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**THE POSITIVE CASE FOR CENTRALIZATION IN HEALTHCARE REGULATION:
THE FEDERALISM FAILURES OF THE ACA**

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I. INTRODUCTION

In the immortal words of Vice President Joe Biden, the Patient Protection and Affordable Care Act¹ (“ACA” or the “Act”) is a “big f---ing deal.”² It accomplishes the United States’ most sweeping reform of healthcare law and our greatest expansion of healthcare access since the 1965 enactment of Medicare³ and Medicaid.⁴ Nevertheless, the ACA leaves a few things to be desired. Like many sweeping reforms, the 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 a national project entrusted solely to the central government.⁵

Our concern here is not with constitutional limits on national or state authority. Although such limits undoubtedly exist and although those limits are certainly important, this Article will focus on the functional advantages that the state governments on the one hand and the national government on the other⁶ can bring to healthcare regulation. Our concern is not, for example,

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¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of the U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

² Nick Graham, ‘A Big F---ing Deal’: Biden’s Health Care Reform F-Bomb on Live TV (VIDEO), HUFFINGTON POST (Mar. 23, 2010, 12:24 PM), http://www.huffingtonpost.com/2010/03/23/a-big-fucking-deal-bidens_n_509927.html.

³ See 42 U.S.C. § 1395 (2006).

⁴ See 42 U.S.C. § 1396 (2006).

⁵ For the sake of clarity and consistency, we will use “national government” or “central government” rather than “federal government” to refer to Congress, the presidency, and the Article III judiciary. We will use “federal” and “federalism” to refer to a system comprised of one national government and several sub-national governments, in this case one national government and fifty state governments.

⁶ See generally Larry E. Ribstein & Bruce H. Kobayashi, *The Economics of Federalism*, (Illinois Law and Econ. Working Papers Series, Working Paper No. LE06-001, 2006), *available at* <http://ssrn.com/abstract=875626>.

whether the individual mandate exceeds Congress's authority under the Commerce Clause⁷ or whether the Medicaid expansion represents an unconstitutional commandeering of state agencies.⁸ Instead, it is whether the ACA's private insurance regulations, public insurance provisions, and health and wellness incentives would be best managed at the state or national level. Assuming that the goals of controlling the costs of medical care, expanding Americans' access to healthcare coverage, and bolstering the quality of medical interventions are worthy goals, who should be in charge of overseeing them? Should it be the state governments, the national government, or some combination of the two?

Early in this nation's history, our resounding answer was that healthcare and public health regulations should be left exclusively to the states.⁹ In the New Deal and Great Society movements, however, the national government intervened in many areas of state control, including healthcare,¹⁰ and the emergent healthcare regulatory system has been one of mixed and often confused authority. Only a handful of healthcare programs, most notably Medicare¹¹ and the Military Health System ("MHS"),¹² are governed exclusively at the national level, while countless others, including Medicaid,¹³ the State Children's Health Insurance Program ("SCHIP"),¹⁴ and the vast majority of private health insurance regulations,¹⁵ are governed jointly or, perhaps more accurately, *disjointedly* at the national and state levels.

⁷ See, e.g., Mark A. Hall, *The Constitutionality of Mandates to Purchase Health Insurance*, 37 J.L. MED. & ETHICS 40 (2009) (discussing constitutional question of compulsory health insurance prior to the passage of the Affordable Care Act and finding that it would be valid under Congress' Commerce Clause powers); David B. Rivkin Jr., Lee A. Casey & Jack M. Balkin, *A Healthy Debate: The Constitutionality of an Individual Mandate*, 158 U. PA. L. REV. PENNUMBRA 93 (2009) (debating the constitutionality of the individual mandate); *Virginia v. Sebelius*, 728 F.Supp.2d 768 (E.D. Va. 2010) (finding the individual mandate is an unconstitutional exercise of the commerce clause as regulating "inactivity"); Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, HOFSTRA L. REV. (forthcoming 2011), available at <http://ssrn.com/abstract=1663947> (discussing the health reform nullification movement). See generally *Complaint for Declaratory and Injunctive Relief, Virginia v. Sebelius*, No. 3:10 Civ. 188 (E.D. Va. Mar. 23, 2010), http://www.oag.state.va.us/PRESS_RELEASES/Cuccinelli/Comm%20v.%20Sebelius%20-%20Complaint%20filed%20with%20Court%20_323_10.pdf; see also *Complaint, Florida v. Sebelius*, (N.D. Fla. March 23, 2010) (No. 3:10-cv-91) (complaint includes 13 states), <http://docs.justia.com/cases/federal/district-courts/florida/flndce/3:2010cv00091/57507/1/>.

