomas, and Kennedy—take this opportunity to further limit federal power, or could the liberal wing of the Court sway one of these Justices (most wrongly predicted Justice Kennedy) to uphold the mandate? The Court ultimately defied this simplistic narrative, and many expectations, by answering yes—to both.

By upholding the mandate and the ACA, the Court in *NFIB* preserved a powerful new version of cooperative federalism in healthcare—one that creates a federal platform for state experimentation, innovation, and regulation to facilitate meaningful choice in the private health insurance market. At the same time, Chief Justice Roberts penned parts of the opinion that seemed more consistent with federalism-based attacks on health reform and demands for more robust limits on the government's commerce and spending powers.[26] Of particular import was the Court's unprecedented finding that the Medicaid expansion was structured in a coercive way and so could not be made a required condition of Medicaid participation generally.[27] *NFIB* gives states the choice to opt in to the expansion or to refuse participation in it, creating uncertainty for the poorest residents in states that have opposed reform. More fundamentally, however, this holding raises questions about whether the Spending Clause will now be seen as a more viable site for federalism-based attacks, in general, and specifically if this will be used to limit the federal government's ability to adapt spending conditions to changing realities in longstanding healthcare programs like Medicaid and Medicare. The constitutional and health policy implications of *NFIB* will likely be explored for years to come, and this Article contributes to the beginning of this exploration.

This Article proceeds as follows: Part II provides an overview of the public and private expansions of the ACA, as well as the political and legal attacks mounted immediately after it was passed. Part III describes the legal and political commentary leading up to *NFIB*, highlighting the dominant narratives used to frame the challenges.

26. *See infra* Parts III & VI.

27. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2604, 2608.

Parts IV and V explore the Court's decision in *NFIB* in greater detail. Part IV explains the rationale of a divided Court in upholding the mandate. Chief Justice Roberts wrote the majority opinion, joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan, holding that the individual coverage requirement was constitutional under the taxing power. Justices Scalia, Kennedy, Thomas, and Alito (the "Joint Dissenters") issued a joint dissent concluding that the mandate could not be justified under the taxing power or the commerce power. Chief Justice Roberts, this time writing for himself, also concluded that the mandate would violate the Commerce Clause.

Part IV.A begins with the Commerce Clause holding because this is where *NFIB*'*s* constitutional analysis begins, and this issue received the most attention. This section highlights the importance of the activity-inactivity distinction central to Chief Justice Roberts's opinion and to the joint dissent. Although the Joint Dissenters did not join the Chief Justice's opinion on this issue, all five Justices made clear that the commerce power does not permit Congress to "compel the purchase of an unwanted product," in this case health insurance.

Part IV.B looks more closely at the taxing-power justification for the mandate, describing the Justices' struggle over the proper characterization of the shared responsibility payment as a "penalty" (which must be justified under the commerce power) or a "tax" (which can be easily satisfied under the broader taxing power). A majority of the Court concluded that the shared responsibility payment functions more like a tax on the choice not to buy insurance than a true penalty that forces people to buy insurance.

Part V describes the rationale of a divided Court in upholding a limited version of the Medicaid expansion based on its unprecedented finding of coercion. Part V.A analyzes the coercion holding. This time, seven Justices, in two separate opinions, found the expansion as structured coercive. Central to this coercion finding was the characterization of the expansion as a "new" and different program, rather than an example of the typical eligibility expansions upheld in the past. Chief Justice Roberts, joined by Justices Breyer and Kagan, and the Joint Dissenters, all expressed the concern that states could not have anticipated this dramatic transformation and that conditioning existing Medicaid funds on participation in this

new program created a threat that served no purpose other than to force unwilling states to participate. This threat, especially in light of the amount of funding at risk, was coercive.

Part V.B describes the Court's remedy for this violation, and this is where the decision broke down along the familiar 5-4 divide. Writing for a majority of the Court, Chief Justice Roberts, joined by Justices Breyer, Kagan, Ginsburg, and Sotomayor, held that the Court could simply sever the coercive penalty provision and held that Congress could not withdraw existing Medicaid funding from states that refuse to participate in the expansion. The Court preserved the expansion as an option for states and left the rest of the ACA intact.

Part VI explores the implications of *NFIB*. Part VI.A suggests that *NFIB* raises important questions about the commerce power and the power to tax and spend as future sites of federalism-based attempts to limit federal power. It also considers the importance of judicial restraint in how the Roberts Court defines its role in this struggle. Part VI.B considers the potentially beneficial and harmful implications for health reform implementation and the future of health policy. This Article concludes by briefly describing future challenges that may keep lawyers and commentators busy for some time to come, but that cannot stop the implementation of reform that is already underway.

II. OVERVIEW OF THE ACA AND KEY PROVISIONS SUBJECT TO CHALLENGE

The linchpin of the ACA's reform is its expansion of public and private insurance coverage. Despite rhetoric describing the ACA as a federal takeover, the ACA builds upon the existing private–public patchwork of insurance coverage.[28] The ACA assumes that people already eligible for Medicare and Medicaid, or fortunate enough to be covered through their employers, would keep that coverage.[29] The

28. *See, e.g.*, Alison Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 8 (2010) ("The individual mandate has been held up as the 'American' way to achieve universal coverage, where every citizen can choose her own insurance, and commercial insurers can compete for profit.").

29. *See* 42 U.S.C. § 18011 (2010) (preserving of the right to maintain existing coverage); *see also* CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 13, 16, 18 tbl.1 (2012) [hereinafter "CBO ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE ACA"], *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf (estimating the effects of the ACA's insurance coverage provisions

ACA's goal was to patch up some of the holes in this existing scheme by increasing insurance options for those excluded from the existing insurance market, either because coverage was unaffordable or because they were considered too high risk and denied coverage.[30] Nonetheless, the ACA has generated a wide range of political and legal responses, including challenges to this expansion.

A. Insurance Expansion in the ACA

1. Medicaid Expansion

The primary public reform is the expansion of Medicaid eligibility. Medicaid is a joint federal–state program established in 1965 to facilitate healthcare access for the very poor.[31] It is voluntary: states have the option to receive federal matching funds for healthcare services provided to Medicaid beneficiaries as long as the states comply with federal program conditions.[32] The federal

on health insurance coverage); Hoffman, *supra* note 28, at 8, 15 (noting that the ACA was designed "to address the problem of [the] estimated 46 million uninsured Americans" and that the ACA "envision[s] using government mandates to achieve universal coverage without fundamentally restructuring the existing payment and delivery systems"). A number of studies provide support for this assumption about employer-based coverage. *See, e.g.*, DELOITTE CTR. FOR HEALTH SOLUTIONS & DELOITTE CONSULTING, 2012 DELOITTE SURVEY OF U.S. EMPLOYERS: OPINIONS ABOUT THE U.S. HEALTH CARE SYSTEM AND PLANS FOR EMPLOYEE HEALTH BENEFITS 5 (2012), *available at* http://www.deloitte.com/view/en_US/us/Insights/centers/center-for-health-solutions/21c1f310fb8b8310VgnVCM3000001c56f00aRCRD.htm?id=us_furl_chs_employersurvey_072412 (finding that most employers do not intend to drop coverage, but that for those that do, prohibitive cost would be the likely cause); KEN JACOBS ET AL., RESEARCH BRIEF: NINE OUT OF TEN NON-ELDERLY CALIFORNIANS WILL BE INSURED WHEN THE AFFORDABLE CARE ACT IS FULLY IMPLEMENTED 3 (2012), *available at* http://www.healthpolicy.ucla.edu/pubs/files/calsim_Exchange1.pdf (using the California Simulation of Insurance Markets (CalSIM) model to predict changes in healthcare coverage in California under the ACA and finding a small decline in employer-based coverage).

30. *See At Risk: Pre-Existing Conditions Could Affect One in Two Americans*, HEALTHCARE.GOV (last visited Nov. 8, 2012, 2:02 AM), http://www.healthcare.gov/law/resources/reports/preexisting.html; *see also* Hoffman, *supra* note 28, at 8–9, 17–19, 60–63 (describing why the fragmented healthcare market leaves so many uninsured and critiquing whether the ACA can effectively address this problem); Brandon, *supra* note 3 (noting President Obama's urgency in seeking health reform that would cover those with pre-existing conditions or who were otherwise priced out of the insurance market).

31. *See* ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 57, 61–62 (1974).

32. *Id.* at 57; HENRY J. KAISER FAMILY FOUND., MEDICAID AND THE UNINSURED POLICY BRIEF: A HISTORICAL REVIEW OF HOW STATES HAVE RESPONDED TO THE AVAILABILITY OF

government establishes minimal requirements for participation with respect to reimbursement, services provided, and eligibility criteria, but these standards leave a great deal of discretion and flexibility to the states, which are primarily responsible for program administration.[33] For example, although Medicaid mandates coverage for certain categories of the very poor—children, pregnant women, the disabled, and the elderly—it gives states flexibility to cover "optional" categories.[34] Over the years, there have also been numerous amendments to expand eligibility criteria.[35]

In addition, states can seek a waiver to allow them to experiment in ways that may not fully comply with the law but still further the goal of providing healthcare to those in need in a cost-effective way.[36] The federal government has been quite generous in granting states waivers from federal requirements, allowing a great deal of state variation and freedom from federal constraint even beyond that apparently anticipated in the law. States have used waivers to do things like change delivery methods, alter benefits and cost sharing, modify provider reimbursement, and increase the number of people covered.[37]

FEDERAL FUNDS FOR HEALTH COVERAGE 2 (2012) [hereinafter HISTORICAL REVIEW OF MEDICAID], *available at* http://www.kff.org/medicaid/upload/8349.pdf.

33. STEVENS & STEVENS, *supra* note 31, at 57–61. For example, subject to often vague federal standards or guidance, states are the ones that actually set reimbursement rates for healthcare providers, oversee the utilization review process for services, and determine whether and how to extend coverage for groups or services that are deemed optional by the federal government. *See* Brietta R. Clark, *Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration is Undermining Its Own Health Reform Goals*, 55 HOW. L.J. 771, 793–804 (2012) (describing the state flexibility created by the Medicaid Act).

34. *See* STEVENS & STEVENS, *supra* note 31, at 61–65.

35. *See* Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 16–18 (2006); *see also* ANDY SCHNEIDER ET AL., THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE MEDICAID RESOURCE BOOK app. I 175–77 (2002), *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageid=14255 (outlining the "major changes enacted by Congress since the initiation of Medicaid in 1965").

36. *See* Clark, *supra* note 33, at 778–79.

37. *See* KAISER COMM'N ON KEY FACTS, HENRY J. KAISER FAMILY FOUND., FIVE KEY QUESTIONS AND ANSWERS ABOUT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS: EXECUTIVE SUMMARY 1 (June 2011), *available at* http://www.kff.org/medicaid/upload/8196.pdf ("Currently, 30 states and the District of Columbia operate one or more comprehensive Section 1115 Medicaid waivers that involved an estimated $54.6 billion in federal outlays in 2011. These waivers generally fall into several categories, including waivers to implement managed care, to expand coverage with limited benefits, to restructure federal financing, and to expand coverage to low income adults in preparation for the Medicaid expansion in 2014."); *see also* TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE

The reality of this state–federal relationship is important to understand for a few of reasons. First, every state participates in the Medicaid program now because of the generous federal matching funds and state flexibility.[38] Second, states have been important innovators in healthcare delivery and financing, experimenting with managed care, medical homes and hospital consolidations, and expanding clinics and outpatient care.[39] Most importantly, the fact that so many states look for ways to expand coverage beyond the mandatory categories highlights the problem of a dysfunctional system that continues to exclude so many people. Despite these state-driven reforms, many childless adults and the working poor remain excluded; thus, Medicaid expansion was a logical part of reform.[40]

PROGRAMS AND A RIGHTS-BASED RESPONSE 172 (2003) (stating that Arizona, Tennessee, and Oregon have adopted innovative approaches that have expanded coverage for the poor). Of course, this flexibility allows states to cut optional programs or groups later. *See* VERNON K. SMITH ET AL., HENRY J. KAISER FAMILY FOUND., MOVING AHEAD AMID FISCAL CHALLENGES: A LOOK AT MEDICAID SPENDING, COVERAGE AND POLICY TRENDS 7 (Oct. 2011) [hereinafter MOVING AHEAD AMID FISCAL CHALLENGES], *available at* http://www.kff.org/medicaid/upload/8248.pdf ("Eighteen states in both [fiscal years] 2011 and 2012 reported eliminating, reducing or restricting benefits. Elimination of, or limits on, dental, therapies, medical supplies and DME and personal care services were most frequently reported."); Abby Goodnough, *Medicaid Cuts Are Part of a Larger Battle in Maine*, N.Y. TIMES, Dec. 24, 2011, at A11 (detailing Maine Governor Paul R. LePage's proposed cuts in "optional benefits, including dental care and room and board at assisted living centers," as well as his plan to make nineteen- and twenty-year-olds and childless adults ineligible, which would reduce the Medicaid rolls by sixty-five thousand).

38. HISTORICAL REVIEW OF MEDICAID, *supra* note 32, at 1 ("Past experience shows that the availability of federal funds has served as an effective incentive for states to provide health coverage to meet the health and long-term care needs of their low-income residents despite state budget pressures.").

39. *See generally* LEIGHTON KU & CHRISTINE FERGUSON, GEORGE WASHINGTON UNIV. SCH. OF PUB. HEALTH & HEALTH SERVS., MEDICAID WORKS: A REVIEW OF HOW PUBLIC INSURANCE PROTECTS THE HEALTH AND FINANCES OF CHILDREN AND OTHER VULNERABLE POPULATIONS 13 (June 2011), *available at* http://www.firstfocus.net/sites/default/files/MedicaidWorks.pdf (providing background information on how states are acting as innovators in healthcare delivery and financing).

40. *See* Rosenbaum, *supra* note 35, at 7 ("From a structural viewpoint, Medicaid can be thought of as a logical response to the nation's market-oriented approach to health care financing and service delivery. Among industrial democracies, the United States stands alone in relying on voluntary markets to insure most of the population. Voluntary markets inevitably exclude persons who are unable to afford the going price or whose individual characteristics make them unattractive customers. With the cost of employer-sponsored family coverage hovering at $10,000 in 2004—among employers that elect to offer any coverage—private insurance is unaffordable to millions of people. Millions more find themselves either entirely or substantially barred from adequate coverage as a result of health problems that affect companies' willingness to offer coverage at any price. Medicaid, in short, stands as the nation's central means of compensating for the lack of a unified, population-based system of health care finance, the

The ACA has expanded eligibility to *all* adults with an income up to 133 percent of the federal poverty level, which is $15,415 per year for a single adult or $31,809 per year for a family of four.[41] It also created incredibly generous federal funding for these "newly eligibles": the federal government will fund 100 percent of most states' costs from 2014 until 2016 and then gradually decrease its share to 90 percent in 2020 and thereafter.[42] Thus, states' share of the cost is capped at 10 percent for services provided and only incidental administrative expenses.[43] When Congress passed the ACA, it expected that all states would want to continue participating in Medicaid and that the expansion would increase the insured by 15.9 million people by 2019.[44] This was due, in part, to the generous federal funding available, and, in part, to the fact that the ACA required states that wanted to continue participating in Medicaid to cover this additional group. Part V of this article explains how *NFIB* has made this expansion optional.

2. Private Insurance Reforms

The private insurance provisions in the ACA were primarily directed at reforming the healthcare market to ensure that individuals and small businesses would have a meaningful choice of affordable

consequence of which is the total or partial exclusion of tens of millions of persons who tend to be poorer and sicker than the norm."); *see also* KRISTOF STREMIKIS ET AL., THE COMMONWEALTH FUND, HEALTH CARE OPINION LEADERS' VIEWS ON VULNERABLE POPULATIONS IN THE U.S. HEALTH SYSTEM 1 (2011), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2011/Aug/1536_Stremikis_HCOL_vulnerable_populations_data_brief.pdf ("Ninety percent of [survey respondents] think the current health system is unsuccessful in achieving equity on the whole . . . and surveyed leaders agree that the [ACA] will be helpful in closing the health care divide.").

41. *See* 42 U.S.C. § 1396a(e)(14)(l) (effective Feb. 22, 2012); *see also* HENRY J. HENRY J. KAISER FAMILY FOUND., A GUIDE TO THE SUPREME COURT'S DECISION ON THE ACA'S MEDICAID EXPANSION 3 & n.10 (2012) [hereinafter "GUIDE TO THE SUPREME COURT'S DECISION"], *available at* http://www.kff.org/healthreform/upload/8347.pdf (providing a comprehensive overview of the Medicaid expansion).

42. GUIDE TO THE SUPREME COURT'S DECISION, *supra* 41, at 3.

43. *Id.*

44. JOHN HOLAHAN & IRENE HEADEN, KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID COVERAGE AND SPENDING IN HEALTH REFORM: NATIONAL AND STATE-BY-STATE RESULTS FOR ADULTS AT OR BELOW 133% FPL 2 (2010), *available at* http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf; *see also* CBO ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE ACA, *supra* note 29, at 1 (explaining that the CBO estimates assumed that every state would expand eligibility).

insurance options.[45] The existing market is segmented into many different groups, each with different protections and access to care. Certain populations can access care through public entitlement programs, as seniors can through Medicare or the groups mentioned above through Medicaid.[46] In the insurance market for employment-based insurance, employees also benefit from special legal protections for members of group plans. For example, employers get tax incentives to provide health insurance as a form of compensation, which means that employees are typically only responsible for paying a portion of the premium.[47] Insurers have also been prohibited from denying or pricing an employee's policy based on that employee's risk, which spreads the risk.[48] These protections, along with employers' bargaining power and the fact that employees tend to be healthy, have helped keep insurance affordable, especially for those employed in mid- to large-sized firms.

Others have been left to fend for themselves in a private market where profit-driven insurers are free to deny coverage or price policies based on individual risk. Prior to the ACA, people in the individual market did not get the same kind of rating protection or tax benefits that would help make coverage affordable,[49] contributing to the problem of a growing uninsured population. There was also the problem of underinsurance: some plans that were affordable had such high deductibles and offered such skimpy coverage that people discovered they could not afford the treatment they needed until it was too late.[50] The ACA is designed to eliminate market impediments to affordable and meaningful coverage and is based on

45. *See* Brandon, *supra* note 3.

46. *See generally* STEVENS & STEVENS, *supra* note 31, at 57 (providing a case-study analysis of the Medicaid program, its genesis, implementation, and the populations it covers).

47. *See* Hoffman, *supra* note 28, at 56–57.

48. *Id.* at 55–57.

49. *See, e.g.*, *id.* at 50–57.

50. *See* Jay Hancock, *The New Normal in Health Insurance: High Deductibles*, KAISER HEALTH NEWS (June 3, 2012), http://www.kaiserhealthnews.org/Stories/2012/June/04/high-deductible-health-insurance.aspx; *Hazardous Health Plans: Coverage Gaps Can Leave You in Big Trouble*, CONSUMERREPORTS.ORG, *available at* http://www.consumerreports.org/cro/2012/05/hazardous-health-plans/index.htm (last updated May 2009).

three pillars of reform: (1) consumer protections; (2) shared responsibility; and (3) the creation of a health benefit exchange.[51]

a. Consumer protections

There are a number of consumer protections designed to ensure consumers' access to affordable and meaningful insurance coverage. The guaranteed-issue requirement and prohibitions on pre-existing condition exclusions remove structural barriers to insurance.[52] Community rating requirements that spread risk more evenly among higher and lower risk individuals, and rate regulation designed to better align premiums with the amount of care and value of coverage provided, improve access by making insurance affordable.[53] Finally, to ensure meaningful coverage, the law includes a number of protections, including prohibitions on caps for certain services and annual limits, rules on cost-sharing limits for preventive and other kinds of services, and a minimal set of "essential benefits" that plans must cover.[54] The ACA also tries to improve coverage for groups that have historically fallen through the gaps of the insurance market (like young adults) and those disproportionately impacted by certain exclusions (like women and people living with HIV/AIDS).[55]

b. Shared responsibility and the individual mandate

The shared responsibility aspect of reform spells out how various actors will help pay for or contribute to this new system, including the government, employers, and individuals. The federal

51. *See* SUMMARY OF NEW HEALTH REFORM LAW, *supra* note 5, at 1.

52. *See* 42 U.S.C. § 300gg-1 to -5 (Supp. IV 2007–2011).

53. *See id.* § 300gg.

54. *Id.* § 300gg-6; *id.* § 300gg-11; *id.* § 18021

55. *See, e.g.*, *id.* 300gg-14 (extending dependent coverage for young adults up to age twenty six); *see also* INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 18 (2011) ("The ACA has the potential to transform the way in which the U.S. health care system addresses women's health issues in many ways. It expands access to coverage to millions of uninsured women, ends discriminatory practices such as gender rating in the insurance market, eliminates exclusions for preexisting conditions, and improves women's access to affordable, necessary care. The Women's Health Amendment . . . introduced by Senator Barbara Mikulski and which was added to the ACA, expands on these improvements by requiring that all private health plans cover—with no cost-sharing requirements—a newly identified set of preventive health care services for women."); JEFFREY S. CROWLEY & JEN KATES, THE AFFORDABLE CARE ACT, THE SUPREME COURT, AND HIV: WHAT ARE THE IMPLICATIONS? (2012), *available at* http://www.kff.org/hivaids/upload/8363.pdf (describing the different provisions in the ACA that will help increase access to HIV and AIDS treatment).

government helps by providing subsidies for people who may not be able to afford insurance on their own and tax credits for small businesses with no more than twenty-five employees.[56] Employers with fifty or more employees are expected to help by either providing the option for employment-based coverage or paying an assessment based on the number of employees seeking insurance through the exchange.[57] Individuals can meet their responsibility either by purchasing insurance from a qualified health plan (the "mandate") or by making a shared responsibility payment (also called a "penalty").[58] This mandate or penalty aspect of the reform has generated the most controversy.

The President, then-Senator Obama, campaigned in 2008 against the individual mandate but was convinced thereafter about its necessity.[59] Benefits and responsibility must go hand-in-hand: it is necessary to require citizens to obtain insurance coverage to ensure that healthy people are part of the insurance pool to help spread the risk. This guards against adverse selection by consumers, which is the process of waiting until one is sick or in need of insurance before entering the pool. Requiring insurance companies to cover everyone at generally comparable pricing, without a mandate, could lead to a "death spiral" of insurers fleeing the market, undermining access goals.[60] Indeed, this is exactly what happened in states that tried this without a mandate; Massachusetts has been successful because its reform included a mandate, which is why it served as the model for the ACA.[61]

56. *See* SUMMARY OF HEALTH REFORM LAW, *supra* note 5, at 2–3.