⁸ See *Complaint for Declaratory and Injunctive Relief, Virginia v. Sebelius* (2010) (No. 3:10 Civ. 91) (alleging that Medicaid expansion and requirements for state-run health insurance exchanges and high risk pools violate the Tenth Amendment by "commandeering the [states] and their employees as agents of the federal government's regulatory scheme at the states' own cost.").

⁹ See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

¹⁰ See *id.* at 235–90, 367–74.

¹¹ 42 U.S.C. § 1395 (2006).

¹² See 10 U.S.C. §§ 1071–1110 (2006).

¹³ 42 U.S.C. § 1396 (2006).

¹⁴ 42 U.S.C. § 1397aa (2006).

¹⁵ See *Employee Retirement Income Security Act of 1974*, 29 U.S.C. §§ 1001–1461 (2006) (preempting state regulation of employer provided benefits including health benefits); see

Part of the reason that lawmakers have chosen “cooperative federalism”¹⁶—or this disjointed mess—is that Congress is self-consciously a federalist institution. Despite being the lawmaking body for the central government (or perhaps, from the Framers’ perspective, *because* it is the lawmaking body for a central government¹⁷), Congress is structured to be protective of states’ interests. The Senate in particular embodies the Founders’ state-protective instinct, providing each state with equal representation notwithstanding their wildly varying populations.¹⁸ It is therefore structurally difficult to pass legislation that would centralize regulatory authority in the national government at the expense of state control. This story of senatorial protection for federalism certainly played out in the ACA’s passage; the House version of the bill would have centralized regulatory authority far more than the enacted Senate bill did.

Our problem with this structural story and with the legislation that results from it is that the modern era of law and regulation is dramatically different from that of the founding. In a largely technocratic age, in which regulation centers increasingly on data and analysis and in which data flow instantaneously and human beings flow quickly across state borders, the functional advantages of state and local regulation have all but disappeared. This is especially true in a field like healthcare, which benefits significantly from aggregation of information across large numbers of people—which benefits from economies of scale. Additionally, in an era of increasingly data-driven regulation, the central government is capable of capturing many of the historic advantages of state and local regulation without leaving any implementation

generally THE HENRY J. KAISER FAM. FOUND., HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 2008 UPDATE (2008), *available at* <http://www.kff.org/insurance/upload/7766.pdf> (providing an overview of state licensing procedures and competing federal regulation preempting state control); MILA KOFMAN & KAREN POLLITZ, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE, HEALTH INSURANCE REGULATION BY STATES AND THE FEDERAL GOVERNMENT: A REVIEW OF CURRENT APPROACHES AND PROPOSALS FOR CHANGE 1, (2006), *available at* <http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf> (discussing the divide between federal and state regulatory powers prior to the enactment of the Health Insurance Marketplace Modernization and Affordability Act); Russell Korobkin, *The Battle over Self-insured Health Plans, or “One Good Loophole Deserves Another”*, 5 YALE J. HEALTH POL’Y L. & ETHICS 89 (2005) (describing ERISA preemption and the differing standards regulating private and self-insurers).

¹⁶ See generally Frank R. Strong, *Cooperative Federalism*, 23 IOWA L. REV. 459, 479-82 (1938) (introducing a symposium on “cooperative federalism”); see also Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Healthcare*, 12 U. PA. J. CONST. L. 1325, 1338 (2010) (cooperative federalism programs are those in which a state “receive[s] a percentage-on-the-dollar match from the federal government for every state dollar spent.”); Susan Rose-Ackerman, Comment, *Cooperative Federalism and Co-optation*, 92 YALE L.J. 1344 (1983) (discussing the desirability of cooperation through federal funding programs vis-à-vis preemption or commandeering state officials).

¹⁷ See 3 THE RECORDS OF THE FEDERAL CONVENTION OF 1787, at 359 (Max Farrand ed., rev. ed. 1966).

¹⁸ See Herbert Wechsler, *The Political Safeguards of Federalism: The Role of the States in the Composition and Selection of the National Government*, 54 COLUM. L. REV. 543, 547-48 (1954).

authority to the state governments. Because data-driven regulation is largely objectivist, the national government can run policy experiments that tell us as much as or even more than state-based experimentation; it can gather variegated data on local policy preferences; and it can vary policy implementation to respond to those preferences.

The ACA recognizes much of this modern story by placing national agencies at the forefront of implementing healthcare reform. But in several significant respects, the Act falls short of centralizing regulatory authority in the national government. It leaves states responsible for implementing the insurance exchanges, the general regulations of private insurance, the Medicaid and SCHIP programs, and several demonstration projects.

This paper proceeds as follows. Part II makes the case that the national government is functionally superior to state and local governments for healthcare regulation in the modern age. Part III considers the successes and failures of the ACA in centralizing healthcare regulation. Part IV concludes.

II. FUNCTIONAL FEDERALISM AND HEALTHCARE REGULATION

There are a number of purely functional factors that one can consider when choosing between state and national governments for regulating healthcare. Each level of government captures different advantages, and each suffers from different disadvantages. In analyzing functional rather than constitutional federalism, scholars generally consider the following factors: (1) experimentation, (2) voice, (3) diversity, (4) exit, (5) uniformity, (6) scale, (7) spillover prevention, and (8) redistribution.¹⁹ The first four factors represent advantages of smaller governments; the latter four represent advantages of the national government.

This part will briefly describe each of the functional factors, positing first, that the national government's advantages are particularly important for healthcare regulation and, second, that the national government can (and sometimes does) design healthcare regulations to recapture many of the states' functional advantages without using state governments for implementation.

A. *The Functional Factors*

1. Advantages of State and Local Governance

a. *Experimentation*

Experimentation—the ability of states to act as laboratories of democracy²⁰—is probably the most frequently invoked functional advantage of state governance.²¹ In a federal system, the smaller units of government—in our case the states—can run live tests of different policy approaches. The national government can then see which approaches work and which don't and can choose whether or not to enact a successful approach nationwide. If policy leaders hypothesize, for example, that capping noneconomic and punitive damages in medical

¹⁹ See generally Ribstein & Kobayashi, *supra* note 6; Scott L. Greer & Peter D. Jacobson, *Health Care Reform and Federalism*, 35 J. HEALTH POL. POL'Y & L. 203 (2010).

²⁰ *New Ice State Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

²¹ See, e.g., Craig Volden, *State as Policy Laboratories: Emulating Success in the Children's Health Insurance Program*, 50 AM. J. POL. SCI. 294 (2006); Charles Fried, *Federalism—Why Should We Care?*, 6 HARV. J.L. & PUB. POL'Y 1 (1982).

malpractice litigation will reduce the practice of defensive medicine, will curb inflation in liability insurance, or will improve the quality of medical care, then they can convince a handful of representative states, say California and Texas, to enact such caps. They can then see what actually happens. If the caps work to accomplish the stated goals, then other states' legislators can enact the same caps, or Congress can enact them nationwide.²² If the caps do not work, policymakers can try a different approach elsewhere. State governance thus provides information about the usefulness of a given policy approach.