57. *See id.* at 1.

58. *See id.* at 1; *see also* 26 U.S.C. § 5000A (2011) (describing the requirement to maintain minimum essential coverage); 42 U.S.C. § 18091 (2005) (describing congressional findings as to the requirement to maintain minimum essential coverage).

59. *See* Andrew Cline, *How Obama Broke His Promise on Individual Mandates*, THE ATLANTIC (June 29, 2012, 12:36 PM), http://www.theatlantic.com/politics/archive/2012/06/how-obama-broke-his-promise-on-individual-mandates/259183/.

60. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2614 (2012).

61. *Id.*

c. Health benefit exchanges and the role of states

A health benefit exchange is the mechanism through which this new system of benefits and responsibility will be realized.[62] The ACA gives states two options: states can get federal funding to help them create their own exchanges, or, if they choose not to participate, the federal government will create a federal exchange for people in states without one.[63] Federal regulators will play an important role in helping to guide states about what the ACA requires, but both the ACA and the approach of federal regulators reflect the kind of flexibility and deference to state discretion that has been typical of the federal–state partnership in Medicaid.[64]

States that choose to participate will have the power to define a number of elements of reform, including the essential minimum benefits that must be provided by all qualified health plans, cost-sharing and tiered options offered by plans, systems for eligibility screening and enrollment, and consumer assistance plans.[65] The exchanges will ensure that required disclosures about plan content and rates are made and that information provided to consumers is clear and unbiased.[66] The ACA also requires that exchanges seek and use input from key stakeholders (including individual consumers, consumer advocates, the business community, healthcare providers, and health plans) in making these decisions, but states have a great deal of discretion about how to do this.[67] These are just a few

62. *See* SABRINA CORLETTE, JOANN VOLK & KEVIN LUCIA, THE CTR. ON HEALTH INS. REFORMS & NAT'L ACAD. OF SOC. INS., PLAN MANAGEMENT: ISSUES FOR STATE, PARTNERSHIP AND FEDERALLY FACILITATED HEALTH INSURANCE EXCHANGES 1–3 (2012), *available at* https://gushare.georgetown.edu/xythoswfs/webui/_xy-8409729_2-t_aPsiEpMD (describing the exchange as the "lynchpin" of the ACA's provisions to expand access to quality, affordable coverage).

63. *See id.* at 1; *see also* 42 U.S.C. § 18041 (2006) (describing state obligations in administering the exchanges).

64. *See generally* MICAH WEINBERG & LEIF WELLINGTON HAASE, THE COMMONWEALTH FUND, STATE-BASED COVERAGE SOLUTIONS: THE CALIFORNIA HEALTH BENEFIT EXCHANGE (2011), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1507_Weinberg_california_hlt_benefit_exchange_ib.pdf (documenting and analyzing the state-based coverage solutions chosen by California in adopting its exchange); CORLETTE, VOLK & LUCIA, *supra* note 62 (describing the flexible approaches that states have in establishing exchanges under the ACA).

65. *See* CORLETTE, VOLK & LUCIA, *supra* note 62.

66. *See id.* at 12–15.

67. 45 C.F.R. § 155.130 (2012)); *see also* THE CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP'T OF HEALTH & HUMAN SERVS., BLUEPRINT FOR APPROVAL OF

examples of the active role states can have in shaping health reform implementation. Moreover, just as in the Medicaid context, U.S. Department of Health and Human Services ("HHS") has indicated a willingness to consider waivers for states or insurers that need more time to adjust to new requirements.[68]

B. Responses and Legal Challenges to Reform

In light of the media attention to the political and legal challenges to healthcare reform, one could easily get the impression that the reforms are wildly unpopular. In fact, the ACA reforms have yielded a range of responses from states and the public generally. Some states have welcomed the reforms, eagerly anticipating Medicaid funding to help them expand coverage[69] and moving quickly to take advantage of the funding available for the creation of the exchanges.[70] Notably, there has been bipartisan support in these states.[71]

AFFORDABLE STATE-BASED AND STATE PARTNERSHIP INSURANCE EXCHANGES 21–25 (2012), *available at* http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf (outlining suggested requirements for exchanges in engaging stakeholders).

68. *See* Elizabeth Weeks Leonard, *The Rhetoric Hits the Road: State Challenges to the Affordable Care Act Implementation*, 46 U. RICH. L. REV. 781, 806–07 (2012) (noting the responsiveness of the HHS to state insurance commissioners and the significant state flexibility that HHS has given in the form of waivers for certain insurance regulations).

69. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., HOW IS THE AFFORDABLE CARE ACT LEADING TO CHANGES IN MEDICAID TODAY? 1 (May 2010), *available at* http://www.kff.org/medicaid/upload/8312.pdf.

70. The federal government has issued more than $1.6 billion in grants. *See Health Insurance Exchange Establishment Grants, 2012*, STATEHEALTHFACTS.ORG, http://statehealthfacts.kff.org/comparetable.jsp?ind=954&cat=17 (last visited Oct. 1, 2012); s*ee also State Actions to Address Health Insurance Exchanges*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/state-actions-to-implement-the-health-benefit-exch.aspx (last updated Oct. 2012) (providing an overview of how states plan to implement the exchange requirements of the ACA).

71. *See, e.g.*, WEINBERG & HAASE, *supra* note 64, at 3 (noting that in California there "was a great deal of accord among the principals and staff of the Democratic-controlled legislature and the Republican Schwarzenegger administration, and the legislative process moved very quickly"); *Colorado First State to Pass Exchange Legislation with Bipartisan Support*, STATE HEALTH ACCESS DATA ASSISTANCE CTR. (June 3, 2011), http://www.shadac.org/blog/colorado-first-state-pass-exchange-legislation-bipartisan-support; *see also* Abby Goodnough, *Liking It or Not, States Prepare for Health Law*, N.Y. TIMES, Sept. 24, 2012, at A1 ("Republicans who support state-run exchanges say they are embracing a fundamental conservative belief: that states should make their own decisions rather than cede control to the federal government.").

Other states are supportive of reforms but have taken a more cautious approach. Uncertainty about the fate of reform made some states wary of making any investments initially.[72] Some doubt their capacity to establish a health benefit exchange and maintain it once federal funding is no longer available.[73] Finally, financial concerns make some states reticent to expand Medicaid despite generous federal funding; what appears to be a relatively small share of the cost is still significant in light of the numbers of newly eligible and the serious budgetary challenges the states face.[74] Nonetheless, states that did not initially embrace reform are finding it difficult to resist the generous funding and are reconsidering their position.[75] There is also evidence of significant support among individuals and small businesses for consumer protections—like the guaranteed-issue requirement and prohibition on pre-existing condition exclusions—and federal subsidies and tax credits.[76] Predictably, the mandate has been more controversial.[77]

72. *See Timing Matters: States Waiting for a Supreme Court Decision to Plan an Exchange*, HENRY J. KAISER FAMILY FOUND. (May 25, 2012), http://www.kff.org/healthreform/quicktake_SCOTUS_exchanges.cfm.

73. HHS created another option for these states: a federal–state exchange option that gives states the flexibility to decide which aspects of reform implementation it would like to oversee and which it would like the federal government to undertake. *See* THE CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 67.

74. *See* Dan Diamond, *How Much Will States' Medicaid Expansions Really Cost?*, CALIFORNIA HEALTHLINE (July 18, 2012), http://www.californiahealthline.org/road-to-reform/2012/how-much-will-states-medicaid-expansions-really-cost.aspx; *see also* KAISER FAMILY FOUND., UPDATE: STATE BUDGETS IN RECESSION AND RECOVERY (2011), *available at* http://www.kff.org/medicaid/upload/8253.pdf (analyzing recent trends in state government finances).

75. *See* Goodnough, *supra* note 71 (noting that some Republican state leaders are having "underground" discussions about establishing exchanges); *see also* Tom Cohen, *Some States Not Changing Course Amid Rising Tide of Health Care Reform*, CNN (July 4, 2012, 7:54 PM), http://www.cnn.com/2012/07/04/politics/health-care-states/index.html (noting that even for states with conservative lawmakers ideologically opposed to reform, the financial incentives may create an offer too good to refuse).

76. *See* Patricia Zengerle, *Most Americans Oppose Health Law But Like Provisions*, REUTERS (June 24, 2012, 1:13 AM), http://www.reuters.com/article/2012/06/24/us-usa-campaign-healthcare-idUSBRE85N01M20120624; J.D. Harrison, *Mixed Emotions: Small Business Owners, Advocates Respond to Health-care Ruling*, WASH. POST (June 28, 2012), http://www.washingtonpost.com/business/on-small-business/mixed-emotions-small-business-owners-advocates-respond-to-health-care-ruling/2012/06/28/gJQAALaI9V_story.html; *see also* NPR, HENRY J. KAISER FAMILY FOUND. & HARVARD SCH. OF PUB. HEALTH, THE PUBLIC ON REQUIRING INDIVIDUALS TO HAVE HEALTH INSURANCE (Feb. 2008), *available at* http://www.kff.org/kaiserpolls/upload/7754.pdf (investigating public sentiments about healthcare reform).

77. *See* NPR, HENRY J. KAISER FAMILY FOUND. & HARVARD SCH. OF PUB. HEALTH, *supra* note 76. In a recent poll about health reform, the only individual element to garner substantially unfavorable views was the mandate/penalty provision. *Id.* But the poll also found that six in ten

States, individuals, organizations, and lawmakers opposed to reform have been extremely vocal, attacking reform on every front. At the federal level, Republican politicians have threatened repeal as well as other obstructionist political measures, such as defunding and the use of legislative hearings, to impede reform implementation.[78] Some Republican-led states announced their refusal to participate in the private or public insurance expansion, with the individual mandate serving as the focal point of these attacks.[79] Others have gone even further, passing nullification legislation to obstruct federal reform efforts.[80]

But the most pervasive and viable form of attack has been legal challenges filed by individuals, business associations, religious organizations, and states[81] in courts throughout the country. These

people support a broad approach to ensure everyone has coverage, which includes an individual mandate. *Id.* For some, support for the mandate seemed tied to expansion of public insurance and the availability of subsidies. For those opposing a mandate, the main reason for opposition was concern about people being forced to buy insurance if they cannot afford it. *Id.*

78. Elizabeth Weeks Leonard, *Rhetorical Federalism: The Role of State Resistance in Health Care Decision-Making*, 39 J.L. MED. & ETHICS 73, 73–74 (2011).

79. *See* Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms*, NAT'L COUNCIL OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-ppaca.aspx (last updated Oct. 19, 2012) (detailing in Table 1 the state laws challenging or opting out of the insurance reforms).

80. *See* Cauchi, *supra* note 79 (describing the various state measures enacted or proposed by members of at least forty-seven state legislatures to "limit, alter or oppose selected state or federal actions" relating to health reform, but also noting that "because the U.S. Supreme Court upheld the individual coverage mandate, which does not require a state role, the federal law fully applies and any contradictory state laws will have no current effect on [ACA] provisions"). Seven states have also recently enacted laws intended to create "Interstate Health Compacts." *Id.* "[T]hese take a first step toward allowing a group of states to join together to establish broad health care programs that operate outside of the [ACA] or other federal law. However, these compacts do not block [ACA] implementation, and are not yet binding; they will require congressional approval because they seek to substitute state control where federal law and regulations exist. These states (including Georgia, Indiana, Missouri, Oklahoma, South Carolina, Utah and Texas) aim to obtain, 'primary responsibility for regulating health care goods and services' within their boundaries." *Id.* Some states, including Missouri, Montana, New Hampshire, Utah, and Wyoming, have taken extreme measures, passing legislation barring any state official from assisting the federal government with reform efforts. *See id.*

81. Importantly, within these states, there was internal divide about reform, often along party lines. *See* Charles Monaco, *In the States, Voices of Determination on Implementing Obamacare*, PROGRESSIVE STATES NETWORK (July 9, 2012, 6:07 PM), http://www.progressivestates.org/news/blog/in-the-states-voices-determination-on-implementing-obamacare (describing efforts by the Working Group of State Legislators for Health Reform to support reform, including two amicus briefs filed by more than five hundred state lawmakers from all fifty states arguing that the mandate and Medicaid expansion are constitutional); *see also* Brief Amici Curiae of State

challenges overwhelmingly focused on the constitutionality of the individual mandate, but other aspects of the reform—including the Medicaid expansion, employer mandate, and state-exchange option—were also challenged.

1. Claims That Did Not Reach the Supreme Court: What *NFIB* Is Not About

A number of challenges were raised in the lower courts that never gained traction and were easily dismissed for failure to state a proper claim. For example, states challenged the employer mandate provision as applied to state employers: it would require large state employers to offer and automatically enroll state employees in federally approved insurance plans or else face substantial penalties and assessments.[82] States alleged that the employer mandate not only violated Congress's interstate commerce power, but also violated the Ninth and Tenth Amendments by infringing on state sovereignty. These claims were easily dismissed based on longstanding precedent allowing similar regulation of state employers.[83]

States also challenged the creation of the health benefit exchanges on similar state sovereignty grounds, despite the fact that the ACA does not require states to operate an exchange. They argued that they were being coerced into operating the exchange "under threat of [the federal government] removing or significantly curtailing their long-held regulatory authority" that federal regulation

Legislators from the Fifty States et al. Supporting Respondents (Medicaid), Florida v. Dep't of Health & Human Servs., 132 S. Ct. 604 (2011) (No. 11-400), 2012 WL 588461 (arguing in favor of upholding the ACA). For Iowa and Washington, this dispute resulted in these states appearing on both sides of the challenge to health reform. After Washington state's attorney general, Republican Rob McKenna, joined the multistate challenge in *Florida ex rel. Attorney General v. U.S. Department of Health & Human Services*, the state's Democratic governor, Cris Gregoire, criticized the move as not representing the best interests of Washington residents, and the Governor filed an amicus brief in support of the reform. Amicus Brief of the Governor of Washington Christine Gregoire in Support of Petitioners (Minimum Coverage Provision), Dep't of Health & Human Servs. v. Florida, 132 S. Ct. 604 (2011) (No. 11-398), 2012 WL 160228. In Iowa, the governor caused the state to join the challenge, but attorney general Tom Miller signed an amicus brief, also on behalf of Iowa, in support of health reform. Brief of the States of Maryland et al. as Amici Curiae in Support of Petitioners, Dep't of Health & Human Servs. v. Florida, 132 S. Ct. 604 (2011) (No. 11-398), 2012 WL 160230.

82. *See* Cauchi, *supra* note 79.

83. *See* Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011) (granting summary judgment); Thomas More Law Ctr. v. Obama, 651 F.3d 529 (6th Cir. 2011) (denying plaintiff's motion for a preliminary injunction), *abrogated by* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

of insurance markets would "'displace State authority over a substantial segment of intrastate insurance regulation . . . that the States have always possessed under the police powers provided in the Constitution.'"[84] These, too, were easily dismissed based on longstanding precedent recognizing the federal government's power to regulate in the area of health and safety under its commerce and spending powers. The Court viewed this state exchange option as precisely the kind of voluntary federal–state partnership used in other programs—like Medicaid—and permitted under the Constitution.[85]

Finally, with respect to the individual mandate, individual plaintiffs and religious organizations brought challenges claiming infringements on constitutionally protected rights, but these have not fared any better.[86] For example, in *Florida ex rel. McCollum v. U.S. Department of Health and Human Services*, the district court dismissed plaintiffs' challenge to the mandate on substantive due process grounds.[87] The court rejected the plaintiffs' broad characterization of fundamental rights as including the "freedom to eschew entering into a contract, to direct matters concerning dependent children, and to make decisions regarding the acquisition and use of medical services," all of which they claimed the mandate

84. *See, e.g.*, Florida *ex rel.* McCollum v. U.S. Dep't of Health & Human Servs., 716 F. Supp. 2d 1120, 1151–54 (N.D. Fla. 2010) (dismissing the challenge for failure to state a claim); Liberty Univ. v. Geithner, 753 F. Supp. 2d 611, 636–37 (W.D. Va. 2010) (rejecting a Tenth Amendment challenge to provisions in the ACA under which the federal government will either set up its own exchange to facilitate the regulation and sale of insurance or give states the option to set up its own under certain conditions because states are given a choice).

85. *See McCollum*, 716 F. Supp. 2d at 1155 (citations omitted) (analogizing to a case upholding similar federal legislation to create a nationwide program to protect the environment that created "'a program of cooperative federalism that allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory programs, structured to meet their own particular needs,'" and noting that a "wealth of precedent" makes clear that the federal government has this power); Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010) (dismissing district plaintiff's first and second claims for relief and denying plaintiffs' motion for preliminary injunction).

86. *See, e.g.*, *McCollum*, 716 F. Supp. 2d at 1120, 1161–62 (rejecting a substantive due process challenge and finding that the mandate does not implicate any of the fundamental rights that would merit closer scrutiny); *Liberty Univ.*, 753 F. Supp. 2d at 637–47 (rejecting challenges to the ACA based on the Religious Freedom Restoration Act and the Free Exercise, Establishment, Free Speech and Association, and Equal Protection clauses of the U.S. Constitution).

87. *McCollum*, 716 F. Supp. 2d at 1161–62.

would violate.[88] Rather, the court held that "[f]undamental rights are a narrow class of rights involving the right to marry, have children, direct the education of those children, marital privacy, contraception, bodily integrity, and abortion; and the Supreme Court is 'very reluctant to expand' that list."[89]

2. Questions Reaching the Supreme Court in *NFIB*

Plaintiffs had more success challenging the mandate as exceeding the Article I powers that Congress used to justify it. Congress's primary justification for the mandate was its power to regulate interstate commerce.[90] This argument seemed to generate the most debate among legal scholars and commentators in the media because it was considered a novel question that could go either way.[91] This view was reinforced by the split that surfaced between the circuit courts of appeals, making Supreme Court review inevitable.[92]

Alternatively, the federal government argued that the mandate could also be upheld as an exercise of Congress's taxing power.[93] This claim received less attention by commentators and was viewed as much weaker by courts; no lower court upheld the mandate on this basis because the shared responsibility payment used to enforce the mandate was labeled a penalty that must be justified under the commerce power, not a tax subject to the broader power to tax and spend for the general welfare.[94] Nonetheless, the issue ultimately ended up before the Supreme Court.

88. *Id.* at 1161 (quoting Plaintiffs' Memorandum in Opposition to Defendants' Motion to Dismiss at 43–44, *McCollum*, 716 F. Supp. 2d 1120 (No. 3:10-cv-91-RV/EMT)).

89. *Id.* at 1161–62 (quoting Doe v. Moore, 410 F.3d 1337, 1343 (11th Cir. 2005)).

90. *See* 42 U.S.C. § 18091 (2006).

91. *See, e.g.*, Mark Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825, 1827–29 (2011); Stewart, *supra* note 22; Kevin Sack, *Florida Suit Poses a Challenge to Health Care Law*, N.Y. TIMES, May 10, 2010, at A10.

92. *Compare* Thomas More Law Ctr. v. Obama, 651 F.3d 529, 549 (6th Cir. 2011) (upholding the mandate under the commerce power), *abrogated by* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012), *with* Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1312–13 (11th Cir. 2011) (holding that the individual mandate exceeded Congress's commerce power), *aff'd in part, rev'd in part sub nom.* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

93. Reply Brief for Petitioner (Minimum Coverage Provision) at 21–25, Dep't of Health & Human Servs. v. Florida, 132 S. Ct. 604 (2011) (No. 11-398), 2012 WL 748426, at *21–25.

94. *Florida ex rel. Att'y Gen.*, 648 F.3d at 1314 ("Beginning with the district court in this case, all have found, without exception, that the individual mandate operates as a regulatory

Finally, the Medicaid challenge also reached the Supreme Court, despite the fact that lower courts treated this challenge almost as dismissively as the nonsurviving claims described above. Only Judge Roger Vinson of the Northern District of Florida, and then the Eleventh Circuit on appeal, viewed this claim as plausible enough to survive a motion to dismiss, but both ultimately rejected it.[95] The lack of attention to this issue by legal scholars, mainstream media, and even jurists affirmed a growing consensus that this claim was not viable.[96] Consequently, it came as quite a surprise to many when the Court eventually granted certiorari on the issue.

These challenges reached the Supreme Court in the case of *NFIB*, and the Court granted certiorari on four questions. As just noted, two of the questions focused on the constitutionality of the individual mandate and the Medicaid expansion.[97] One of the other questions was a threshold procedural question that the Court had to answer before it could hear the substantive challenge to the mandate: whether the challenge was barred by the Anti-Injunction Act ("AIA").[98] As described further in Part IV.B, the AIA essentially prevents taxpayers from bringing suits to challenge a tax before they pay it. Like the constitutional question about whether the mandate could be justified as an exercise of the taxing power, this question turned on whether the proper characterization of the "shared responsibility payment" was as a tax or penalty. If the payment was properly viewed as a tax, then the AIA would bar plaintiffs from challenging it until 2015 (the earliest that a shared responsibility payment would be due). Although the federal government did not raise this claim at the appellate level, the Court took up the question.

The Court also granted certiorari on the issue of severability. Specifically, plaintiffs argued that if the individual mandate had been found unconstitutional, the entire law would have to fall because the mandate was an essential part of the reform and could not be severed

penalty, not a tax."). *But see infra* note 160 (citing articles that argued that the taxing power was either an equally viable or even stronger justification for upholding the mandate prior to *NFIB*).

95. *Id.* at 1240–41.

96. *See infra* Part III. *But see infra* note 162 (noting an exception to the dominant scholarly discourse, which viewed the spending power as escaping meaningful Tenth Amendment limits).

97. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2577 (2012).

98. *Id.* at 2582.

from the Act.[99] The severability question argued in the lower courts, as well as the specific question on which the Court granted certiorari, assumed that the issue would arise because of the mandate being found unconstitutional.[100] As described further in Parts IV and V, however, because the mandate was held constitutional, the Court ultimately had to consider the severability question in light of its Medicaid holding.

III. THE DOMINANT NARRATIVE IN THE HEALTH REFORM DEBATE

Two themes have pervaded the dominant narrative in the health reform debate. First, in the legal debates on the mandate, the most vocal opponents of reform have staked out their position as protectors of federalism, while casting those who defend federal power as nationalists who look to the federal government to solve every problem.[101] These federalism-based concerns derive from the structure of our government as one of dual sovereignty, in which the federal government's power is limited and arises from specific enumerated powers in Article I of the Constitution, and the states are granted plenary power to regulate. The Tenth Amendment, which provides that all rights not expressly granted to the federal government are otherwise retained by the states and the people, is viewed by some as an important check on federal power.[102] In this narrative, federalists not only are concerned with fidelity to the constitutional principles of limited government as necessary for protecting states' rights, but they also see states' rights as a proxy for individual liberty.[103] Federal power is viewed as an inherent threat to

99. Reply Brief for Private Petitioners on Severability at 18, *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 2566 (Nos. 11-393 & 11-400), 2012 WL 864595 at *18.

100. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 603 (2011) (granting certiorari limited to the issue of severability presented by Question 3 of the petition). Question 3 for Petition No. 11-400 focused on whether the mandate, if held unconstitutional, could be severed from the rest of the law. On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit, Florida v. U.S. Dept. of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011) (No. 11-398).

101. *See generally* Leonard, *supra* note 68 (discussing the rhetoric of federalism as states' response to the ACA); Mario Loyola, *Trojan Horse: Federal Manipulation of State Governments and the Supreme Court's Emerging Doctrine of Federalism*, 16 TEX. REV. L. & POL. 113 (2011) (discussing the tension between nationalism and federalism).

102. *See* U.S. CONST. amend. X.

103. *See, e.g.*, Stewart, *supra* note 22.

states and individual liberty, and opposition to reform protects these federalist principles.

Second, the narrative leading up to *NFIB* focused largely on the mandate as a valid exercise of the commerce power. Disconnected from the rest of reform, the mandate proved to be an easy target for attack. As a result, messages about how reform would actually serve federalism interests were diluted. Finally, the focus on the commerce power meant that the scope and limits of the federal government's power to tax and spend as tools for insurance expansion went underexplored prior to *NFIB*.

A. Safeguarding Federalism by Limiting Federal Power

1. The Political Narrative

Politically, opponents of reform have used the rhetoric of federalism to justify their attempts to undermine healthcare reform. They paint reform as a federal takeover of healthcare, using terms like "Obamacare" and inflammatory rhetoric about how the mandate will lead to the destruction of civilization as we know it.[104] Indeed some of this rhetoric even made its way into legal briefs and court decisions, making dire predictions of a parade of horribles that would result if the mandate were to be upheld:

> [T]he federal government will have the absolute and unfettered power to create complex regulatory schemes to fix every perceived problem imaginable and to do so by ordering private citizens to engage in affirmative acts, under penalty of law, such as taking vitamins, losing weight, joining health clubs, buying a GMC truck, or purchasing an AIG insurance policy, among others. The term "Nanny

104. *See* Leonard, *supra* note 68, at 820–21 (noting the partisan rhetoric that has accompanied state resistance to health reform); Stewart, *supra* note 22 (describing how a video title "Wheat, Weed and Obamacare: How the Commerce Clause Made Congress All-Powerful" was used to cast defenders of the government's power to enact the ACA as creating "an unlimited, amorphous government that can make us do whatever it wants," and how broccoli became the defining symbol of this power); *see also* REPUBLICAN STUDY COMMITTEE, HOUSE REPUBLICAN RESPONSES TO OBAMACARE 2 (2010), *available at* http://rsc.jordan.house.gov/uploadedfiles /rsc_solutions_in_response_to_obamacare_sept2010.pdf (describing a "Democrats' government takeover of health care" and passage of "Obamacare" as a "monstrosity of a law").

> State" does not even begin to describe what we will have wrought if in fact the Health Care Reform Act falls within any imaginable governmental authority. To be sure, George Orwell's *1984* will be just the primer for our new civics.[105]

These arguments reflect a recurring theme of federal power as a threat to individual liberty, which has been explained in varied ways as based on an individual's right to make his/her own decisions, to be free from compulsory participation in a socialized medical system, and to be free from infringements on religious liberty.[106] States' resistance to reform centered on the mandate despite the fact that the mandate did not directly implicate their interests. In this narrative, states' objections were premised on their role in protecting their residents' liberty.[107]

Another theme reflected in these arguments is the idea that reform essentially steps on the states' turf. States used this to explain their vehement opposition to the health benefit exchanges and the individual mandate—despite the fact that the exchanges are optional and that the federal government has a long history of creating health policy.[108] States portrayed themselves not only as fighting for their own sovereign power, but also as protectors of the people's ability to govern themselves.[109] This notion of a sphere of state regulation that should be off-limits to federal power was also the basis on which

105. *See* Plaintiff's Motion for a Preliminary Injunction & Brief in Support at 17–18, Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (2011) (No. 2:10-cv-11156).

106. *See, e.g.*, Richard M. Salsman, *A Finalized Path to Full, Socialized Medicine in America—Thanks to Conservatives*, FORBES MAGAZINE (June 28, 2012) http://www.forbes.com/sites/richardsalsman/2012/06/28/a-finalized-path-to-full-socialized-medicine-in-america-thanks-to-conservatives; Jedidiah Purdy & Neil Siegel, *The Liberty of Free Riders: The Minimum Coverage Provision, Mill's "Harm Principle," and American Social Morality*, 38 AM. J.L. AND MED. 374, 376–79 (2012); *see also supra* Part II.B.1 (detailing legal challenges to healthcare reform).

107. *See, e.g.*, Cauchi, *supra* note 79 (providing an overview of various state nullification laws). In Wyoming, a proposed constitutional amendment "states that residents have the right to make their own health care decisions, while 'any person may pay, and a health care provider may accept, direct payment for health care without imposition of penalties or fines for doing so.' [It] [a]lso provides that the state 'shall act to preserve these rights from undue governmental infringement.'" *Id.* (internal citations omitted) In Tennessee, a statute declares a "public policy that every person within the state 'shall be free to choose or to decline to choose any mode of securing health care services without penalty or threat of penalty;' [and] requires that no state or local public official, employee, or agent 'shall act to impose, collect, enforce, or effectuate any penalty in this state.'" *Id.* (internal citations omitted).

108. Brief of State Respondents as Amici Curiae Supporting Petitioners at 11–12, Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (No. 11-398).

109. *Id.*

hopeful Republican candidate Mitt Romney tried to distinguish the reform enacted in Massachusetts under his leadership from "Obamacare."[110]

The problem with this political narrative is that it does not reflect a realistic understanding of the legal scope of federal power or the federal–state balance critical to existing health policy. As noted in Part II.B, lower courts rejected individual rights-based claims, as well as state claims based on antiquated notions of a uniquely state sphere of regulatory power. Rather, the only viable challenge to reform on the private side was to the individual mandate and whether Congress exceeded the Article I powers it used to justify the mandate: the power to regulate interstate commerce and the power to tax and spend.[111] Since 1937, these powers have been successfully used by the federal government to vastly expand its regulatory reach into almost every area affecting one's daily life, including labor, education, the environment, public safety, and, of course, healthcare financing and delivery.[112]

This expansion does not mean that there are no limits on federal power. But the absolutist rhetoric in the political narrative has not accurately reflected these limits. Federalism-based concerns also played a prominent role among legal scholars weighing in on the health reform debate, but their arguments reflected a more nuanced discussion of the proper balance of federal–state power.

2. The Legal Narrative

Framing federalism as a "choice between federal and state action [as] simply binary"—with states and the federal government having "exclusive" powers—has long been rejected, even by scholars professing federalist concerns.[113] Yet, these scholars insist that our federalism structure creates a "preference" for decentralized

110. Robert I. Field, *Obamacare v. Romneycare: Is There a Difference?*, PHILLY.COM (Sept. 26, 2012), http://www.philly.com/philly/blogs/fieldclinic/Obamacare-vs-Romneycare-Is-there-a-difference.html.

111. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2584–91.

112. *See* Robert J. Pushaw, Jr., *The Medical Marijuana Case: A Commerce Clause Counter-Revolution?*, 9 LEWIS & CLARK L. REV. 879, 888–94 (2005).

113. *See* 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, 207 (2011).

decision making and a "presumption" against federal regulation.[114] A number of theories have been offered to justify this presumption. One of the most common is that limits on federal power foster local experimentation and thus innovation.[115] Another is that state sovereignty ensures that decisions impacting people's lives will be made at the state level, ensuring better local participation and clear political accountability.[116] This, in turn, is viewed as enabling people to protect themselves and thus their liberty. For example, Baker and Berman assert:

> A state's freedom from federal interference, like an individual's freedom from governmental restrictions on expression or private choices, is a freedom to make choices, not just a freedom to choose wisely. That is, federalism, including judicially enforced limits on Congress's spending power, seeks to create a space within which a subnational political community can make choices about how to govern itself without interference from the national government. This is out of respect not for the autonomy or dignity of states *qua* states, but for the capacity of communities at a subnational level to exercise political self-governance.[117]

This link between state sovereignty and individual liberty reflects a liberty-based view of federalism that has animated arguments against the mandate as a violation of our system of limited government, which is legally distinct from objections grounded in individual rights-based claims.[118]

114. *Id.* at 202 ("This federalist structure supports a general, albeit rebuttable, presumption that any given policy question should be addressed by state governments.").

115. *See, e.g.*, Jack Balkin, *Commerce*, 109 MICH. L. REV. 1, 40 (2010).

116. *See, e.g.*, Randy E. Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional*, 5 N.Y.U. J.L. & LIBERTY, 581, 632–33 (2010) (explaining why allowing the federal government to use the taxing power to impose the mandate despite not calling it a tax initially proves that "the individual insurance mandate was designed to obviate political accountability" that would normally curb government excess).

117. Lynn A. Baker & Mitchell N. Berman, *Getting off the Dole: Why the Court Should Abandon Its Spending Doctrine, and How a Too-Clever Congress Could Provoke It to Do So*, 78 IND. L.J. 459, 479–80 (2003).

118. *See, e.g.*, *id.*; Barnett, *supra* note 116, at 626–27, 632–33. Barnett goes even further to propose an "anti-commandeering principle" of federalism that applies to individuals, as well as states:

> As we have seen, the anti-commandeering cases that limit the commerce power of Congress were ultimately grounded by the Supreme Court in the text of the Tenth Amendment. Yet the letter of . . . [it] is not limited to states. . . . As Justice Thomas has written, the Tenth Amendment "avoids taking any position on the division of power

Even scholars who articulate federalism-based concerns about health reform acknowledge the potential benefits of federal action that can be consistent with our system of dual sovereignty.[119] There are two prominent theories proposed to explain when federal action is desirable according to, and consistent with, federalist principles—cooperative federalism and collective-action federalism. Cooperative federalism reflects the idea that the federal and state governments often view their powers as complementary, working together to solve problems that may implicate local and national interests.[120] This often occurs through the federal government's spending power: it offers states funding to encourage states to work with the federal government, according to some set of standards or expectations established through conditions attached to the funding.[121] Indeed the federal government's longstanding partnership with states in Medicaid is seen as a prototypical example of this.[122] The ACA's approach to the health benefit exchanges is another example: federal funding is offered to states that want to create their own state exchanges, and federal subsidies are used to encourage and empower

> between the state governments and the people of the States" . . . . In this way, . . . [it] recognizes *popular* as well as state sovereignty.

Id. at 626–27 (emphasis in original). *See also* Abigail R. Moncrieff, *Cost-Benefit Federalism: Reconciling Collective Action Federalism and Libertarian Federalism in the Obamacare Litigation and Beyond*, 38 AM. J.L. & MED. 288, 289 (2012) (describing federalism-based objections to reform as reflecting a view that "federalism exists for reasons other than efficiency of regulation and particularly that the Founders created the federal structure for the protection of individual liberty," and referring to this view as "libertarian federalism").

119. *See, e.g.*, Adler, *supra* note 113, at 207–12; Robert J. Pushaw, Jr. & Grant S. Nelson, *A Critique of the Narrow Interpretation of the Commerce Clause*, 96 NW. U. L. REV. 695, 718 (2002) (agreeing that a contemporary originalist approach is consistent with most, but not all, modern legislation). Pushaw later argued that even under this broad interpretation the mandate is unconstitutional. *Loyola Hosts Debate on Health Care Mandate*, SUMMARY JUDGMENTS: LOYOLA LAW SCHOOL, LOS ANGELES FACULTY BLOG (Mar. 10, 2011), http://llsblog.lls.edu/faculty/2011/03/loyola-hosts-debate-on-healthcare-mandate.html. Defenders of reform acknowledge some limits, but understand these limits to allow a great deal of room for federal regulation consistent with our constitution. *See, e.g.*, Balkin, *supra* note 115, at 5 (applying a "contemporary originalist" approach to find a collective-action theory of federalism that explains the modern regulatory state and supports the constitutionality of the mandate). Others have argued that the Tenth Amendment should not be understood to limit the federal spending power. *See, e.g.*, Erwin Chemerinsky, *Protecting the Spending Power*, 4 CHAP. L. REV. 89, 89 (2001).

120. *See* Adler, *supra* note 113, at 207–12.

121. *See* Chemerinsky, *supra* note 119, at 93–96.

122. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2629 (2012) (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

individuals to buy health insurance. The ACA's structure is the hallmark of cooperative federalism: it combines the benefits of federal funding with state flexibility and oversight.[123]

Collective-action federalism views federal action as a legitimate method to solve problems that may seem local in nature, but which have broader implications and which states are either unwilling to solve or incapable of solving on their own.[124] Health reform has been justified under this theory. The funding and blueprint for exchanges create a platform that can enhance states' ability and willingness to solve the growing problem of the uninsured and rising healthcare costs.[125]

Some view the question of the mandate's constitutionality as reflecting a tension between theories of cooperative and collective-action federalism used to justify the mandate on the one hand, and the liberty-based view of federalism used to attack its constitutionality on the other.[126] However, some scholars criticize the way each of these theories is applied to the constitutional question in the first instance.

For example, scholars have argued that a liberty-based theory of federalism that views federal intervention as inherently threatening to liberty is an empty theory that does not reflect an appreciation for what people need to actually realize liberty. Brennan makes this point in his critique of Barnett's liberty-based argument against the mandate:

123. *See* Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20 KAN. J.L. & PUB. POL'Y 266 (2011) ("[T]he [ACA] entrusts large swaths of its implementation to the states.").

124. *See* Robert D. Cooter & Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 STAN. L. REV. 115, 115–16 (2010) (arguing that Article I § 8 generally should be understood to authorize Congress's additional powers to address collective-action problems and that this theory should inform the Court's understanding of the division of powers between the federal government in states, which has lead the authors to propose replacing the distinction between economic and noneconomic activity with the distinction between collective and individual choice by states).

125. *See* Moncrieff, *supra* note 118, 288–91; Neil S. Siegel, *Free Riding on Benevolence: Collective Action Federalism and the Minimum Coverage Provision*, 75 LAW & CONTEMP. PROBS. 29, 29–34 (2012); *see also Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2611 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) (noting that the mandate is necessary to deal with the collective-action problem of the national economic implications of the growing number of uninsured who are "free riders" in a system that guarantees emergency care and where states cannot resolve the problem on their own).

126. Moncrieff, *supra* note 118, at 289 (citations omitted) ("According to this view, there is inherent value to state power that ought to be preserved against national encroachments.").

> Barnett wants us—indeed, wants the Supreme Court—to begin from a presumption of liberty and, what he takes to be its correlate, a presumption against regulation. Leaving aside for the moment the unstated justifications for those presumptions, however, we should note that a presumption in favor of liberty does not itself entail an absence of regulation. For example, some individuals may not be "free" to be healthy unless they obtain medical care. These same individuals may not be able to obtain medical care unless they have health insurance. And they may on occasion not have health insurance unless regulations compel them to buy it. The category of "liberty" is not exhausted by negative liberty, or freedom from interference; it also includes positive liberty, or freedom to act or be in a certain way. The freedom to be healthy may be enhanced by regulation, and this apparently is what Congress thought when it passed [the ACA].[127]

Indeed, a number of scholars have argued generally for a more robust definition of liberty that not only contains negative rights but also acknowledges the importance of a positive right to basic needs, including the right to health, which gives meaning to this notion of liberty.[128] Moreover, those knowledgeable about health insurance markets have offered compelling arguments for why federal reform is necessary to remove market impediments that prevent individuals from accessing the healthcare so critical for realizing the promise of liberty.[129]

127. Patrick McKinley Brennan, *The Individual Mandate, Sovereignty, and the Ends of Good Government: A Reply to Professor Randy Barnett*, 159 U. PA. L. REV. 1623, 1641 (2011) (emphasis omitted) (footnote omitted).

128. For scholars arguing more specifically that the mandate is consistent with, and critical for, a more robust theory of liberty that includes the right to health, refer to NORM DANIELS, JUST HEALTH CARE 36–58 (1985); Larry Gostin, *Securing Health or Just Health Care*, 39 ST. LOUIS U. L.J. 7, 9 (1994); Hoffman, *supra* note 28, at 40–41; Ronald Dworkin, *A Bigger Victory Than We Knew*, N.Y. REV. OF BOOKS (Aug. 16, 2012), http://www.nybooks.com/articles/archives/2012/aug/16/bigger-victory-we-knew/?pagination=false.

129. Some argue that Congress is too restrained and will need to act more boldly and centralize more functions in order to better achieve goals of insurance market reform. Moncrieff & Lee, *supra* note 123, at 266 ("[T]he Act entrusts large swaths of its implementation to the states. This Article argues, from a purely functional perspective, that the federalist structure in the ACA is a mistake. Healthcare regulation in the modern age should be national project entrusted

On the other side of the debate, scholars objecting to greater federal regulation of healthcare raise concerns about how theories of cooperative and collective-action federalism work in practice. Cooperative federalism justifications for federal spending in healthcare have been dismissed based on assumptions that the federal government's use of its funding is inherently coercive and usurps state authority.[130] For example, Loyola challenges the characterization of Medicaid as the prototypical example of cooperative federalism, saying that the Medicaid expansion provisions "show how illusory state 'prerogative' really is in the conditional federal grants context."[131] Adler similarly criticizes the Medicaid expansion, describing the problem of political "lock-in" that makes it effectively impossible for states to opt out of Medicaid altogether.[132]

Some acknowledge the potential benefit of cooperative federal action to solve collective-action problems, but they define the benefits so narrowly, or make flawed assumptions about the countervailing costs of federal action, that the scope of federal power they would deem legitimate is severely limited. For example, in rejecting the collective-action justification for health reform, Adler acknowledges only limited efficiency gains from certain kinds of federal action, such as data collection or economies of scale that could enable firms to offer standardized products throughout the nation.[133] The health and financial benefits expected from health reform do not meet his criteria for the kind of benefits that would

solely to the central government."). The Moncrieff and Lee also note that "[p]art of the reason that lawmakers have chosen 'cooperative federalism'—or this disjointed mess—is that Congress is structured to be protective of states' interests." *Id.* at 268.

130. *See, e.g.*, Loyola, *supra* note 101, at 116–17 (describing the conditional federal grants in the ACA as an "example[] of 'cooperative federalism' [that is] incompatible with 'the structural framework of dual sovereignty,'" and stating that "[w]herever federal programs confront states with a choice between subordinating local preferences to federal ones, on the one hand, and giving up either revenue or regulatory autonomy on the other, there is coercion"). Yet states' opposition to establishing health benefit exchanges (and consequently getting federal funds to do so) undermines this notion of inherent coercion. *See, e.g.*, *State Exchange Profiles: Missouri*, HENRY J. KAISER FAMILY FOUND. HEALTH REFORM SOURCE, http://healthreform.kff.org/State-Exchange-Profiles/missouri (last visited Sept. 29, 2012) ("[I]n April 2012, the Missouri legislature rejected a $50 million federal grant to upgrade the state's Medicaid information technology system because lawmakers saw it as a possible framework for building an exchange.").

131. *See* Loyola, *supra* note 101, at 134.

132. *See* Adler, *supra* note 113, at 215.

133. *Id.* at 205–06, 218.

justify federal action.[134] Moreover, Adler seems to assume the inevitability of certain costs of intervention—namely, lack of state experimentation and political accountability—that he says would not outweigh any benefit.[135] These assumptions animate his criticism of reform generally, but his criticism of the Medicaid expansion is particularly revealing.

Adler characterizes the Medicaid expansion as "dramatically reshap[ing] federal-state relations" and characterizes these reforms as "increasing pressure on state governments to follow the federal government's lead."[136] As evidence of this conclusion, Adler relies on an article about the Tennessee Medicaid Managed Care program ("TennCare") to make a very specific, and uncontroversial, point—the phenomenon of political "lock-in."[137] Yet, this article's authors present a far more nuanced picture of the state's power than is reflected in Adler's critique and that undermines Adler's conclusion that federal action impedes state experimentalism and accountability.[138]

In the TennCare article, authors Blumstein and Sloan describe how Tennessee obtained a federal waiver for a Medicaid demonstration program in 1993 so that it could establish a Medicaid managed care plan.[139] Despite its concerns over Medicaid costs, Tennessee decided to experiment with managed care as a way to increase healthcare coverage of Medicaid beneficiaries and non-

134. *Id.* at 216.

135. *See id.* at 202, 207.

136. *Id.* at 199.

137. *Id.* at 215 (citing to James F. Blumstein & Frank A. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 VAND. L. REV. 125, 141–42 (2000)).

138. I am not claiming that Blumstein and Sloan would say there is no federalism problem with how the Medicaid expansion is being implemented. In fact, James Blumstein, Professor of Law at Vanderbilt University School of Law, filed an amicus brief recognizing the flexibility inherent in much of the traditional Medicaid program, but arguing that the expansion as structured under the ACA does not leave states with a meaningful choice about whether to participate in the expansion. Brief of James F. Blumstein as Amicus Curiae in Support of Petitioners (Medicaid Issue) at 20–29, Florida v. U.S. Dep't of Health & Human Servs., 132 S. Ct. 604 (2011) (No. 11-400), 2012 WL 195306, at *20–29. Blumstein does not suggest the expansion be struck down, however; he argued that treating the expansion as a "new program" to which states have the choice to opt in would avoid the coercion problem. *Id.* at *36. This is the compromise the Supreme Court ultimately struck in the case. *See* Part V.B.

139. Blumstein & Sloan, *supra* note 137, at 129–32.

Medicaid-eligible Tennesseans who were either uninsured or uninsurable.[140] The authors describe the results of TennCare's experiment:

> [Since implementation, it] has increased coverage beyond its Medicaid core by nearly a half-million people, and has achieved its access goals while spending less than the negotiated budget neutrality cap . . . . The 1997 Balanced Budget Act institutionalized TennCare's mandated managed care approach by authorizing states, without seeking a waiver, to require Medicaid beneficiaries to . . . receive medical care benefits through managed care entities.
>
> TennCare, therefore, represents a major state-initiated healthcare reform effort.[141]

Thus, Tennessee viewed federal funding as leverage for it to find a creative way to care for more citizens while reducing cost. Moreover, TennCare's experiment provided a model for reform that other states followed, leading to changes in federal law to make such reforms easier to accomplish.[142] The bottom line is that with federal help, states drove reform; they were not passive recipients of federal mandates imposed from on high.

Baker and Berman's critique of federal healthcare regulation reveals flaws similar to Adler's. In an article written prior to the ACA, Baker and Berman attack the cooperative federalism at work in the Medicaid program. They insist that "judicially enforced limitations on the spending power increase and preserve diversity among the states within the realm of what is constitutionally permitted, thereby ultimately increasing aggregate social welfare."[143]

140. *Id.* at 130.

141. *Id.* at 131.

142. *Id.*

143. Baker & Berman, *supra* note 117, at 470–71 (footnote omitted). To be fair, in the text where this assumption is developed, authors use some qualifying language:

> [S]tate-by-state variation will *almost always* satisfy more people than would the imposition of a uniform national policy, and will *almost always* therefore increase aggregate social welfare. . . . [S]tate-by-state diversity will *generally* allow government to accommodate the preferences of a greater proportion of the electorate, as long as those preferences are unequally distributed geographically. And . . . this is *likely* to mean that the imposition of national uniformity in the absence of consensus will reduce aggregate social welfare relative to the existence of state-by-state diversity.

Id. at 471 (emphasis added). However, in a footnote, the authors explain this qualification is necessary because of legitimate differences in how to measure welfare; they do not acknowledge

And they criticize "advocates of national power [as] often giv[ing] too little weight to the value of self-governance by state political communities."[144] Yet these criticisms ignore state flexibility in the law itself, as well as contrary evidence drawn from the implementation of Medicaid reforms in practice. In particular, they do not consider accounts by legal scholars, policy analysts, and social scientists describing in detail how Medicaid managed care reforms have provided an opportunity for increased public participation in shaping health policy at the local level.[145] This opportunity for local participation is due in part to federal laws requiring consultation of stakeholders, but it is also due to the fact that these reforms are state driven.

Thus, in challenging cooperative and collective-action based theories for federal action in healthcare, scholars make, at best, incomplete and, at worst, inaccurate assumptions about the effects of federal action on states and individuals. These assumptions are, in turn, used to support a presumption against regulation and to reinforce a narrative of reform as a theoretical threat to federalism, without regard to how reform might further federalism goals in practice. Finally, some legal scholars have undermined a more nuanced and thoughtful federalist critique of reform by adopting oversimplified and sensational descriptions of the Act as a "dramatic[] reshap[ing] [of] federal–state relations in health care policy" or as a "health care revolution" that "radically alter[s] the relationship between individuals and the government."[146] Consequently, federalism-based objections in both the political and legal arenas have tended to obscure the reality that the ACA, structurally and functionally, creates a platform that empowers state experimentation and gives individuals greater choice in the market—

how federal funding has already sparked state diversity and innovation in the Medicaid program, and how federal law can help ensure public participation and local accountability. *Id.* at n.64.

144. Baker & Berman, *supra* note 117, at 479.

145. *See, e.g.*, COLLEEN M. GROGAN & MICHAEL K. GUSMANO, HEALTHY VOICES, UNHEALTHY SCIENCE: ADVOCACY AND HEALTH POLICY FOR THE POOR (2007) (examining Connecticut's Medicaid advisory board process, and providing prescriptive advice for creating a participatory process in state level health policymaking that meaningfully addresses the health concerns for the poor and dispossessed).

146. *See* Adler, *supra* note 113, at 199–200.

a reality that undermines the federalism-based justifications for limiting federal power.[147]

B. Focus on the Mandate and the Commerce Clause Debate

The federalism narrative in the mainstream media and in much legal commentary sharpened around the Commerce Clause challenge to the individual mandate. This may seem odd because the most obvious "threat" to states' rights, or the legal question that most directly implicated federal-state boundaries, was the Medicaid challenge. States' interests were much less clear in the private insurance reform context, where the challenge centered on the *individual* mandate. Nonetheless, Medicaid and the power to tax and spend were largely absent from the public debate.

1. The Mandate and the Parade of Horribles: An Easy Target

One reason that the debate focused on the mandate was that it was an easy political target. It proved to be a compelling rhetorical example of government forcing its way into our personal decisions, which played into fears of big government. As already noted, President Obama had disclaimed it as a candidate and the mandate was controversial, even among reform supporters. For states, the individual mandate was thought to be a powerful weapon in attacks on reform.[148] Legally, the mandate was understood to be an unprecedented exercise of federal power,[149] and opponents viewed this as a compelling invitation for the Court to impose greater limits on federal power. This hope was understandable in light of the narrowing of federal power by the Rehnquist Court,[150] and predictions that such narrowing would continue under the Roberts Court.[151] Finally, by their own admission, lawmakers viewed the

147. *Id.* In fairness, this may be due in part to the newness of the exchanges and the fact that many details are still to be decided. However, even a cursory review of the number and character of the decisions that are already clearly delegated to the states challenges these assumptions.

148. *See* Leonard, *supra* note 78, at 73.

149. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2586 (2012).

150. *See* Baker & Berman, *supra* note 117, at 460; Chemerinsky, *supra* note 119, at 89.

151. *See, e.g.*, Adam Winkler, *Can They Kill Health Care in Court?*, DAILY BEAST (Mar. 22, 2010, 8:37 PM), http://www.thedailybeast.com/articles/2010/03/23/how-to-kill-health-care-in-court.html.

mandate as "essential" to the other reforms included in the ACA.[152] As a legal matter, this meant that striking down the mandate could jeopardize the entire Act.

Although the legal question headed to the Supreme Court was whether the mandate was unconstitutional because Congress exceeded the scope of its enumerated powers under the Constitution, the idea that the mandate infringed on liberty resonated more strongly among reform opponents. Liberty-based theories of federalism were used to try to persuade people that upholding the mandate would empower the federal government to try to control every aspect of our lives.[153] The focus on the mandate allowed those opposed to reform to create an overly simplistic narrative about a federal takeover of healthcare that threatened individual liberty and reinforced assumptions that states and others challenging the mandate were acting as protectors of this liberty. The mandate was floating out on its own in this narrative—disconnected from the rest of the private or public reforms that provided the necessary context for understanding how the ACA could actually further, not threaten, federalism principles.

2. The Medicaid Expansion: A More Formidable Federalist Foe

There were many reasons why Medicaid did not get as much attention as the mandate. First, unlike the mandate, Medicaid has been around a long time and the expansion did not appear to create a novel question of law that would generate exciting commentary and debate. Moreover, even though a significant number of people had benefited from or held favorable attitudes toward Medicaid, many were still unaware of some basic facts about it.[154] The concept of an

152. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2591–92.

153. *See, e.g.*, Barnett, *supra* note 116; Moncrieff, *supra* note 118; Stewart, *supra* note 22.

154. *See* HENRY J. HENRY J. KAISER FAMILY FOUND., KAISER HEALTH TRACKING POLL 3, 5 (2011) [hereinafter Kaiser Health Tracking Poll], *available at* http://www.kff.org/kaiserpolls/upload/8190-F.pdf (describing the results of a public poll on the importance of Medicaid where almost half of the participants said that Medicaid is "very" or "somewhat" important). Although this poll reflects significant support for Medicaid, it does not necessarily evidence widespread understanding of the federal–state partnership in Medicaid. For example, out of 1,203 adults polled, in the part of the Kaiser Health Tracking Poll that asked about block grants, participants

individual mandate is pretty simple; the massive legislative and regulatory intricacies that shaped the federal–state interaction in Medicaid made it much harder to understand, and thus attack. There also was not as clear a divide between the support and opposition to the expansion. As noted in Part II, despite the fact that twenty-six state officials signed on to the challenge, there was widespread support for the expansion among lawmakers in these and other states. Unfortunately, its supporters were not always as vocal.[155]

More significantly, however, challenges to the Medicaid program did not fit the simplistic narrative that reform threatened federalism principles. Courts had consistently affirmed the spending power as a tool of cooperative federalism, consistent with the spirit of dual sovereignty embodied in the Constitution, and Medicaid in particular has been the prototypical example. Moreover, state opposition to a Medicaid expansion that was extremely generously funded by the federal government, and that would have helped ensure healthcare access for the very poor who have been excluded from public and private insurance, did not present a compelling or sympathetic picture of states. It actually undermined the picture of states as protectors of individual liberty, or at least highlighted an empty notion of liberty adopted by many reform challengers.

Finally, states' concerns regarding Medicaid were far more nuanced than the objection to the expansion. In fact, their more immediate concerns related to the effect of the individual mandate on existing Medicaid eligibles.[156] Despite anti-welfare-program rhetoric that has painted people as expecting government to take care of all of their needs, the reality is that a number of eligible people have not enrolled in Medicaid for a variety of reasons—stigma, bureaucracy,

were first given descriptions of the current Medicaid system as well as what the proposed changes would mean. *Id.* at 1–2.

155. *See, e.g.*, John E. McDonough, *Medicaid's Moment (Guest Opinion)*, KAISER HEALTH NEWS (July 13, 2011), http://www.kaiserhealthnews.org/columns/2011/july/071311mcdonough.aspx?referrer=search ("[W]hile Democrats are effusive in their praise of Medicare, their silence in response to public attacks on Medicaid has been deafening—during the fight over health reform legislation and since."). Former President Clinton finally mentioned it in his speech at the Democratic National Convention, but even then he focused more on how it benefits the middle class and poor children with autism. Bill Clinton, Former U.S. President, Remarks at the Democratic National Convention (Sept. 5, 2012), (transcript available at http://abcnews.go.com/Politics/OTUS/transcript-bill-clintons-democratic-conventionspeech/story?id=17164662).

156. *See, e.g.*, Brietta Clark, *State Reactions to Medicaid Reforms*, HEALTH CARE JUSTICE BLOG (Mar. 30, 2010), http://www.healthcarejusticeblog.org/2010/03/state_reactions.html.

lack of information, or a fear of other consequences.[157] If the mandate leads to increased enrollment of existing eligibles, this will cost states much more than the newly eligibles because existing eligibles are subject to the traditional federal matching formula under the original program.[158] To the extent state opposition was driven by the desire to avoid the costs of covering people to whom states already had a legal duty, this would have undermined the picture of states as protecting individuals' liberty interests.

3. Regulating Commerce Versus the Power to Tax and Spend

As already noted above, the government's own framing of the constitutional basis for the mandate, as well as the apparent consensus developing among lower courts, sharpened the focus of federalism-based objections to reform on the scope of federal power

157. *See, e.g.*, Brietta R. Clark, *The Immigrant Health Care Narrative and What It Tells Us About the U.S. Health Care System*, 17 ANNALS HEALTH L. 229, 254–56 (2008) (noting that immigrants who are eligible for Medicaid may be afraid to seek public health benefits for a number of reasons, including the fear of jeopardizing their immigration status or exposing undocumented family members to government officials who could have them deported); Brietta R. Clark, *Using Law to Fight a Silent Epidemic: The Role of Health Literacy in Health Care Access, Quality, & Cost*, 20 ANNALS HEALTH L. 253, 258–67, 282–83 (2011) (describing the problem of poor health literacy, which impacts approximately ninety million people in the U.S, and explaining how it impedes people's ability to process the kind of information used on insurance enrollment forms and required to navigate the healthcare system). In their 2010 study, John Holahan and Irene Headen note that changes in coverage under the ACA will vary depending on how aggressive the federal government and states are in their outreach and enrollment campaigns to the public. The study presents an "enhanced scenario," which reflects the kind of aggressive outreach that will be needed to promote more robust participation in Medicaid and to further reduce the number of uninsured in this low-income population, as compared to the standard scenario. The study predicts that "a new culture of coverage along with outreach efforts are likely to yield more participation . . . [by] *both those* made newly eligible for coverage under health reform *and eligible for coverage prior to changes in reform*." HOLAHAN & HEADEN, *supra* note 44, at 5.

158. HOLAHAN & HEADEN, *supra* note 44, at 6 ("Under these higher participation assumptions, new spending for Medicaid would continue to be mostly federal . . . [but] [t]he share of spending borne by the federal government will be somewhat lower under the higher participation assumptions, primarily due to higher take-up among those who are eligible under pre-PPACA rules. Since the states will receive lower federal matching rates for those previously eligible, states will be responsible for a higher share of their costs."); *see also Medi-Cal Could Grow to 10.5M Enrollees by 2019, Report Finds*, CALIFORNIAHEALTHLINE (Oct. 27, 2010), http://www.californiahealthline.org/articles/2010/10/27/medical-could-grow-to-105m-enrollees-by-2019-report-finds.aspx (noting that reform could lead to more than 500,000 currently eligible residents to enroll in California's Medicaid program).

under the Commerce Clause. This made sense given the fact that the commerce power had been a frequent site for federalism-based struggles over the proper balance of federal-state power,[159] and that with few exceptions, scholars focused on the mandate as reviving this debate over the commerce power.[160]

Legal questions involving the taxing and spending powers were largely neglected because they were much less controversial. A consensus seemed to be developing that the mandate could not be justified under the taxing power, but that the Medicaid expansion could be easily justified by the spending power.[161] The test

159. *See* Pushaw, Jr., *supra* note 112, at 888–94 (providing a brief overview of the evolution of the Commerce Clause doctrine) ("Congress did not begin to invoke the Commerce Clause to enact large-scale legislation until the late nineteenth century. The Court, seeking to protect regulatory power over 'local' matters, adopted an unduly restrictive definition of 'commerce'—buying, selling, and shipping goods—and hence struck down many federal laws dealing with activities such as manufacturing and labor. The Court initially applied this jurisprudence to invalidate New Deal legislation, which systematically addressed matters formerly left to the states, such as agriculture, employment, manufacturing, and banking. This judicial resistance ended in 1937, when the Court upheld the National Labor Relations Act . . . in *NLRB v. Jones & Laughlin Steel Corp*."). Over the next several decades, a narrow majority of the Court embraced a more expansive view of the Commerce Clause power, which has been used to uphold a vast expansion of federal power through laws such as the Fair Labor Standards Act applied to a small lumber company whose employees engaged in local manufacturing, the Civil Rights Act of 1964, which banned racial discrimination in public accommodations, and criminal bans on loan sharking. *Id.*; *see also* Balkin, *supra* note 115 (using a lens of "contemporary originalism" to explore how the evolution of Commerce Clause jurisprudence has dovetailed with the rise of the modern regulatory state); Randy E. Barnett, *The Original Meaning of the Commerce Clause*, 68 U. CHI. L. REV. 101 (2001) (exploring historical documents to establish that the original meaning of the Commerce Clause was narrow); Pushaw & Nelson, *supra* note 119 (arguing that the language of the Commerce Clause plausibly lends itself to a broader reading and that this reading is preferable to a narrow one).

160. *See* Balkin, *supra* note 115, at 44. A search of law review articles revealed that many more people had written about the Commerce Clause issue than other issues prior to *NFIB*; *see also* Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825, 1827–28 (2011) (noting the sharpening focus on the Commerce Clause in part due to trends among lower courts). Even among scholars who addressed the commerce and taxing powers, far more emphasis was placed on the commerce power. However, some scholars did focus on the taxing argument as a strong justification for the mandate. *See, e.g.*, Akhil Amar, *The Lawfulness of Health-Care Reform*, YALE L.J. ONLINE (forthcoming), *available at* http://ssrn.com/abstract=1856506 (last visited Nov. 8, 2012); Robert D. Cooter & Neil S. Siegel, *Not the Power to Destroy: An Effects Theory of the Tax Power*, 98 VA. L. REV. 1195 (2012), *available at* http://www.virginialawreview.org/articles.php?article=403; Brian D. Galle, *Conditional Taxation and the Constitutionality of Health Reform*, 120 YALE L.J. ONLINE 27 (2010), *available at* http://yalelawjournal.org/images/pdfs/889.pdf.

161. *See, e.g.*, Nicole Huberfeld, *Post-Reform Medicaid Before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS HEALTH L. 513, 527–33 (2012); Mark Hall, *Individual Versus State Constitutional Rights Under Reform*, 42 ARIZ. ST. L.J. 1233, 1237–41 (2010/2011); Leonard, *supra* note 68, at 787–88, 793; Steven D. Schwinn, *The Framers'*

governing Congress's ability to act pursuant to its spending power was viewed as extremely easy to satisfy, making this a less viable site for enforcing robust limits on federal power. There seemed to be a consensus that the spending power was "untouchable" and a "loophole" that allowed the federal government to circumvent more robust Tenth Amendment limits on other federal powers.[162] Although the taxing power is also quite broad, very few people thought that the shared responsibility payment used to enforce the mandate could plausibly be viewed as a tax subject to this broad federal power.

This seemed to lull most people into an expectation that the mandate, and not Medicaid, would be the ACA's Achilles' heel and that the commerce power, not the taxing and spending power, would determine the law's fate. This also meant that legal debates about the power to tax and spend, as well as policy discussions about the consequences of the ultimate holding, were not nearly as well fleshed out as they could have been. Indeed, many people were caught by surprise when the Roberts Court upheld the mandate as an exercise of the taxing power and upheld only a limited version of the expansion due to an unprecedented finding of coercion.

IV. UPHOLDING THE MANDATE WITH A TWIST: THE TAXING POWER SAVES THE DAY

Challenges to the ACA centered on whether the individual mandate and the Medicaid expansion exceeded Congress's Article I powers. Federalism concerns about limited federal government, state

Federalism and the Affordable Care Act, 44 CONN. L. REV. 1071, 1096–97 (2012). *But see* Loyola, *supra* note 101.

162. *See* Baker & Berman, *supra* note 117, at 460 ("[M]any commentators . . . have proposed that Congress should respond to the Rehnquist Court's states' rights decisions by using the spending power to circumvent those limitations on congressional power."); *see also* Mark Tushnet, *Alarmism Versus Moderation in Responding to the Rehnquist Court*, 78 IND. L.J. 47, 52 (2003) (describing the Court's observance of a loophole in which "Congress could induce state compliance" using its spending power). But, for a notable exception, see Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. REV. 441 (2008). Huberfeld describes *Arlington Central School District Board of Education v. Murphy*, a decision rendered by the first Roberts Court, arguing that it may become "a benchmark for Spending Clause jurisprudence." *Id.* at 441. She suggests that *Arlington* "refashioned the foundational clear statement rule to a 'clear notice' standard that requires more specific statutory language from Congress and that is particularly attuned to the state's viewpoint." *Id.* She predicts that "[t]his analytical shift may narrow Congress's ability to place conditions on federal spending." *Id.*

sovereignty, and individual liberty figured prominently in the Court's consideration of these questions. At the beginning of the opinion, Chief Justice Roberts framed the specific constitutional questions as arising out of a fundamental and perpetual question about the proper scope of federal power in our system of dual sovereignty, where the "National Government possesses only limited powers; the States and the people retain the remainder."[163] Roberts went on to explain the important interests served by limiting federal power:

> "State sovereignty is not just an end in itself: Rather, federalism secures to citizens the liberties that derive from the diffusion of sovereign power." . . . Because the police power is controlled by 50 different States instead of one national sovereign, the facets of governing that touch on citizens' daily lives are normally administered by smaller governments closer to the governed. The Framers thus ensured that powers which "in the ordinary course of affairs, concern the lives, liberties, and properties of the people" were held by governments more local and more accountable than a distant federal bureaucracy.[164]

The government defended the mandate on two grounds—its power to regulate interstate commerce and its taxing power. In defining the scope of these powers, Chief Justice Roberts further cautioned that they "must be read carefully to avoid creating a general federal authority akin to the police power."[165] In light of the overwhelming focus on the commerce power prior to *NFIB*, it makes sense that the Court began with this issue and that this argument received the greater amount of attention by the Justices.

A. Why the Mandate Exceeds the Commerce Power: The Activity–Inactivity Distinction

The Constitution authorizes Congress to "regulate Commerce with foreign Nations, and among the several States, and with the

163. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2577 (2012). The Court noted that although the "Federal Government has expanded dramatically over the past two centuries, . . . it still must show that a constitutional grant of power authorizes each of its actions." *Id.* at 2578. The Court contrasts this with the "general power of governing, possessed by the States but not by the Federal Government, as the 'police power.'" *Id.*

164. *Id.* (citations omitted).

165. *Id.* (citations omitted).

Indian Tribes."[166] The Court has interpreted this to allow Congress to regulate "'the channels of interstate commerce,' 'persons or things in interstate commerce,' and 'those activities that substantially affect interstate commerce.'"[167] This last prong has been understood to give Congress expansive power to reach activities that may be local or noneconomic in nature but that in the aggregate have a substantial effect on interstate commerce.[168]

One case that illustrates the breadth of this power is *Wickard v. Filburn*.[169] In *Wickard*, the Court upheld a federal law that limited the amount of wheat that a local farmer could grow solely for his own consumption and not for commerce.[170] The Court held that although growing wheat for consumption is a local activity, Congress could reach it based on the concern that the amount of wheat farmers grew for their own use would diminish demand and thus have a substantial effect on the commercial market for wheat.[171] In rejecting the appellee's claims that the regulation exceeded the scope of the commerce power because such effects were at most "indirect," the Court noted that such questions "are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect' and foreclose consideration of the actual effects of the activity in question upon interstate commerce."[172]

The federal government's power to regulate interstate commerce has also been understood broadly because the Constitution authorizes Congress to "make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers."[173] *Gonzales v. Raich* is an example of this power's breadth.[174] In *Raich*, the Court upheld federal legislation enacted to regulate the interstate market in

166. U.S. CONST. art. I, § 8, cl. 3.

167. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2578.

168. *Id.* at 2578–79.

169. Wickard v. Filburn, 317 U.S. 111 (1942). The Court has described *Wickard* as "perhaps the most far reaching example of Commerce Clause authority over intrastate activity." United States v. Lopez, 514 U.S. 549, 560 (1995).

170. *See Wickard*, 317 U.S. at 118–19.

171. *Id.* at 125.

172. *Id.* at 119–20.

173. U.S. CONST., art. I, § 8, cl.18.

174. Gonzales v. Raich, 545 U.S. 1, 17 (2005).

marijuana, but which also prohibited the local possession and cultivation of marijuana.[175] The plaintiffs brought suit seeking an exemption from the regulation on the basis that the federal government had no power to regulate marijuana that is locally grown and consumed.[176] The Court denied the exemption based on the government's argument that marijuana is a fungible commodity and thus could be easily diverted into the interstate market.[177] Because Congress's attempt to regulate the interstate market would be undercut without the ability to regulate intrastate possession and consumption, the law was upheld as a necessary and proper aspect of the larger regulatory scheme. Indeed, even Justice Scalia in *Raich* recognized the breadth of the necessary and proper clause, noting that it "empowers Congress to enact laws in effectuation of its [commerce] power[] that are not within its authority to enact in isolation."[178]

In *NFIB*, the federal government relied heavily on the expansive substantial effects test from *Wickard*,[179] as well as the vast discretion given to the federal government through the necessary and proper clause as understood in *Raich*, to justify the mandate.[180] Despite acknowledging the breadth of the commerce power, as illustrated by *Wickard* and *Raich*, however, a majority of the Court concluded that the Commerce Clause was not broad enough to permit Congress to require individuals to purchase insurance through the individual mandate.[181]

175. *Id.* at 32–33 (2005) (challenging application of the federal Controlled Substances Act to two California residents who suffered from a variety of medical conditions and grew and consumed medical marijuana pursuant to the terms of the California's Compassionate Use Act).

176. *See* Brief for Respondents at 12, *Raich*, 545 U.S. 1 (No. 03-1454).

177. *Raich*, 545 U.S. at 22.

178. *Id.* at 37, 39 (Scalia, J., concurring) (describing the "necessary and proper" power as broader than the "substantial effects" test and describing the relevant question as "simply whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power").

179. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2585–86 (citing United States v. Darby, 312 U.S. 100, 118–19 (1941), and Wickard v. Filburn, 317 U.S. 111, 127–28 (1942) for the substantial effects test).

180. *Id.* at 2593.

181. Chief Justice Roberts, writing only for himself, reached this conclusion in Part III-A of the opinion. *Id.* at 2585–93 (opinion of Roberts, C.J.). Justices Scalia, Kennedy, Thomas, and Alito did not join in any part of the Chief Justice's opinion, but they agreed the mandate exceeded the scope of Congress's Commerce Power, largely for the same as Chief Justice Roberts. *See id.* at 2644–50 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting). *See also*, Jonathan D. Varat, *Supreme Court Foreword, October Term 2011: Federalism Points and the Sometime Recognition*

1. The Substantial Effects Test

As part of the ACA, Congress included legislative findings of the substantial and harmful commercial effects of the growing numbers of uninsured and the uncompensated care problem.[182] Based on lower court decisions, challengers' briefs, and the Justices' opinions, there does not appear to have been any serious dispute about the substantial effect of uninsurance on interstate commerce.[183] Rather, five Justices of the Court found the mandate to be a violation of the commerce power because of a missing element: activity.[184] In separate opinions, Chief Justice Roberts and the Joint Dissenters (Justices Scalia, Kennedy, Thomas, and Alito) concluded that as broad as the federal government's commerce power may be it does not allow the government to compel someone to purchase an unwanted product. These Justices found evidence for their interpretation of the commerce power as having a threshold activity requirement in the constitutional text and precedent.

For example, Chief Justice Roberts noted that the text of the clause limits the government's power to *regulating* commerce, which "presupposes the existence of commercial activity to be regulated."[185] He contrasted language used in the Commerce Clause with the language of other enumerated powers that expressly gave Congress the power to create, like the power to coin money or raise

of Essential Federal Power, 46 LOY. L.A. L. REV. 411, 417 (2013) ("Probably out of pique that Chief Justice Roberts was not willing to go nearly as far as they would, the joint dissenters conspicuously did not join any aspect of his lead opinion and officially withheld any concurrence in his opinion at all, even though the dissent, in at least some respects, essentially mirrored some of the Chief Justice's conclusions and reasoning.").

182. *See* 42 U.S.C. § 18091(2).

183. *See, e.g. id.* at 2585–93 (opinion of Roberts, C.J.) (holding that the mandate exceeds the commerce power due to lack of "activity" but not disputing the assertion that the failure to obtain insurance has a substantial effect on interstate commerce); *id.* at 2609–18 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) (providing a more detailed summary of the evidence of the substantial effect on interstate commerce that justifies upholding the mandate under the commerce power).

184. *Id.* at 2586, 2593 (opinion of Roberts, C.J.); *id.* at 2647–50 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

185. *Id.* at 2586 (opinion of Roberts, C.J.); *accord id.* at 2647–50 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

and support armies.[186] Moreover, the Chief Justice and the Joint Dissenters noted that although no prior case explicitly required activity, precedent has made clear that existing activity was presumed.[187] Finally, all five Justices were particularly concerned that to hold otherwise would undermine the principle of a limited federal government inherent in our dual sovereign system:

> The Government's theory would erode those limits, permitting Congress to reach beyond the natural extent of its authority, "everywhere extending the sphere of its activity and drawing all power into its impetuous vortex" . . . [and] would give Congress the same license to regulate what we do not do, fundamentally changing the relation between the citizen and the Federal Government.[188]

Writing in dissent, Justice Ginsburg, joined by Justices Breyer, Kagan, and Sotomayor, criticized this reasoning on several grounds. Justice Ginsburg argued that neither precedent nor the text or history of the Constitution requires the Commerce Clause to be interpreted as having an activity requirement.[189] Even if there were such a requirement, she disagreed with the characterization of the failure to purchase insurance as inactivity. Rather, she agreed with the government that the inevitability of needing healthcare, coupled with laws entitling people to certain kinds of healthcare without regard to their ability to pay, means that no one can opt out of the health market.[190] Indeed, Justice Ginsburg cited numerous statistics showing that need for healthcare may be unpredictable but not unavoidable.[191] These unique attributes of the healthcare system and

186. *Id.* at 2586 (opinion of Roberts, C.J.) ("The language of the Constitution reflects the natural understanding that the power to regulate assumes there is already something to be regulated.").

187. *Id.* at 2587 ("As expansive as our cases construing the scope of the commerce power have been, they all have one thing in common: They uniformly describe the power as reaching 'activity.' It is nearly impossible to avoid the word when quoting them."); *id.* at 2647-48 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

188. *Id.* at 2589 (quoting THE FEDERALIST NO. 48, at 309 (James Madison) (Clinton Rossiter ed., 1961) (opinion of Roberts, C.J.); *accord id.* at 2648 ("[I]f every person comes within the Commerce Clause power of Congress to regulate by the simple reason that he will one day engage in commerce, the idea of a limited Government power is at an end").

189. *Id.* at 2621 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

190. *Id.* at 2618–20.

191. *Id.* at 2610–11, 2618.

the significant cost of healthcare also mean that healthcare delivery and financing decisions are necessarily linked.[192]

Thus, Ginsburg argued, an activity–inactivity distinction was meaningless because everyone is "active in the market for health care."[193] For this reason, Ginsburg agreed with the government's characterization of the failure to get insurance as a decision to "self-insure" that is properly subject to commercial regulation because it inevitably results in costly, uncompensated care.[194] She rejected the characterization of the mandate as a government compelled "purchase of a discrete, unwanted product" and instead viewed it as Congress "defining the terms on which individuals pay for an interstate good they consume."[195]

2. The Necessary and Proper Clause

In considering the government's claim that the mandate was an essential part of a broader regulatory scheme to regulate commerce, the Chief Justice did not question whether the mandate was in fact a "necessary" part of the regulatory framework that required insurance companies to issue insurance and prohibited them from engaging in individualized risk rating, and the Joint Dissenters devoted only three lines of their opinion to speculation that the government could have achieved its regulatory goals through other means.[196] Rather, the

192. Ginsburg also relied on this uniqueness argument to counter federalist concerns that the mandate will lead to a slippery slope of federal mandates. *Id.* at 2623. But the Chief Justice was not persuaded, accusing the federal government and the Justice Ginsburg of engaging in word play designed to circumvent practical limits on federal power. *Id.* at 2587–90 (opinion of Roberts, C.J.).

193. *Id.* at 2618 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). Ginsburg also criticized this "activity–inactivity" distinction as the kind of "formalistic nomenclature" rejected in *Wickard* and a distraction from the real question about the link between the challenged regulation and effects on commerce. *Id.* at 2622 (citing *Wickard* for the proposition that questions of Congress's power under the Commerce Clause "are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect' and foreclose consideration of the actual effects of the activity in question upon interstate commerce" (quoting Wickard v. Filburn, 317 U.S. 111, 120 (1942)).

194. *Id.* at 2622–23.

195. *Id.* at 2620.

196. *See id.* at 2592 (opinion of Roberts, C.J.) (noting that the Court is very deferential to Congress's determination about what is "necessary" and has upheld laws that are "'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise'"); *see also id.* at 2612 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) (contrasting the success in Massachusetts with the mass exodus of insurers from states that attempted to guarantee

Chief Justice and the Joint Dissenters' focus was on the importance of an activity requirement as a constitutional limit to federal power and why the Necessary and Proper Clause could not be used to circumvent this requirement.[197] For example, after explaining how deferential the Court has been to Congress on the this prong, the Chief Justice emphasized the "proper" part of this clause as an important limiting principle on the otherwise expansive reach of this provision, noting that laws that are not "consist[ent] with the letter and spirit of the constitution[]' . . . are not '*proper* [means] for carrying into Execution' Congress's enumerated powers."[198] According to the Chief Justice and the Joint Dissenters, such laws undermine the structure of government established by the Constitution and must be declared unconstitutional.

In their opinion, Justices Scalia, Kennedy, Thomas, and Alito provided a more vivid description of the unchecked federal power that would result from allowing the government to mandate insurance:

> Congress has impressed into service third parties, healthy individuals who could be but are not customers of the relevant industry, to offset the undesirable consequences of the regulation. . . . If Congress can reach out and command even those furthest removed from an interstate market to participate in the market, then the Commerce Clause becomes a font of unlimited power, or in Hamilton's words, "the hideous monster whose devouring jaws . . . spare neither sex nor age, nor high nor low, nor sacred nor profane."[199]

access to affordable insurance coverage without a mandate). In fact, challengers relied on the characterization of the mandate as "necessary" to the larger regulatory framework in arguing that other parts of the reform could not be severed from the mandate and thus would have to fall with the mandate if found unconstitutional. *But see id.* at 2644–47 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (questioning the necessity of the mandate and suggesting alternatives).

197. *Id.* at 2591 (opinion of Roberts, C.J.) (noting that the necessary and proper clause "does not license the exercise of any 'great substantive and independent power[s]' beyond those specifically enumerated"); *id.* at 2649 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (emphasis in original) (explaining that "the Commerce Clause, even when supplemented by the Necessary and Proper Clause, is not *carte blanche* for doing whatever will help achieve the ends Congress seeks by the regulation of commerce").

198. *Id.* at 2592 (emphasis and alterations in original) (quoting McCulloch v. State, 17 U.S. 316, 421 (1819) and Printz v. United States, 521 U.S. 898, 899 (1997)).

199. *Id.* at 2645 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (citing THE FEDERALIST NO. 33, at 202 (Alexander Hamilton) (Clinton Rossiter ed., 1961)).

Considering the prominent role that such concerns played in these Justices' decision to find the mandate unconstitutional under the commerce power, it was no doubt a surprise to his conservative colleagues when Chief Justice Roberts joined Justices Ginsburg, Breyer, Sotomayor, and Kagan to uphold the mandate as a constitutional exercise of the taxing power.

B. The Mandate as a Constitutional Exercise of the Taxing Power: The Tax–Penalty Distinction

The Constitution provides that Congress may "lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States."[200] This power to tax and spend has been interpreted as extremely broad—much broader in fact than the commerce power. The Supreme Court has made clear that this "grant gives the Federal Government considerable influence even in areas where it cannot directly regulate," which means that the "Federal Government may enact a tax on an activity that it cannot authorize, forbid, or otherwise control."[201] Thus, the fact that the federal government cannot mandate people to buy insurance under its commerce power is not determinative of the federal government's power to tax those who do not have insurance in the form of a shared responsibility payment. This does, however, raise an important question about whether the challenged payment can be properly characterized as a "tax" that can be justified under the broad taxing power or must be treated as a "regulatory penalty" used to enforce a mandate that must be justified within the narrower commerce power.

This tax–penalty distinction was also implicated by another claim asserted by the federal government early in the litigation—that the legal challenge to the mandate was premature under the Anti-Injunction Act ("AIA").[202] The AIA provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is

200. U.S. CONST. art. I, § 8, cl. 1.
201. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2579 (majority opinion).
202. *Id.* at 2584.

the person against whom such tax was assessed."[203] Effectively, this means that individuals must pay their taxes before they can bring a suit to challenge them.[204] The earliest that a taxpayer who fails to get insurance will have to pay the shared responsibility payment is 2015; if the AIA had applied, it would have prevented a challenge to the mandate until that time.[205]

By the time litigation reached the Supreme Court, the federal government had abandoned this AIA claim, likely because it needed the matter resolved in order to encourage more states to begin reform implementation in time for the 2013 due date for exchanges to be up and running. Nonetheless, because this was a threshold issue that determined whether it was even appropriate for the Court to hear the substantive challenges, the Court appointed an amicus to argue that the action was barred by the AIA.[206]

To better understand the basis for competing characterizations of the shared responsibility payment as a tax or penalty, it is important to understand a bit more about the legal and political context in which this question arises. First, despite the overwhelming focus on the mandate, the fact is that the ACA actually gives people a choice between purchasing a qualified health plan and making a shared responsibility payment.[207] Second, for those who are subject to the mandate and fail to buy insurance, they must make the required payment to the IRS as part of their tax filing; and like taxes, the amount due is determined, in part, as a percentage of income.[208] If one fails to make the payment, it can be withheld by the IRS from a refund otherwise due to the taxpayer.[209]

203. 26 U.S.C. § 7421(a) (effective December 21, 2000).

204. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2582 (explaining that the purpose of this provision is to "protect[] the Government's ability to collect a consistent stream of revenue, by barring litigation to enjoin or otherwise obstruct the collection of taxes").

205. *Id.* at 2580.

206. The Court appointed Robert A. Long to brief and argue the proposition that the AIA bars the current challenges to the individual mandate. *Id.* at 2582 n.2. Plaintiffs and the federal government argued against this interpretation. Reply Brief for Private Respondents on the Anti-Injunction Act at 1–3, Dep't of Health & Human Servs. v. Florida, 132 S.Ct. 604 (2011) (No. 11-398), 2012 WL 605833, at *1–3; *see Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2583–84 (holding that the government is correct in contending that the AIA does not bar the suit).

207. 26 U.S.C. § 5000A (2010).

208. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2593–94 (opinion of Roberts, C.J.).

209. *Id.*

On the other hand, the ACA labels the payment a "penalty" that is treated *like* taxes.[210] Moreover, the President and lawmakers have consistently referred to the shared responsibility payment as a "penalty" that would be used to enforce the mandate to buy insurance, not as a "tax" on one's choice to buy insurance.[211] Indeed, the government has made clear that a mandate is essential to the success of health reform since buying insurance is crucial for solving the cost shifting and other financial consequences of the uninsured; the shared responsibility payment is an alternative, but not a desirable one.[212] Finally, no lower court had held that the payment could be conceived of as a tax for purposes of the constitutional analysis, and only one had held that it functioned like a tax for purposes of the AIA bar.[213]

210. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2583 (majority opinion) ("[The] penalty for not complying with the mandate 'shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68,'" which, "in turn 'shall be assessed and collected in the same manner as taxes.'"); *see also* 26 U.S.C.A. § 5000A(g)(1) (2010).

211. CONG. BUDGET OFFICE, PAYMENTS OF PENALTIES FOR BEING UNINSURED UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv_Mandate_Penalty .pdf; *see also* Interview by George Stephanopoulos with President Barack Obama (ABC television broadcast Sept. 20, 2009), *available at* http://abcnews.go.com/blogs/politics/ 2009/09/obama-mandate-is-not-a-tax/ (rejecting characterizations of the mandate as a tax and repeatedly describing the shared responsibility payment as a means to ensure more people take responsibility for purchasing health insurance).

212. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2596 (opinion of Roberts, C.J.) (noting that the whole point of the shared responsibility payment is to incentivize the purchase of health insurance).

213. *See, e.g.*, Seven-Sky v. Holder, 661 F.3d 1, 5–10 (D.C. Cir. 2011), *abrogated by Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 2566 (applying a functional analysis to reject the "tax" label for purposes of the AIA bar and only considering the constitutionality of the mandate under the commerce power); Thomas More Law Ctr. v. Obama, 651 F.3d 529, 539–40, 549 (6th Cir. 2011), *abrogated by Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 2566 (rejecting the "tax" label for purposes of the AIA bar and noting that there is no reason to consider the taxing power justification for the mandate because it is a constitutional exercise of the commerce power). In concurring opinions, Judges Sutton and Graham specifically considered and rejected the taxing power theory as justification for the mandate. *Thomas More Law Ctr.*, at 550–54, 566. The Fourth Circuit was the only court to hold that the Anti-Injunction Act, which "[b]y its terms . . . bars suits seeking to *restrain* the assessment or collection of a tax," barred a challenge to the mandate. Liberty Univ., Inc. v. Geithner, 671 F.3d 391, 401 (4th Cir. 2011), *abrogated by Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 2566; *see id.* at 397–401 (vacating the judgment of the district court because it lacked jurisdiction to decide the constitutionality of the act). Consequently the court did not reach the merits of the constitutional analysis. Despite this holding, however, the court left unanswered the question of whether the assessment could still be considered a "penalty" for purposes of the constitutional analysis. *Id.* at 413 ("Plaintiffs' remaining contention as to why the AIA does not

Thus, in order to answer the legal questions before it, the Supreme Court had to decide whether the payment was a tax or a penalty, and the Court surprised most people by deciding that it was both.

1. Why the Anti-Injunction Act Does Not Apply: The Payment as a Penalty

On the only issue about which all nine Justices could agree, the Supreme Court held that the Anti-Injunction Act did not bar the plaintiffs' challenge, concluding that the shared responsibility payment could not be viewed as a tax for purposes of applying the bar.[214] Although this result was not surprising, the Court's reasoning did not follow the trend of the lower courts.

The lower courts considering the issue seem to have assumed that the analysis of whether the payment should be considered a tax or a penalty would be the same for both the AIA and constitutional questions.[215] While the specific label given to the payment by Congress was important, the lower courts applied a functional test to look beyond the label to determine whether the payment actually

bar their challenge to the individual mandate is that it imposes an unconstitutional regulatory penalty 'not designed to raise revenue,' which assertedly violates the Commerce Clause [and] the Taxing and Spending Clause . . . . The problem with this argument is that a claim that an exaction is an unconstitutional regulatory penalty does not insulate a challenge to it from the AIA bar."); *see also id.* at 423 (Davis, J., dissenting) ("Before today, nine federal judges had expressly considered the application of the Anti-Injunction Act, and all nine held it inapplicable to the Affordable Care Act's mandates.").

214. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2584 (majority opinion); *id.* at 2655–56 2645 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

215. *See, e.g.*, Florida *ex rel.* McCollum v. U.S. Dep't of Health & Human Servs., 716 F. Supp. 2d 1120, 1130 (N.D. Fla. 2010) ("A fundamental issue overlaps the defendants' challenges to several of the plaintiffs' claims, and that is whether the individual mandate penalty is a 'tax' within Congress's broad taxing power and thus subject to the Anti-Injunction Act, or instead, a 'penalty' that must be authorized, if at all, by Congress's narrower Commerce Clause power. Because of the importance of this issue, I will analyze it first and at some length."). The district court went on to hold that the payment was not a tax for the AIA or for the constitutional analysis. *Id.* at 1136–44. A number of courts did not have to address the taxing power issue after finding that the AIA did not bar the claim because they found the mandate was constitutional under the commerce power. *See, e.g.*, *Thomas More Law Ctr.*, 651 F.3d at 549. Nonetheless, in concurring opinions, Judge Sutton and Graham agreed that the challenge was not barred by the AIA, and would have gone further to hold that the mandate could not be justified as an exercise of the taxing power. *Id.* at 550–54, 566. Although the Fourth Circuit in *Liberty* applied a functional analysis to the tax-penalty question, it left open the possibility that the payment could be treated like a tax for the purposes of the AIA but a penalty under the constitutional analysis. *Liberty Univ.*, 671 F.3d at 413. But not all of the judges agreed. In a concurring opinion, Judge Wynn insisted that his "conclusion that the mandates are (constitutional) taxes inevitably leads back to the AIA's bar to this case." *Id.* at 415 (Wynn, J., concurring).

functioned more like a tax or a penalty, and all but one concluded that the payment was more accurately considered a penalty than a tax.[216] The amicus appointed to argue the AIA claim before the Supreme Court similarly relied on a functional test but used it to argue for the opposite result—that the payment looked more like a tax, and thus should be subject to the AIA bar.[217] The Supreme Court rejected the functional test used by the courts and the amicus:

> *Amicus* argues that even though Congress did not label the shared responsibility payment a tax, we should treat it as such under the Anti-Injunction Act because it functions like a tax. It is true that Congress cannot change whether an exaction is a tax or a penalty for *constitutional* purposes simply by describing it as one or the other. Congress may not, for example, expand its power under the Taxing Clause, or escape the Double Jeopardy Clause's constraint on criminal sanctions, by labeling a severe financial punishment a "tax."
>
> The Anti-Injunction Act and the Affordable Care Act, however, are creatures of Congress's own creation. How they relate to each other is up to Congress, and the best evidence of Congress's intent is the statutory text. We have thus applied the Anti-Injunction Act to statutorily described "taxes" even where that label was inaccurate.[218]

Amicus offered additional arguments that did not rely on this tax characterization. For example, amicus argued that the AIA had been applied to other kinds of assessments and that by considering the

216. *See, e.g.*, *Liberty Univ.*, 671 F.3d at 404 ("[T]he Supreme Court has repeatedly instructed that congressional labels have little bearing on whether an exaction qualifies as a 'tax' for statutory purposes. . . . In light of this history, it is not surprising that no federal appellate court, except the Sixth Circuit in *Thomas More*, has ever held that the label affixed to an exaction controls, or is even relevant to, the applicability of the AIA."); *Thomas More Law Ctr.*, 651 F.3d at 539–40; *see also* Florida v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1314 (11th Cir. 2011) ("It is not surprising to us that all of the federal courts, which have otherwise reached sharply divergent conclusions on the constitutionality of the individual mandate, have spoken on this issue with clarion uniformity. Beginning with the district court in this case, all have found, without exception, that the individual mandate operates as a regulatory penalty, not a tax.").

217. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2583.

218. *Id.* (citations omitted); *accord id.* at 2656 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) ("What qualifies as a tax for purposes of the Anti-Injunction Act, unlike what qualifies as a tax for purposes of the Constitution, is entirely within the control of Congress").

Anti-Injunction Act and Affordable Care Act together, Congress's intent to make the Anti-Injunction Act applicable to the individual mandate became clear.[219] The Court did not find these arguments convincing,[220] emphasizing the importance of the penalty label as evidence of Congress's intent.[221] The Court found the AIA inapplicable.[222]

2. The Constitutional Analysis: Reconceptualizing the Payment as a "Tax"

In contrast to the AIA analysis, the Supreme Court did not defer to Congress's label for the purpose of determining whether the payment could be characterized as a "tax" that could be used to uphold the mandate as a valid exercise of Congress's taxing power.[223] The Court said that it must look beyond the label and apply a functional test to determine whether the payment effectively functioned more like a tax subject to the taxing power or a penalty subject to the Commerce Clause.[224] This time, Chief Justice Roberts, joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan, found that the shared responsibility payment could be characterized as a tax and upheld the mandate under the taxing power.

219. *See id.* at 2583.

220. Essentially, amicus argued that by directing that the penalty be "assessed and collected in the same manner as taxes,'" Congress intended to have the penalty treated as a "tax" for purposes of the AIA bar as well. *Id.* at 2583. The federal government contested this interpretation, arguing that this provision was meant only as a directive to the "Secretary of the Treasury to use the same 'methodology and procedures'" for collection of taxes. *Id.* The Court found the federal government's argument more persuasive. *Id.* at 2583–84. Amicus also pointed to another provision of the Internal Revenue code—§ 6201(a)—which "authorizes the Secretary to make 'assessments of all taxes (including interest, additional amounts, additions to the tax, and assessable penalties).'" *Id.* at 2584. It argued that this was evidence that penalties should be treated like taxes, including for purposes of the AIA bar, but the Court rejected this argument as well. *Id.* The Court noted that although this interpretation seems reasonable when reading the statute in isolation, it is clear from a more comprehensive reading of the Internal Revenue Code as a whole that taxes and penalties are treated as distinct terms and have different legal consequences in other instances. *Id.* Thus, the Court found that one provision merely authorizing the Secretary to assess penalties as part of its tax assessment "does not equate assessable penalties to taxes for other purposes." *Id.*

221. *Id.* at 2583 (citation omitted).

222. *Id.* at 2584; *id.* at 2656 2649 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (emphasis in original).

223. *Id.* at 2594 (opinion of Roberts, C.J.) ("It is up to Congress whether to apply the Anti-Injunction Act to any particular statute, so it makes sense to be guided by Congress's choice of label on that question. That choice does not, however, control whether an exaction is within Congress's constitutional power to tax.").

224. *Id.* at 2594–95.

It was clear that this was not an easy decision for the Chief Justice to make. Writing for himself, Chief Justice Roberts began this part of the opinion by noting that the government's taxing-power argument presented a serious conceptual challenge to the Court:

> The Government's tax power argument asks us to view the statute differently than we did in considering its commerce power theory. In making its Commerce Clause argument, the Government defended the mandate as a regulation requiring individuals to purchase health insurance. The Government does not claim that the taxing power allows Congress to issue such a command. Instead, the Government asks us to read the mandate not as ordering individuals to buy insurance, but rather as imposing a tax on those who do not buy that product.[225]

The government's use of terms like "coverage requirement" and "mandate" makes the law look regulatory in nature and appears to create a legal obligation to do something—purchase insurance—that must be authorized by the Commerce Clause. Indeed, this was the assumption that pervaded the federal government's rhetoric and primary legal justification both in the ACA and in its briefs and arguments before the Court.[226] In fact, Chief Justice Roberts almost immediately conceded that this was "the most straightforward reading of the mandate."[227] But he also acknowledged that statutes can have different meanings and said that as long as the government's alternative reading of the statute was a reasonable one,

225. *Id.* at 2593 (citation omitted).

226. *See, e.g.*, *id.* at 2584–91.

227. *Id.* at 2573–74. Justice Ginsburg, writing for Justices Breyer, Sotomayor, and Kagan, concurred with most of the Chief Justice's rationale for upholding the mandate under the taxing power. *Id.* at 2576. But Justice Ginsburg did not join the part of Chief Justice Roberts's opinion where he concluded that "the most straightforward reading of the mandate is that it commands individuals to purchase insurance," and that because the Commerce Clause does not support the individual mandate, it is necessary to turn to the taxing power as an alternative justification. *Id.* In Justice Ginsburg's concurrence, she wrote separately to make clear that she disagreed with the Chief Justice and the Joint Dissenters on the commerce issue and that she did not think it was necessary to even address the commerce issue in light of the fact that a majority agreed that the coverage requirement, *Id.* at 2628-29 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). She did not express an opinion about what she considered to be the most natural reading of the mandate or the apparent inconsistency between the taxing-power and commerce-power justifications raised by the Joint Dissenters.

the Court had a "plain duty. . . to adopt [this reading if it] will save the Act."[228]

The Chief Justice then considered the reasonableness of the government's tax characterization under the functional analysis. This time, writing for a majority, he asked whether the shared responsibility payment looked more like a tax, which could be upheld under the extremely broad taxing power, or whether it must be viewed as a regulatory penalty for a mandate, which five Justices had already decided would violate the commerce power.[229] The Court concluded that the payment could be viewed as functioning like a tax in many respects:

> [I]t is paid into the Treasury by "taxpayer[s]" when they file their tax returns. It does not apply to individuals who do not pay federal income taxes because their household income is less than the filing threshold in the Internal Revenue Code. For taxpayers who do owe the payment, its amount is determined by such familiar factors as taxable income, number of dependents, and joint filing status. [Moreover,] [t]he requirement to pay is found in the Internal Revenue Code and enforced by the IRS, which—as we previously explained—must assess and collect it "in the same manner as taxes." [Finally,] [t]his process yields the essential feature of any tax: it produces at least some revenue for the Government. Indeed, the payment is expected to raise about $4 billion per year by 2017.[230]

Moreover, the Court found that the assessment does not have the usual indices of a penalty for unlawful conduct. In distinguishing the ACA payment from the kind of penalty typically subject to the stricter Commerce Clause test, the Court looked at three things: the amount due, the absence of a scienter requirement, and the means of collection.[231] First, the Court noted that for most Americans the amount due will be far less than the price of insurance, which gives consumers a real choice between making the payment to the government or buying insurance; thus the payment does not look like

228. *Id.* at 2593–94 ("The question is not whether that is the most natural interpretation of the mandate, but only whether it is a 'fairly possible' one.").

229. *Id.* at 2593.

230. *Id.* at 2594 (citations omitted).

231. *Id.* at 2595–96.

a "'prohibitory' financial punishment" that is designed to force compliance with the mandate.[232] This was supported by CBO estimates that four million people each year will choose to pay the IRS rather than buy insurance.[233]

Second, the coverage requirement is solely enforced through IRS collection of the shared responsibility payment, and the ACA prohibits the IRS from using its harshest collection tools, such as liens, levies, and criminal prosecution, which are more consistent with punitive sanctions.[234] Finally, the fact that there is no scienter requirement, coupled with the government's affirmation that people can comply with the law either by purchasing insurance or paying the tax, suggests that the government is not trying to penalize wrongful behavior but rather is using a tax to merely encourage people to purchase insurance.[235] The majority highlighted the fact that people are in compliance with the law if they choose to pay the tax, which undermines the challengers' (and dissent's) characterization of the failure to purchase insurance as unlawful. Although the majority acknowledged that the payment is designed to encourage the purchase of insurance and thus serves a "regulatory function," precedent has made clear that many taxes serve a dual regulatory and revenue raising purpose.[236]

The Joint Dissenters issued a scathing dissent, criticizing the majority's assumption that the payment could be legitimately conceived of as a penalty and tax at the same time for purposes of applying two different constitutional standards.[237] They accused the

232. *Id.*

233. *Id.* at 2597.

234. *Id.* at 2596; *see also* 26 U.S.C.A. § 5000A(g)(2) (2010) (barring criminal prosecutions and prohibiting the Secretary of Health and Human Services from using notices of lien and levies).

235. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2595–96.

236. *Id.* As the Court noted:

> '[E]very tax is in some measure regulatory. To some extent it interposes an economic impediment to the activity taxed as compared with others not taxed.' That § 5000A seeks to shape decisions about whether to buy health insurance does not mean that it cannot be a valid exercise of the taxing power.

Id. at 2596 (citation omitted).

237. *Id.* at 2650–51 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (emphasis in original) (citations omitted). The dissent did admit that the payment can be "both [a tax and penalty] for statutory purposes since Congress can define 'tax' and 'penalty' in its enactments any way it wishes." *Id.* at 2651 n.5.

majority of ignoring precedent that established "a clear line between a tax and a penalty: '[A] tax is an enforced contribution to provide for the support of government; a penalty . . . is an exaction imposed by statute as punishment for an unlawful act.'"[238] They also argued that the threshold question of whether the provision is a tax or penalty should have turned on the Government's framing, and it was clear that the Act adopted a framing of "wrongdoing" through its use of terms like "shall," "requirement," and "penalty."[239] Finally, the dissent pointed to the harms created by the majority's holding, saying that the majority was rewriting the statute in a way that allows Congress to avoid political backlash from raising taxes, while also shielding it from the constitutional implications of creating a mandate that violates the commerce power.[240]

In light of its holding, the Court then had to consider whether the "tax" violated a constitutional limit on direct taxes. The Constitution provides that "No Capitation, or other direct, Tax shall be laid, unless in Proportion to the Census or Enumeration herein before directed to be taken."[241] This requirement means that any "direct tax" must be apportioned so that each State pays in proportion to its population.[242] The Court explained that this is an unclear clause with a very narrow application.[243] It then briefly concluded that a tax on not having insurance "does not fall within any recognized category of direct tax" because it is not a capitation[244] or a tax on the ownership of land or personal property.[245]

Chief Justice Roberts concluded this part of the opinion by considering a more fundamental objection to upholding the mandate in light of the federalism-based concerns that animated the Commerce Clause opinions by the Chief Justice and the Joint

238. *Id.* at 2651 (citing United States v. Reorganized CF&I Fabricators of Utah, Inc., 518 U.S. 213, 224 (1996)).

239. *Id.* at 2651–52.

240. *Id.* at 2653–55.

241. U.S. CONST. art. I, § 9, cl. 4.

242. *Id.* at 2598 (majority opinion).

243. *Id.* For a more thorough explanation of the history of the Direct Tax Clause and why it is an "anachronistic doctrine" with "ugly historical roots" that should not be applied to the mandate, see Amar, *supra* note 160, at 14–15.

244. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2599 ("Capitations are taxes paid by every person, 'without regard to property, profession, or *any other circumstance*.'").

245. *Id.*

Dissenters. First, the Chief Justice explained that the activity requirement, which five Justices found to be a limit on the commerce power, has never been relevant to the taxing power: "[I]t is abundantly clear the Constitution does not guarantee that individuals may avoid taxation through inactivity."[246] Second, he emphasized the fact that the taxing power is subject to its own limits, like the Article I prohibition on direct taxes, although the Court found this prohibition was not implicated in this case.[247] Finally, the Chief Justice noted that the taxing power should not trigger the same degree of concern about limiting federal power because "although the breadth of Congress's power to tax is greater than its power to regulate commerce, the taxing power does not give Congress the same degree of control over individual behavior."[248] The power to regulate under the commerce power can be enforced with the most severe criminal sanctions, including huge fines, imprisonment, and all of the other social and civil losses or harm that can result from being branded a criminal.[249] Paying a tax, while it can be burdensome, is not punishment; and in this instance, the ACA leaves individuals with a lawful choice to avoid the tax by getting insurance.

V. *NFIB*'S UNPRECEDENTED FINDING OF COERCION: ALLOWING STATES TO OPT OUT OF THE MEDICAID EXPANSION

While Supreme Court review of the challenge to the mandate was seen as inevitable, the Court's decision to grant certiorari on the challenge to the Medicaid expansion was unexpected. As described in Part II, Medicaid is a longstanding federal–state cooperative health program for the poor. Congress enacted the program pursuant to its spending power and has expressly reserved the right to make changes to the program,[250] which it has done many times in order to expand

246. *Id.*

247. *Id.* at 2599–2600.

248. *Id.* at 2600.

249. *Id.* This includes the "deprivation of otherwise protected civil rights, such as the right to bear arms or vote in elections; loss of employment opportunities; social stigma; and severe disabilities in other controversies, such as custody or immigration disputes." *Id.*

250. 42 U.S.C. § 1304 of the Social Security Act provides that "[t]he right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress." 42 U.S.C. § 1304 (2006).

the eligibility criteria. In contrast to the novel and unprecedented mandate challenge, courts have routinely held that amendments to the Medicaid program are constitutional under Congress's spending power.[251] By granting certiorari on this question, the Court signaled its willingness to consider more robust limits on Congress's spending power.

A. The Spending Power

Article I, Section 8, Clause 1 of the U.S. Constitution gives Congress the power "to pay the Debts and provide for the . . . general Welfare of the United States."[252] The Court has interpreted this power very broadly to allow the federal government to use federal funds as an incentive to states to adopt a federal regulatory regime. In other words, the federal government can use spending conditions to encourage a state to take actions that it could not directly require them to take.[253]

The plaintiffs in this case were not challenging the federal government's power to attach conditions to Medicaid funding generally. Rather the plaintiffs were challenging how the government structured this particular expansion. Pursuant to Congress's right to amend Medicaid program conditions, the ACA enacted this expansion as an amendment to the existing Medicaid program. This meant that Congress made states' continuing participation in Medicaid—and thus the receipt of funding for beneficiaries eligible under pre-ACA criteria—conditional upon states' participation in the expansion.[254] This is significant, states argued, because a provision of the Medicaid Act predating the ACA gives HHS the power to terminate the funding of states that do not comply with Medicaid program requirements.[255] As a result, states that refuse to participate in the expansion could lose *all* Medicaid funding.

It is important to note that terminating all Medicaid funds was the most extreme option under this provision; the Secretary had the

251. *See* Leonard, *supra* note at 68, at 788 n.47.

252. U.S. CONST. art. I, § 8 cl. 1.

253. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2601–02 (citation omitted).

254. *Id.* at 2601.

255. 42 U.S.C. § 1396(c) (providing that if a state's Medicaid plan does not comply with the Act's requirements, the Secretary of Health and Human Services may declare that "further payments will not be made to the State"). *But see Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 2566 (invalidating application of this provision to states that refuse to participate in the expansion).

discretion to take less drastic steps, such as terminating payments only for the categories of service directly affected by the noncompliance while continuing to allow payments for areas unaffected by this failure.[256] In fact, the federal government has *never* terminated all of a state's funding due to noncompliance, and there was no evidence that the federal government intended to do so when the suit was brought.[257] State plaintiffs alleged that merely structuring the expansion this way created a "threat [that] serves no purpose other than to force unwilling States to sign up for the dramatic expansion in healthcare coverage effected by the Act" and thus was coercive in violation of the Tenth Amendment.[258]

1. The *Dole* Test Before *NFIB*

Challenges to the spending power require the courts to balance the right of the federal government to attach conditions to ensure the appropriate use of its funds with fears that this power could be used to usurp state authority. To this end, the Supreme Court in *South Dakota v. Dole*[259] established a four-prong test for determining the constitutionality of Spending Clause legislation:

> First, the exercise of the spending power must be in pursuit of the general welfare. Second, the conditions on the receipt of federal funds must be reasonably related to the legislation's stated goal. Third, Congress's intent to condition funds on a particular action must be unambiguous and must enable the states to knowingly exercise their choice whether to participate. Finally, the federal legislation

256. *Id.*

257. Doing so would only undermine the federal government's own goals for expanding coverage for the most vulnerable among us, and it would be a dramatic departure from its typical flexibility and willingness to issue states waivers. Moreover, the claim was filed minutes after the legislation was signed so there was no time for such a threat.

258. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2603.

259. 483 U.S. 203 (1987) (upholding the National Minimum Drinking Age Act, which directed the Secretary of Transportation to withhold 5 percent of the federal highway funds otherwise payable to a state if that state permitted the purchase of alcoholic beverages by individuals under twenty-one years of age).

> cannot "induce the States to engage in activities that would themselves be unconstitutional."[260]

This *Dole* test has long been understood to be very easy to satisfy. Indeed, the *NFIB* plaintiffs did not initially challenge any of these requirements.[261] In reviewing the challenge below, both the Florida district court and the Eleventh Circuit found the test easily satisfied.[262] It was beyond dispute that spending to improve healthcare for those most in need furthers the general welfare. Second, conditioning all Medicaid funds on the expansion was seen as "undeniably related to the purpose of the Medicaid Act, which is to 'provid[e] federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons.'"[263] Third, Congress expressly reserved its right "to alter [or] amend" the program conditions in the future, which satisfied the "unambiguous or knowing choice" requirement.[264] Finally, there was no claim that the expansion was otherwise unconstitutional.[265]

Both the district court and Eleventh Circuit made clear that the focus of the plaintiffs' claim was on an additional limit on the use of the spending power also articulated in *Dole*—the anticoercion principle.[266] This anticoercion limit was derived in part from the Tenth Amendment's reservation of certain powers to the states, which was understood to prohibit Congress from employing its

260. Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1263 (11th Cir. 2011) (citation omitted) (citing to South Dakota v. Dole, 483 U.S. 203 (1987)), *aff'd in part, rev'd in part sub nom*. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 2566.

261. Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1266 (N.D. Fla. 2011) (citations omitted) ("Preliminarily, I note that in their complaint the state plaintiffs appear to have relied solely on a 'coercion and commandeering' theory. Nowhere in that pleading do they allege or intimate that the Act also violates the four 'general restrictions' in *Dole*, nor did they make the argument in opposition to the defendants' previous motion to dismiss. . . . Apparently expanding that argument, the state plaintiffs now argue (very briefly, in less than one full page) that the Act's Medicaid provisions violate the four general restrictions. This belated argument is unpersuasive. . . . [T]he only real issue with respect to Count IV . . . is whether the Medicaid provisions are impermissibly coercive and effectively commandeer the states."), *aff'd in part, rev'd in part*, 648 F.3d 1235 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom*. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 2566.

262. *See id.* at 1263–69.

263. *Florida ex rel. Att'y Gen.*, 648 F.3d at 1263 n.63 (quoting Harris v. McRae, 448 U.S. 297, 301 (1980)).

264. *See id.* at 1267.

265. *See id.* at 1263.

266. *Id.* The doctrine was first developed in 1937 in *Steward* and has been affirmed repeatedly by the Supreme Court. *See* Charles C. Steward Mach. Co. v. Davis, 301 U.S. 548 (1937).

spending power "in such a way as to 'coerce' the states into compliance with the federal objective."[267] The clearest application of this anticoercion principle occurs where legislation explicitly mandates some action by states or state officials. For example, the Court has invalidated legislation compelling state law enforcement officers to perform federally mandated background checks on handgun purchasers[268] and legislation compelling a state to either take title to nuclear waste or enact particular state waste regulations.[269]

The anticoercion principle in the spending context is much more challenging and amorphous because spending conditions are structured to preserve state choice. But the Court in *Dole* said that "in some circumstances the financial inducement . . . [may be] so coercive as to pass the point at which 'pressure turns into compulsion.'"[270] This idea that the amount of inducement could become so large as to be coercive has been reaffirmed in other cases, but prior to *NFIB* the Court had never invalidated Spending Clause legislation on this basis.[271] Moreover, as the Eleventh Circuit explained in its decision below, most federal courts have found the anticoercion principle at best incoherent and at worst completely unworkable.[272] The Court has been criticized for not providing any guidance for distinguishing coercion from mere temptation or an offer that is too good to refuse.[273] The doctrine itself has been criticized as creating the perverse result that the more generous the federal government is with its funding, the greater the chance the amount could be seen as coercive and the less control the federal government may have over its own funds.[274]

267. *Florida ex rel. Att'y Gen.*, 648 F.3d at 1264.

268. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2602 (2012) (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.) (citing Printz v. U.S., 521 U.S. 898, 933 (1997)).

269. *Id.* (citing New York v. United States, 505 U.S. 144, 174–75 (1992).

270. South Dakota v. Dole, 483 U.S. 203, 211 (citing *Steward Mach. Co*., 301 U.S. at 590).

271. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2634 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

272. *See Florida ex rel. Att'y Gen.*, 648 F.3d at 1265 ("[F]ederal courts have been similarly reluctant to use it.").

273. *See, e.g.*, Celestine Richards McConville, *Federal Funding Conditions: Bursting Through the* Dole *Loophole*, 4 CHAP. L. REV. 163 (2001); *see* Chemerinsky, *supra* note 119, at 102.

274. *See* Chemerinsky, *supra* note 119, at 104.

2. After *NFIB*: A New Theory of Coercion or the *Dole* Test with Teeth?

For the first time, the Court in *NFIB* found a federal spending condition to be coercive. The Court's decision was surprising not only because it was unprecedented, but also because it was the only substantive aspect of the case that did not result in the usual 5–4 divide. Seven Justices, through two separate opinions, agreed that requiring participation in the expansion as a condition of existing Medicaid funding was coercive.[275] The notion that states must have had a "genuine" or "real choice" in deciding whether to participate in the expansion was key to this holding.[276]

Chief Justice Roberts, writing for himself, Justice Breyer, and Justice Kagan, began by discussing the tension between the federal government's right to direct the use of its funds for the general welfare and the importance that this power does not undermine states' choice about whether or not to participate as partners in implementing federal policy objectives.[277] He compared this kind of federal–state partnership to a contract, emphasizing the importance of states "knowingly and voluntarily accept[ing] the terms of the 'contract.'"[278] He also emphasized the importance of "scrutiniz[ing] Spending Clause legislation [in order] to ensure that Congress is not using financial inducements to exert a 'power akin to undue influence.'"[279] The Joint Dissenters mirrored this approach in their separate opinion.[280] In finding the expansion coercive, all seven

275. Justices Breyer and Kegan joined in Chief Justice Robert's opinion, while Justices Scalia, Kennedy, Thomas, and Alito reached the same conclusion in their joint dissent. *See id.* at 2601–09 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.); *id* at 2656–68 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting). *See also* Varat, *supra* note 181, at 418. ("In fact, on this point the dissenters, despite withholding their official concurrence, were explicit in noting that '[s]even Members of the Court agree that the Medicaid Expansion, as enacted by Congress, is unconstitutional." (quoting *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2666–67 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting)).

276. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2607–08 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.).

277. *Id.* at 2603.

278. *Id.* at 2602.

279. *Id.*

280. *Id.* at 2659-2660 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) (describing federal funding conditions in a federal-state program as contractual in nature and noting that "just as a contract is voidable if coerced, '[t]he legitimacy of Congress' power to legislate under the spending power . . . rests on whether the State *voluntarily* and knowingly accepts the terms of the 'contract'") (citations omitted) (emphasis in original).

justices considered both the nature of the threat as well as the amount of financial inducement at stake.[281]

a. Nature of the inducement

For Chief Justice Roberts, the nature of the inducement used by the federal government for the Medicaid expansion was problematic because when funding conditions "take the form of threats to terminate *other* significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes"[282] rather than as mere encouragement. Critical to this analysis was Chief Justice Roberts's view of the expansion, not as an extension of the existing Medicaid program, but rather as a "new health care program" and thus different one.[283] The Chief Justice and the Joint Dissenters seemed to agree that despite the fact that the federal government expressly reserved the right to amend the program, states could not have anticipated this kind of program change:

> The Medicaid expansion . . . accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. *Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories*. *Under the [ACA], Medicaid . . . is no longer a program to care for the neediest among us*, but rather an element of a comprehensive national plan to provide universal health insurance coverage.
>
> . . . .
>
> . . . A State could hardly anticipate that Congress's reservation of the right to "alter" or "amend" the Medicaid

281. *Id.* at 2602–07.

282. *Id.* at 2604 (emphasis added).

283. *Id.* at 2606 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.); *id.* at 2657 (Scalia, Kennedy, Thomas & Alito, JJ. dissenting) (describing the expansion as "dramatic" and referring to Medicaid eligibility categories that existed prior to the ACA as "the old Medicaid program").

> program included the power to transform it so dramatically.[284]

Chief Justice Roberts did not explain his determination that under the ACA Medicaid would no longer be a program for the neediest among us, which is striking in light of the fact that the expansion still would have targeted the extremely poor who are unlikely to be able to get insurance through employment or on the individual market. Rather, he seemed to rely on anachronistic assumptions about who qualifies as "in need."[285]

For Chief Justice Roberts and the Joint Dissenters, the extremely generous federal funding for the expansion did not undermine states' coercion argument. In fact, Roberts saw it as further evidence that the expansion was in fact a new and separate program, which, in turn, reinforced the coercive nature of the threat.[286] This characterization of the expansion as a "new" program is important because it makes the relationship between new and existing program funds more tenuous and thus makes a threat to withhold one for the other look like coercion. This characterization also supports states' claims that they could not have anticipated it as part of the original Medicaid conditions, further undermining the notion that they had a real choice to accept this possibility when they joined Medicaid.

284. *Id.* at 2605–06 (emphasis added); *accord id.* at 2664 (Scalia, Kennedy, Thomas & Alito, JJ. dissenting) (noting that "the offer that the ACA makes to the States–go along with a dramatic expansion of Medicaid or potentially lose all federal Medicaid funding–is quite unlike anything that we have seen in a prior spending-power case).

285. Such assumptions have been used to explain the original line drawing in public entitlement programs like Medicaid, but have since been recognized as anathema to sound health policy. *See, e.g*, Rosenbaum, *supra* note 35; STREMIKIS ET AL., *supra* note 40. One recent article suggests that the Court's characterization of the expansion as a new program may be based on its mistaken belief about prior amendments and their connection to existing funding: "The *NFIB* plurality fundamentally misunderstood [Medicaid's] history, leading it to overemphasize discontinuities between the existing Medicaid program and the Medicaid expansion." Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging Into Endless Difficulties: Medicaid and Coercion in the Healthcare Cases* 15 (Boston Univ. Sch. of Law, Working Paper No. 12-40, 2012).

286. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2606 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.) ("Indeed, the manner in which the expansion is structured indicates that while Congress may have styled the expansion a mere alteration of existing Medicaid, it recognized it was enlisting the States in a new health care program. Congress created a separate funding provision to cover the costs of providing services to any person made newly eligible by the expansion.").

b. Amount of the inducement

The second part of the Court's coercion inquiry focused more directly on the question of when *the amount of* financial inducement becomes coercive. Chief Justice Roberts and the Joint Dissenters used *Dole* to distinguish mild encouragement from an inducement that is so significant that it deprives states of meaningful choice.[287] In *Dole* the Court rejected a challenge to the National Minimum Drinking Age Act, which directed the Secretary of Transportation to withhold 5 percent of the federal highway funds otherwise payable to a state if that state permitted the purchase of alcoholic beverages by individuals under twenty-one years of age. The Court held that the amount could only be considered mild encouragement because the threat of loss was only 5 percent of highway funds, which constituted less than half of one percent of South Dakota's budget at the time.[288]

By contrast, the *NFIB* Court found that the threat of losing all Medicaid funds was so great as to have the effect of being "a gun to the head" of states that would force them to participate in the expansion.[289] By one estimate, termination of all of a state's Medicaid funds could amount to a loss of over 10 percent of the state's overall budget.[290] Moreover, the state would lose the extensive and costly administrative investments already made.[291] Finally, the Court noted the secondary effects of the funding loss, such as how it would impact states' ability to receive funding for other services that are dependent on Medicaid participation. To the Court, this threat was enough to deprive states of any real choice in deciding whether to participate.[292]

287. *Id.* at 2604–05 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.); id. 2662-2664 (Scalia, Kennedy, Thomas & Alito, JJ. dissenting).

288. South Dakota v. Dole, 483 U.S. 203, 211–12 (1986).

289. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2604; *accord id.* at 2664 (Scalia, Kennedy, Thomas & Alito, JJ. dissenting) (concluding that "the offer of the Medicaid Expansion was one that Congress understood no State could refuse").

290. *Id.* (noting that the federal government has provided $3.3 trillion to states for the existing Medicaid program).

291. *Id.*

292. Unlike the majority, Justices Ginsburg and Sotomayor viewed the generous federal funding of the expansion as evidence that states were not being asked to undertake an onerous burden that the federal government would have to force them to take. *Id.* at 2632 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). The Court rejected this argument, viewing the amount of new funding provided as irrelevant to the coercion analysis:

Justices Ginsburg and Sotomayor dissented from the holding, mainly criticizing the assumptions upon which the Court based its coercion holding. They disagreed with the characterization of the program as new and believed that states were on notice about the possibility of this kind of expansion in light of prior significant expansions.[293] They also criticized the Court's analysis for affirming an anticoercion principle that has proved unworkable and failed to give future litigants and judges meaningful guidance on how to determine whether a state has a "legitimate choice" to accept or decline federal funds with conditions attached.[294]

The Court's reasoning certainly raises more questions than it provides answers about how the anticoercion principle limits the typically broad *Dole* test. Although the Court purported to apply a coercion test, its reasoning about the nature of the threat was based on the Court's finding that two of the *Dole* requirements were not met—the "reasonably related" and "knowing choice" requirements—that were thought to have been easily satisfied by the lower courts, Justices Ginsburg and Sotomayor, and even the plaintiffs initially.

B. Severability in a Different Light

The final question the Court had to consider was severability: if any provision was found unconstitutional, could that provision be severed from the ACA, leaving the rest of the Act intact, or would other parts of the Act have to fall as well? As noted in Part II, the overwhelming assumption by everyone, including the Supreme Court, was that this question would arise as a result of the mandate being struck down. Indeed, the severability question on which the Court granted certiorari was specifically tied to the mandate, and at oral arguments, very little time was given to this question in the Medicaid context.

"[T]he size of the new financial burden imposed on a State is irrelevant in analyzing whether the State has been coerced into accepting that burden. 'Your money or your life' is a coercive proposition, whether you have a single dollar in your pocket or $500." *Id.* at 2605 n.12 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.); *see also id.* at 2666 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) ("[T]he ACA offer is not an 'exceedingly generous' gift that no State in its right mind would decline. Instead, acceptance of the offer will impose very substantial costs on participating States.").

293. *Id.* at 2635–39 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

294. *Id.* at 2639–41.

Despite the 7–2 coercion holding, severability was where the justices broke down along familiar lines again. Although Justices Ginsburg and Sotomayor would have found the Medicaid expansion constitutional, they agreed with Chief Justice Roberts and Justices Breyer and Kagan that this kind of constitutional infirmity could be remedied by simply prohibiting application of the coercive penalty provision to states that refuse to participate in the expansion, leaving the expansion in place as an option that states can choose.[295] For the majority, this was a pretty clear-cut issue. The part of the Social Security Act that established Medicaid conditions and contained the penalty provision also contained a provision explicitly requiring any provision of the code held invalid to be severed from the rest of the provision of that Chapter.[296]

The more difficult question to answer was "whether Congress would have wanted the rest of the Act to stand, had it known that States would have a genuine choice whether to participate in the new Medicaid expansion."[297] Unlike the Social Security Act, the ACA did not contain a severability provision. However, the majority relied on a longstanding judicial presumption in favor of severability in finding that "Congress would have wanted to preserve the rest of the Act."[298] Because the unconstitutional penalty provision could be severed from the part of the Act to which it most directly related—the Medicaid expansion—it seemed only logical that it could be severed from the rest of the ACA, whose remaining provisions could "remain fully operative" and were independent of the Medicaid expansion.[299]

295. *Id.* at 2642 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) (noting that although they do not agree with the majority that conditioning the expansion on existing funds is unconstitutional, if it is, the proper remedy is to sever the penalty provision and leave the rest of the Medicaid expansion, and the entire ACA, intact).

296. *Id.* at 2607 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.) ("The Chapter of the United States Code that contains § 1396c includes a severability clause confirming that we need go no further. That clause specifies that '[i]f any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby.' [42 U.S.C.] § 1303."); *id.* at 2642 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

297. *Id.*at 2607.

298. *Id.* at 2608.

299. *Id.*

The Joint Dissenters, on the other hand would have struck not only the Medicaid expansion itself as unconstitutional but the entire ACA.[300] The dissent argued that the federal government relied on the Medicaid expansion as essential to its attempt at creating a near universal healthcare plan, which meant that it could not be severed from the rest of the law.[301] The Joint Dissenters highlighted the gaping holes in coverage that would result from a state's refusal to participate as evidence that the federal government viewed them as essentially linked. They concluded that the "most natural remedy" would be to invalidate the entire Medicaid expansion, which would mean that the rest of the law should be invalidated as well.[302]

VI. IMPLICATIONS OF *NFIB*

As described in Part III, commentary around the health reform challenge focused the constitutional question and federalism debate around the mandate as an exercise of the commerce power. This narrative suggested a dichotomous choice: Would the conservative majority take this opportunity to further limit federal power, or could the liberal wing of the court sway one of the other justices to uphold the mandate? By upholding the mandate under the taxing power and making an unprecedented finding of coercion, the Court defied this simplistic narrative. *NFIB* generates interesting questions about constitutional limits on federal power, reform implementation, and the future of health policy, which will likely be explored by constitutional and health scholars for years to come. This Part suggests some possible implications that deserve attention.

A. Broader Constitutional Law Implications

NFIB generated a range of reactions in the immediate aftermath. Some proponents of reform, especially those focused on the decision to uphold the mandate and the ACA as a whole, saw the decision as affirming the legitimate power of the federal government to address a healthcare crisis of national proportions. Some opponents, on the other hand, likely viewed *NFIB* as creating an unlimited, plenary power by the federal government that betrays our federalist structure

300. *Id.* at 2667–77 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).
301. *Id.* at 2669–76.
302. *Id.* at 2667-68.

and opens the door for further encroachments on state sovereignty and individual liberty. A closer look at the underlying reasoning for the mandate and Medicaid holdings, however, suggests that the implications for the scope of federal power in the future are far less clear.

1. From Commerce to Tax and Spend: A Shifting Battleground for Attacks on Federal Power?

The activity–inactivity distinction creates a new express limit on the commerce power, but the significance of this limit is not clear. The government insisted that a health insurance mandate would not open the door to other kinds of mandates because of the uniqueness of the health insurance market. The inextricability of healthcare treatment and financing, the fact that laws entitle people to certain kinds of care regardless of their ability to pay, and the inevitability of needing healthcare created a unique and compelling problem, and the mandate was an essential part of solving this problem. The government relied on this uniqueness to assuage concerns that the mandate would or could usher in a new unlimited, plenary power for the federal government that it would use to control people's lives.

Moreover, there is no indication in the joint dissent that the activity requirement was intended to roll back earlier interpretations of the commerce power. Even as they found that the mandate exceeded the commerce power, both Chief Justice Roberts and the dissenting justices[303] expressly affirmed earlier cases like *Wickard* and *Raich*, defining the power broadly.[304]

The power to tax and spend was the sleeper issue and will likely generate the most attention going forward as the Court seemed to both expand and limit this federal power. In upholding the mandate and Medicaid expansion, the Court reaffirmed the expansive regulatory scope of the taxing and spending power. Indeed, these holdings may confirm fears that the power to tax and spend is a means of circumventing the more robust Tenth Amendment limits on

303. Only Justice Thomas, in a separate one-paragraph dissent, objected to the substantial effects test as inconsistent with the original understanding of the Commerce Clause. *Id.* at 2677 (Thomas, J., dissenting).

304. *See, e.g*, *id.* at 2588–91 (opinion of Roberts, C.J.); *id.* at 2646–47 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

other federal powers. These fears are likely exacerbated by the fact that the Court upheld a finding of the mandate as a tax based on reasoning perceived by many as less than satisfying or persuasive,[305] and after concluding that it could not be upheld under the commerce power—the site of more successful attempts to narrow federal power. Indeed, Chief Justice Roberts's reluctant and apologetic tone, as well as Justice Ginsburg's neglect of the issue in her concurrence, suggests that not even a majority of the Court was fully persuaded by this justification. While a few legal scholars have offered more persuasive and robust justifications for this holding,[306] this probably does little to assuage those who fear that the trajectory of the Roberts Court is toward greater deference to Congress and a reticence to narrow federal power.

On the other hand, the Court seemed to apply a more robust Tenth Amendment limit on the spending power than it had in the past. The significance of this cannot be overemphasized; courts and legal scholars had all but given up on the idea that the anticoercion principle could be a meaningful limit on the spending power. Even scholars who argued for greater limits on the spending power conceded that the coercion doctrine as it existed was unworkable and thus the least effective way to accomplish this.[307] They proposed alternatives, such as tightening up some of the *Dole* requirements, especially the "relatedness" and "unambiguous" or "knowing choice" requirements.[308] And although the Court in *NFIB* purported to apply the "coercion" doctrine in limiting the Medicaid expansion, the Court in fact seemed to take these scholars up on their invitation to revisit the *Dole* test. *NFIB*'s coercion finding relied not simply on the amount of inducement—the factor presumed to determine coercion in prior Court dicta; it was also based on the conclusion that the federal government failed to satisfy the second and third *Dole* requirements, which had always been easily satisfied for Medicaid

305. *See* Dworkin, *supra* note 128.

306. *See id.*; *see also supra* note 160 (citing legal scholarship that argued that the taxing power provided a better justification for the mandate prior to *NFIB*).

307. *See, e.g.*, Baker & Berman, *supra* note 117, at 517–21; Loyola, *supra* note 101, at 135–42.

308. *See e.g.*, Baker & Berman *supra* note 117, at 511–12.

amendments in the past.[309] Scholars will likely be debating the contours of the spending power after *NFIB* for some time to come: does the Court's reasoning reflect a new theory of coercion, an application of the *Dole* test with teeth, or both?

2. Chief Justice Roberts's Legacy and the Role of Judicial Restraint

Commentary leading up to *NFIB* implicitly and explicitly assumed the Supreme Court had immense power to determine the fate of health reform. It painted a picture of the Court as ideologically driven, and the media stoked predictions that Justices would decide the fate of healthcare reform based on their ideological positions rather than legal precedent.[310] Some feared—and others hoped—that the five conservative Justices on the Court would use this opportunity to push a Republican agenda:[311]

> The Supreme Court may be headed for its most dramatic intervention in American politics—and most flagrant abuse of its power—since *Bush v. Gore*.
>
> The constitutional objections are silly. However, because constitutional law is abstract and technical and because almost no one reads Supreme Court opinions, the conservative majority on the Court may feel emboldened to

309. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2601–06 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.). For a more comprehensive consideration of the Medicaid coercion holding and its implications, refer to Huberfeld, Leonard & Outterson, *supra* note 285.

310. *See, e.g.*, Michael Tomasky, *My Supreme Court-Health Care Prediction*, DAILY BEAST (June 27, 2012), http://www.thedailybeast.com/articles/2012/06/27/my-supreme-court-health-care-prediction.html ("This is easy. I take the darkest and most cynical possible view of the conservative majority; I believe . . . that they are politicians in robes (with the partial exception of Kennedy); as such, I believe they will behave here like politicians and they will render the decision that will inflict the maximum possible political damage on Obama and the Democrats."). But not everyone was so cynical. *See* Meghan Kiesel, *Obamacare Predictions: What Will the Supreme Court Decide?* ABCNEWS (June 27, 2012), http://abcnews.go.com/blogs/politics/2012/06/obamacare-predictions-what-will-the-supreme-court-decide/ (listing predictions from a variety of sources, many predicting that the mandate would be upheld, with some predicting a 6–3 decision).

311. S*ee* Adam Liptak, *Supreme Court Faces Weighty Cases and a New Dynamic*, N.Y. TIMES Sept. 30, 2012, at A1; Akhil Amar, *How to Defend Obamacare*, SLATE (Mar. 29, 2012, 4:07 PM), http://www.slate.com/articles/news_and_politics/jurisprudence/2012/03/supreme_court_and_obamacare_what_donald_verrilli_should_have_said_to_the_court_s_conservative_justices_.html (explaining how the government's counsel should have handled the conservative Justices); Winkler, *supra* note 151.

> adopt these silly objections in order to crush the most important progressive legislation in decades.[312]

These kinds of predictions caused some conservative opponents who were shocked by *NFIB* to blame Chief Justice Roberts for betraying conservative hopes,[313] and it led to widespread speculation about his motives.[314] This speculation was likely exacerbated by a scholarly debate that made it look like the commerce power test could come out either way, leaving the result apparently up for grabs.[315]

Neglected in the commentary and dominant narrative was the concept of the Supreme Court as a federal actor that should show significant restraint when considering the constitutionality of legislation enacted by a democratically accountable body. This concept was not completely missing, however. In one speech, President Obama implored the Court to uphold the law not by making substantive legal arguments about its constitutionality, but by resorting to notions of judicial restraint.[316] An even more pointed

312. Koppelman, *supra* note 17, at 1–2.

313. *See, e.g.*, Katy Waldman, *The Eight Stages of Conservative Greif*, SLATE (June 28, 2012, 6:31 PM), http://www.slate.com/articles/news_and_politics/politics/2012/06/republican_response_to_obamacare_decision_the_eight_stages_of_conservative_grief.html (quoting a tweet by Georgia Rep. Jack Kingston that read "With #Obamacare ruling, I feel like I just lost two great friends: America and Justice Roberts"); Elspeth Reeve, *Time Is on His Side: Conservatives Feel Betrayed by John Roberts*, ATLANTIC WIRE (June 28, 2012), http://www.theatlanticwire.com/politics/2012/06/time-his-side-conservatives-feel-betrayed-john-roberts/54023/; Erick Erickson, *The Supreme Court Forces Us to Deal Within the Political System*, RED STATE BLOG (June 28, 2012), http://www.redstate.com/erick/2012/06/28/the-supreme-court-forces-us-to-deal-within-the-political-system/ ("John Roberts' opinion seems to clearly suggest he wants to keep the Supreme Court out of political fights and was willing to destroy his reputation with conservatives to do it.").

314. *See, e.g.*, Liptak, *supra* note 311 (describing the coming term for the Supreme Court): "The term will also provide signals about the repercussions of Chief Justice John G. Roberts Jr.'s surprise decision in June to join the court's four more liberal members and supply the decisive fifth vote in the landmark decision to uphold President Obama's health care law. Every decision of the new term will be scrutinized for signs of whether Chief Justice Roberts, who had been a reliable member of the court's conservative wing, has moved toward the ideological center of the court." Liptak also says that the term "could clarify whether the health care ruling will come to be seen as the case that helped Chief Justice Roberts protect the authority of his court against charges of partisanship . . . ." *Id.*

315. *See* Pushaw, *supra* note 112, at 882 (noting that justices are particularly vulnerable to such claims in cases involving the commerce power and criticizing the current test as so "malleable" and "vague" that it "can be applied, whether intentionally or not, to promote a particular ideological agenda").

316. *Obama Takes Aim at Supreme Court, Calls Them "Unelected Group of People"*, FOX NATION (Apr. 2, 2012), http://nation.foxnews.com/president-obama/2012/04/02/obama-slams-activist-supreme-court-calls-them-unelected-group-people. Obama states, "Ultimately, I'm

admonition to the Court came from legal scholar Akhil Amar, in an editorial on Slate.com.[317] Styled as an open letter to the Supreme Court, Amar's editorial highlighted the troubling consequences for the Court's own legitimacy if it were to strike down the mandate:

> Nothing in the Constitution or history or structure—or precedents, for that matter—provides suitable support for the "mandates are different" intuition, which cannot survive analytic scrutiny. Such an opinion will not write—or if it does, it will not last.
>
> . . . .
>
> Meaning, with the greatest of respect for an institution and individuals whom I hold dear, I have to teach the stuff that Your Honors write year in and year out to my students. And if a judicial opinion simply fails tests of text, history, structure, and logic—and if it comes down by a 5–4 vote; and if the vote seems to track the party-alignment of appointing presidents; and if the four dissenters are emphatic that the majority's arguments simply don't wash; and if the vast majority of us who study constitutional law professionally, including most conservative scholars, agree that these arguments simply don't wash; and if I already have to do a lot of work to explain *Bush v. Gore*, in context—well, what will I tell my students when they say to me, cynically, that "it's all politics"? What will I say, when they ask me (as I have already been asked by one former student): "Just how many presidential elections are five conservative justices allowed to undo?"[318]

While I will refrain from speculating about the Chief Justice's motives or whether he was swayed by Professor Amar's letter,[319] I

confident that the Supreme Court will not take what would be an unprecedented extraordinary step of overturning a law that was passed by a strong majority of a democratically elected congress. And I would like to remind conservative commentators that for years what we have heard is that the biggest problem is judicial activism and that an unelected group of people would somehow overturn a duly constituted and passed law." *Id.*

317. Amar, *supra* note 311. Amar developed these arguments more fully in a later essay. *See* Amar, *supra* note 160.

318. Amar, *supra* note 311.

319. For speculation about which, if any, legal scholars influenced Chief Justice Roberts's decision to uphold the mandate under the taxing power, refer to Randy Barnett, *The*

do think it is fair to say that Chief Justice Roberts was clearly mindful of limits on the Court's own power and expressly relied upon judicial restraint at key junctures in the decision. The first was in his framing of the case at the very beginning:

> In this case we must again determine whether the Constitution grants Congress powers it now asserts, but which many States and individuals believe it does not possess. Resolving this controversy requires us to examine both the limits of the Government's power, *and our own limited role in policing those boundaries*.[320]

This principle was critical to the Court's decision to uphold the mandate, preserve the Medicaid expansion as an option, and save the rest of the law. Indeed, the joint dissent, which would have held the mandate and Medicaid expansion unconstitutional and invalidated the entire Act, is noteworthy for its apparent apathy toward the principle of judicial restraint. When considering the opinion in its entirety, it becomes clear that Chief Justice Roberts's positions on the underlying substantive questions seem to align more with the conservative justices, and that their divide on the ultimate holdings seems driven by different perspectives on how much restraint the Court should show in light of federalism principles.

B. ACA Implementation and the Future of Health Policy

NFIB could have a significant impact on reform implementation and the future of health policy. Upholding the ACA paves the way for implementation, which will likely change the rhetoric around health reform and increase public support by allowing people to see how reform empowers states and individuals to make meaningful choices. On the other hand, the coercion holding could have serious negative consequences. In the short term, it will undermine implementation of the Medicaid expansion in those states that opt

Unprecedented Uniqueness of Chief Justice Roberts' Opinion, VOLOKH CONSPIRACY (July 5, 2012, 5:14 PM), http://www.volokh.com/2012/07/05/the-unprecedented-uniqueness-of-chief-justice-roberts-opinion/; Robert Cooter & Neil Siegel, *Online ACA Symposium: A Theory of the Tax Power that Justifies—and May Have Informed—the Chief Justice's Analysis*, SCOTUSBLOG (July 9, 2012, 12:48 PM), http://www.scotusblog.com/2012/07/online-aca-symposium-a-theory-of-the-tax-power-that-justifies-and-may-have-informed-the-chief-justices-analysis-2/.

320. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2577 (2012) (emphasis added) (citation omitted).

out. Over the long term, it could potentially serve as a barrier to the federal government's ability to use program amendments to adapt longstanding federal-state programs, like Medicaid, to changing health realities.

1. Moving Beyond Rhetorical Federalism[321]

Opponents of reform claimed the mantle of "protectors of federalism" in the legal debates on the mandate, while casting those who embraced reform as "nationalists" who look to the federal government to solve every problem and who devalue local governance.[322] In this narrative, federal power is viewed as an inherent threat to states and individual liberty. By saving health reform, however, *NFIB* preserves the opportunity for people to understand how the ACA furthers state sovereignty and individual liberty. We can now move beyond vague assertions of threats to state sovereignty and individual liberty, and the benefits of cooperative and collective-action federalism can come to fruition.

The rollout of the health benefit exchanges, in particular, creates an opportunity for states and communities to help shape reform going forward. As described earlier, the ACA continues the trend of vast state discretion and flexibility and requires stakeholder input as part of that process.[323] Different states vary in the approaches they are taking to a wide range of implementation decisions that have been delegated to them: plan design, selection and regulation; the exchange's role and regulatory philosophy; stakeholder participation; information dissemination and marketing; and consumer assistance

321. Some have defended states' use of this kind of federalist rhetoric. *See, e.g.*, Leonard, *supra* note 78 ("While it is easy to dismiss state resistance to ACA as nothing more than Tea Party politics, my counter view suggests several possible values deriving from the anti-health reform movement."). Leonard defines "rhetorical federalism" as the "highly public and vocal invocation of states-rights arguments to frame objections to comprehensive, sea-changing federal policies." *Id.* at 73. She says, "[t]he theory finds normative value in state-based resistance to sweeping federal initiatives although not all strategies employed are condoned." *Id.* My critique in this section is focused more specifically on what Balkin has described as the use of federalism theory as a "rhetorical excuse" for nonregulation. *See* Balkin, *supra* note 115, at 40.

322. *See supra* Part III.

323. To track the various approaches that states are taking toward health reform implementation, see *State Exchange Profiles, Health Reform Source*, HENRY J. KAISER FAMILY FOUND., http://healthreform.kff.org/State-Exchange-Profiles-Page.aspx (last visited Mar. 7, 2013).

programs. These decisions serve as models for the federal government as it designs the federal exchange.[324] In this way, the ACA explicitly values, encourages, and depends on the kind of state experimentation and local decision-making that opponents claim is threatened by federal action.

This is not a prediction that reform will work—that is, that it will solve our healthcare problem by making insurance affordable and increasing access through coverage. Rather, I am making a more limited claim that the ACA creates a "platform of uniform standards on which both states and private parties can innovate,"[325] standards which at least provide an opportunity to increase consumer choice in the healthcare market. If the market reforms are successful, then people will likely come to appreciate how the ACA enhances their freedom to get health insurance, and thus the healthcare they need to fully realize their liberty. If reform does not work—that is, if market reforms do not ultimately guarantee affordable coverage—then people will have no legal obligation to either buy insurance or make the shared responsibility payment, and liberty concerns will not be implicated.

The ACA in action will challenge reform opponents to heed Balkin's admonition to "take the language of experimentation seriously rather than as a rhetorical excuse for nonregulation, or as a way to resist the application of federal constitutional rights."[326] The merits of reform will continue to be up for debate among people who disagree on how much or how little regulation is needed to actually fix the problem.[327] Nonetheless, rhetorical claims about a federal

324. *See, e.g.*, WEINBERG & HAASE, *supra* note 64, at 1 (describing the flexibility in the federal health reform law, and noting that because of California's "front-runner status and the sheer size of its coverage expansion, California's choices will have implications for other states as they address difficult issues, including minimizing adverse selection, promoting cost-conscious consumer choice, and seamlessly coordinating with public programs").

325. Balkin, *supra* note 115, at 40.

326. *Id.*

327. Even in California, the first state to enact legislation and one of the leaders in developing an exchange, there continues to be disagreement about the best approach to take. One example is over how much power regulators should have to deny proposed premium increases found to be unreasonable. *See* Sandy Kleffman, *Health Insurance Rate Regulation Measure Qualifies for California's November 2014 Ballot*, MERCURYNEWS.COM (Aug. 24, 2012), http://www.mercurynews.com/health/ci_21385649/health-insurance-rate-regulation-measure-qualifies-californias-november. There are also important conversations about how choices in health reform implementation will impact access for certain vulnerable populations, like people living with HIV/AIDS, who have relied heavily on essential community providers. *See, e.g.*, CROWLEY & KATES, *supra* note 55; WALTER A. ZELMAN, COMMUNITY-BASED NONPROFIT MEDICAID PLANS

takeover that suppresses state power and individual liberty cannot withstand the reality of implementation.[328]

In fact, if the Court had followed the approach championed by the Joint Dissenters in the name of federalism, the result would have had the perverse, immediate, and long-term consequences of undermining states' rights and individual liberty.[329] Rather than giving states greater choice, which was the result of the majority's compromise, the Joint Dissenters would have deprived states of any choice to take advantage of the federal funding offered for public or private expansion. They ignored the fact that for both the public and private expansions, the ACA empowered states to do things they wanted to do but otherwise could not because of a lack of resources.[330] Finally, they downplayed the role of consumer choice

AND THE NEW HEALTH INSURANCE EXCHANGES: OPPORTUNITIES AND CHALLENGES (2010), *available at* www.statecoverage.org/files/SCI-ZelmanMedicaidExchanges.pdf; Marian Mulkey, *Should California Establish a Basic Health Program for Certain Low-Income Residents?*, *GrantWatch Blog*, HEALTHAFFAIRS (May 10, 2012), *available at* http://healthaffairs.org/blog/2012/05/10/should-california-establish-a-basic-health-program-for-Certain-low-income-residents/?cat=grantwatch. Similar concerns arise about the success of the new small employer exchanges. *See, e.g.*, Timothy S. Jost, *Employers and the Exchanges Under the Small Business Health Options Program: Examining the Potential and the Pitfalls*, 31 HEALTH AFF. 267 (Feb. 2012), *available at* http://www.commonwealthfund.org/Publications/In-the-Literature/2012/Feb/Small-Business-Health-Options-Program.aspx.

328. Interestingly, some of the latest attacks by Republican opponents of reform further undermine their own claims of a federal takeover. *See, e.g.*, Sara Hansard, *Upton, Grassley Call for More HHS Oversight of How States Using Exchange Grant Funds*, BLOOMBERGBNA HEALTH CARE DAILY REP. (Oct. 1, 2012).

329. The Joint Dissenters, and opponents of reform, wrongly assume that the only alternative is no federal action. But as Ginsburg pointed out, the dissent's legal reasoning would limit the federal government's ability to experiment primarily through market-based reform, but not its ability to act on its own. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2612–13 (2012) (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). Justice Ginsburg argued that the ACA's approach was consistent with federalism and far more protective of individual liberty and state governments than the alternative:

> Aware that a national solution was required, Congress could have taken over the health-insurance market by establishing a tax-and-spend federal program like Social Security. Such a program, commonly referred to as a single-payer system . . . would have left little, if any, room for private enterprise or the States. Instead of going this route, Congress enacted the ACA, a solution that retains a robust role for private insurers and state governments.

Id.

330. *Id.* at 2667–68 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting). To date, the federal government has provided generous grants to the states totaling over $1 billion. *Health Insurance Exchange Establishment Grants, 2012*, STATEHEALTHFACTS.ORG, http://statehealthfacts.kff.org/comparetable.jsp?ind=954&cat=17 (last visited Sept. 29, 2012).

in determining whether to buy insurance and devalued the fact that the ACA removes market impediments to healthcare so critical for realizing the promise of liberty.[331]

2. Adaptability of Federal Healthcare Programs

One aspect of the Court's decision has particularly significant implications for the future of health policy: the characterization of the Medicaid expansion as a "new" and "different" program, on which the Court's coercion finding turned. This characterization creates tremendous uncertainty about the federal government's ability to adapt its healthcare programs to evolving knowledge and market realities. As noted earlier, Medicaid was enacted in 1965, and though it initially defined eligibility categories narrowly, its mission was defined more broadly. States have been the drivers of many changes in the Medicaid program as their own needs change, and the flexibility inherent in Medicaid's administrative structure allows the federal government to be responsive to states' needs. Medicaid's evolution reflects an ongoing state–federal conversation about how to cover the greatest number of those in need in a cost-efficient and effective way. Program amendments are part of this conversation; the federal government uses them to encourage or discourage practices based on the results of state experimentation and to provide greater federal support for expanding local need.

The characterization of the expansion as "new" creates the possibility that future program changes will be deemed by courts to be too radical or different to be enforced as a program amendment. The Court failed, however, to give any guidance for determining when changes qualify as dramatic enough to be deemed "new." For example, Chief Justice Roberts could not cite to any text in the Medicaid Act that limited its mission to only the original Medicaid categories. Rather, he simply assumed that extending coverage to all adults under 133 percent of the federal poverty level would mean that Medicaid is no longer a program to help the neediest among us,

331. Scholars familiar with how healthcare markets work tend to argue that the ACA does not go far enough and that greater federal action is necessary to fix market impediments. *See, e.g.*, Moncrieff & Lee, *supra* note 123 (arguing that Congress is too federalist in nature and defers too much to the states).

an assumption which defies reality.[332] Longstanding programs, like Medicaid, will be particularly vulnerable to this uncertainty in light of the magnitude of the change likely to occur over a long period of time and the significant amount of funding upon which states inevitably come to rely.[333]

3. Uncertainty Created by *NFIB*'s "Opt In" Compromise

The Court's Medicaid holding has created a more immediate and practical concern about access for poor, childless adults in states that choose not to participate in the expansion.[334] The ACA provides that adults with an income up to 133 percent of the federal poverty level will be eligible for Medicaid as of 2014, but Medicaid will not be an option for these individuals in the opt-out states.[335] The ACA only provides for federal subsidies to help individuals with an income between 100–400 percent of the federal poverty level.[336] In opt-out states, this means that people below the federal poverty line will be left without any federal subsidy to purchase insurance in the private market and without the Medicaid alternative—making it virtually certain that they will remain uninsured and dependent on

332. *See supra* Part II.A (describing the groups most likely to be uninsured and in need of help prior to the ACA); *see also* STREMIKIS ET AL., *supra* note 40 (defining "vulnerable populations" as including "people with low incomes, the uninsured, and minorities"). The view of a broader population as "in need" is shared by states that have implemented various programs prior to the ACA to address the most serious consequences of gaps in the healthcare market. For example, states have provide targeted help to groups with certain chronic conditions—like breast or prostate cancer, or HIV—offering free or low cost diagnostic care, treatment, and education on prevention. Other programs, such as high risk pools, have a broader scope, but have strict eligibility requirements and are limited in terms of the numbers of people they can take.

333. For a more thorough exploration of the implications of the Medicaid coercion holding, see Huberfeld, Leonard & Outterson, *supra* note 285; Samuel R. Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After* NFIB, 101 GEO. L.J. (forthcoming 2013), *available at* http://ssrn.com/abstract=2128977.

334. *See* GENEVIEVE M. KENNEY ET AL., URBAN INST., HEALTH POLICY CTR , MAKING THE MEDICAID EXPANSION AN ACA OPTION: HOW MANY LOW-INCOME AMERICANS COULD REMAIN UNINSURED, 1 (2012), *available at* http://www.urban.org/UploadedPDF/412606-Making-the-Medicaid-Expansion-an-ACA-Option.pdf. *But see* Ralph Lindeman, *Most States Likely to Expand Coverage Due to Financial Incentives, Speakers Say*, BLOOMBERGBNA HEALTH CARE DAILY REPORT (Oct. 15, 2012).

335. GUIDE TO THE SUPREME COURT'S DECISION, *supra* note 41, at 8.

336. *See id.*

the inconsistent and ever-dwindling patchwork of public hospitals and clinics.

This picture gets even more complicated for the subset of newly eligibles who would otherwise be eligible for federal subsidies for use on the federal exchange. Residents in states that do not opt in to Medicaid expansion are also unlikely to have a state exchange. Recall that states can refuse to establish their own exchanges and thus not participate in the private insurance reforms ("private opt out"). The federal government will establish a federal exchange, with the expectation that residents in these private opt-out states can use their federal subsidies to purchase insurance on this federal exchange. However, at least some reform opponents are now questioning whether these subsidies can be used on federal exchanges, arguing that the ACA authorizes them only for state-based exchanges.[337] Such challenges hurt already vulnerable citizens by restricting their choice in the new private and public expansions, which have already been found constitutional by the Supreme Court. It is difficult to see how these kinds of attacks serve opponents' purported liberty goals.

On the other hand, state opposition to the Medicaid expansion may prove to be more political rhetoric than a firm policy position that can withstand the reality of the market and its residents' needs. When Medicaid and Medicare were first enacted, government encountered the same kinds of accusations of a federal threat to

337. *See* Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 HEALTH MATRIX: J. LAW-MEDICINE 119 (2013) (arguing that the ACA does not permit the use of tax credits and subsidies in federal exchanges created in states without exchanges of their own). *But see* Timothy Jost, *Tax Credits in Federally Facilitated Exchanges Are Consistent with the Affordable Care Act's Language and History*, HEALTH AFFS. BLOG (July 18, 2012), http://healthaffairs.org/blog/2012/07/18/tax-credits-in-federally-facilitated-exchanges-are-consistent-with-the-affordable-care-acts-language-and-history/ (arguing that the legislative history and assumptions by the Congressional Budget Office evidence Congress's intent that premium subsidies to be available in all exchanges). There has been litigation and congressional action around this issue. *See* Ralph Lindeman, *House Oversight Chair Seeks Documents in Federal Exchange-Tax Subsidy Probe*, BLOOMBERGBNA HEALTH CARE DAILY REPORT (Aug. 29, 2012) (noting that Republican Representative Darrell Issa, chairman of the House Oversight and Government Reform Committee, sought information from the IRS in order to challenge the IRS rule that permits tax subsidies for people purchasing insurance on federal exchanges); Amended Complaint for Declaratory and Injunctive Relief at 3–5, 11–21, Oklahoma *ex rel.* Pruitt v. Sebelius, No. CIV-11-030-RAW (E.D. Okla. 2012) (arguing that the IRS rule permitting use of subsidies on federal exchanges expands employer obligations in violation of the ACA and undermines the state's authority to regulate health policy as permitted by the ACA).

states' rights and individual freedom. Yet today every state participates in Medicaid, and Medicare has become an entitlement that seniors and providers fight to keep. Only time will tell.

VII. CONCLUSION

By upholding the ACA, *NFIB* has paved the way for reform, but it has not completely foreclosed political and other legal attacks on reform. On the political side, Republican lawmakers will continue to try to impede funding and implementation efforts, though such attempts have been largely unsuccessful so far.[338] On the legal side, rights-based challenges have been filed claiming that certain aspects of reform are being implemented in an unconstitutional way; however, these claims do not jeopardize the entire law.[339] The ones receiving the greatest attention are those challenging HHS regulations requiring prescription contraception coverage as part of preventive care.[340] But other aspects of the law, such as the provision

338. *See, e.g.*, Erick Erickson, *The Supreme Court Forces Us to Deal Within the Political System*, RED STATE BLOG (June 28, 2012, 10:47 AM), http://www.redstate.com/erick/2012/06/28/the-supreme-court-forces-us-to-deal-within-the-political-system/.

339. One challenge seems designed to try to take a second bite out of the apple by challenging the constitutionality of the mandate, and thus the ACA itself. This latest challenge arises out of the *NFIB*'s characterization of the shared responsibility payment as a tax. The claim is that if it is a tax, then it is subject to the constitutional provision that requires taxes to originate in the House of Representatives, which opponents argue did not happen. *See* Pete Kasperowicz, *GOP Resolution: Healthcare Law Violates Constitution for Not Originating in the House*, HILL'S FLOOR ACTION BLOG (July 20, 2012, 8:07 AM), http://thehill.com/blogs/floor-action/house/239127-gop-resolution-healthcare-law-violates-constitution-for-not-originating-in-the-house.
This claim seems based on a quibble about the way in which the House version of the bill evolved, and thus it is unlikely to be viewed as plausible basis for attack.

340. A number of suits have been brought challenging the HHS's rule requiring employers to provide preventive services, including prescription contraception for women. *See, e.g.*, O'Brien v. U.S. Dep't of Health & Human Servs., No. 4:12-CV-476-CEJ, 2012 U.S. Dist. LEXIS 140097 (E.D. Mo. Sept. 28, 2012) (dismissing plaintiffs' statutory and constitutional claims of infringement on religious liberty and violation of the Administrative Procedure Act); Newland v. Sebelius, No. 1:12-cv-1123-JLK, 2012 U.S. Dist. LEXIS 104835 (D. Colo. July 27, 2012) (granting plaintiffs' motion for a preliminary injunction based on allegations that the mandate violated the Religious Freedom and Restoration Act); Wheaton College v. Sebelius, No. 1:12-CV-01169-ESH, 2012 U.S. Dist. LEXIS 120187 (D.D.C. Aug. 24, 2012) (dismissing plaintiff's motion for a preliminary injunction because the application of the preventive services regulation remains hypothetical and thus the plaintiff cannot demonstrate an injury-in-fact and does not have a ripe claim). The *Wheaton College* case also notes that as of August 24, 2012, twenty-six lawsuits had been brought challenging the preventive services regulations with regard to contraception requirement. *Id.* at *3.

creating an independent payment advisory commission,[341] the use of federal subsidies in federal exchanges,[342] and the Medicaid maintenance of effort provisions in the ACA,[343] have either been challenged or will likely be challenged soon.

A thorough consideration of these challenges is beyond the scope of this Article, but they signal a rocky landscape ahead. Although they will likely keep lawyers and commentators busy for some time to come, they will not undermine reform implementation, which is already underway. *NFIB* has ushered in an exciting new period of reform in which federal officials, states, insurers, providers, advocates, and, most importantly, consumers are working together to try to solve the problem of rising healthcare costs by improving healthcare access. As a result of this process, and as more of the benefits of health reform become available and are understood,[344] there will likely be less support, or even tolerance, for continued attacks on reform.

341. *See* Coons v. Geithner, No. CV-10-1714-PHX-GMS, 2012 U.S. Dist. LEXIS 124196 (D. Ariz. Aug. 31, 2012) (stayed pending the outcome of *NFIB*); Second Amended Civil Rights Complaint for Declaratory and Injunctive Relief at 5–34, Coons v. Geithner, No. CV-10-1714-PHX-GMS (D. Ariz. Aug. 31, 2012), 2012 U.S. Dist. LEXIS 124196.

342. *See supra* note 337.

343. The ACA's maintenance-of-effort (MOE) requirement prohibits states from cutting eligibility standards for certain Medicaid beneficiaries or imposing stricter standards until 2014. Commentators are now speculating about whether these provisions could be vulnerable to the same coercion argument used in *NFIB*. *See* Ralph Lindeman, *Medicaid ACA Opponents Eyeing New Challenge To Law's Maintenance-of-Effort Requirement*, BLOOMBERGBNA, HEALTH CARE DAILY REPORT (Aug. 31, 2012); *see also* Second Amended Civil Rights Complaint for Declaratory and Injunctive Relief, *supra* note 341, at 5–34 (challenging the MOE provisions).

344. *See, e.g.*, *News Release: Through the Affordable Care Act, Americans with Medicare Will Save $5,000 through 2022*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Sept. 21, 2012), http://www.hhs.gov/news/press/2012pres/09/20120921a.html; Secretary Kathleen Sebelius, *The Health Care Law is Saving Americans Money*, WHITE HOUSE BLOG (Sept. 11, 2012), http://www.whitehouse.gov/blog/2012/09/11/health-care-law-saving-americans-money (touting the U.S. Department of Health and Human Services's 2012 Annual Rate Review Report). The report notes that the rate review program, which requires plans to spend at least 80 percent of premiums on healthcare and demonstrate compliance with the law, has already gone into effect and saved Americans about $1 billion on their health insurance premiums. *See also* S.R. Collins, R. Robertson, T. Garber & M.M. Doty, *Young, Uninsured and in Debt: Why Young Adults Lack Health Insurance and How the Affordable Care Act Is Helping*, COMMONWEALTH FUND, (June 2012), http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Jun/Young-Adults-2012.aspx (noting that 6.6 million young adults stayed on their parents plans between November 2010 and November 2011, who would not have been able to prior to the ACA).