b. Voice

The second advantage of small government is that state and local representatives have fewer constituents than national representatives, allowing them to gather more and better information about their electorates' policy preferences. If smaller governments are directly involved in shaping and implementing policy, then each constituent will have greater voice in that project. If, by contrast, the national government is solely responsible for policymaking, the smallest constituent group will be about 560,000 people, the size of the smallest congressional district in the House of Representatives.²³ No matter how conscientious, a single representative cannot communicate effectively with that many people about their specific policy preferences.

c. Diversity and Exit

The third and fourth advantages of state involvement in policy implementation—diversity and exit—are closely related. State or local governmental control has the advantage of allowing policy diversity within a single country. Diversity of this kind has two beneficial effects.²⁴ First, it allows states to fine-tune their policies to the specific needs of their constituencies, in case the citizens of Texas have different needs and preferences on a given policy question than the citizens of California. This is a straightforward advantage of diversity. Second, policy diversity allows residents to exit one jurisdiction in favor of another, thereby facilitating competition among the states for resident taxpayers—a theoretical advantage first advanced by Charles Tiebout.²⁵ Under the Tiebout theory of federalism, the states' diversity of policy approaches allows taxpayers to choose among different bundles of taxes and services by “voting with their feet,” creating a market-like environment that will theoretically result in optimal policy bundles.²⁶ In other words, states will compete for taxpayers by setting policy according to constituents' preferences, and the constituent population that stays in a given state (rather than moving) will be the population that gains the most value from the policy bundle offered.²⁷ If, by contrast, the national government is solely responsible for setting policy and it chooses a monolithic policy bundle for the entire country, then citizens are stuck. The cost of

²² The process of state mimicry of successful policy is known as “policy diffusion” and is an oft-studied phenomenon in political science.

²³ If apportioned correctly, each congressional district should contain about 690,000 people, or 300 million people divided into 435 districts. The state of Wyoming, however, has one representative despite having a total population of about 560,000 people. U.S. CENSUS BUREAU, RESIDENT POPULATION CHANGE (2010).

²⁴ See Greer & Jacobson, *supra* note 19, at 214.

²⁵ See generally Charles M. Tiebout, *A Pure Theory of Local Expenditures*, 64 J. POL. ECON. 416 (1956).

²⁶ *Id.*

²⁷ See generally *id.*

exit in that case—the cost of moving out of the country—is significantly higher than the cost of moving to a different state within the United States.

2. Advantages of National Governance

a. *Uniformity*

Perhaps the best-known and most frequently invoked advantage of national regulation is uniformity: the ability of the national government to set consistent standards nationwide. Uniformity is particularly important when regulated interests, such as manufacturers or employers, operate in several states or nationwide. In that case, state control would force multi-state entities to learn and to comply with up to fifty different sets of rules. Uniformity significantly decreases the costs of compliance.

b. *Scale*

A second advantage of national governance is that it benefits from economies of scale. The term “economies of scale” refers to the cost advantages of expansion or increased production.²⁸ For a standard corporation, the cost per unit of production might go down as the corporation produces more units, especially if the corporation experiences high fixed costs. For government, the same phenomenon might occur if the cost per instance of regulation decreases as the number of regulated individuals increases. Furthermore, government frequently acts like a private corporation or private business, providing goods and services directly, either at taxpayer expense or on a fee-for-service basis. In that case, public programs might benefit from economies of scale for exactly the same reasons that private corporations would: the cost of producing public goods might decrease as the number of units produced increases. For public regulations and public goods that benefit from scale, putting the national government in charge has the obvious advantage of increasing the regime’s or program’s size relative to any given state’s population.

c. *Spillover Prevention*

The third advantage of national control is really a justification for federal intervention—a correction of diseased state governance rather than a true virtue of national governance. The states are sometimes able to externalize the negative effects of their regulatory regimes, distorting their regulatory incentives, and the national government can correct that distortion. The best example of this spillover problem is environmental regulation; the negative effects of under-regulating environmental harms often flow downstream to neighboring states. This problem is the one that gives rise to “races to the bottom” in state regulation.²⁹ Although the national government might also be able to externalize costs onto neighbors—in this case neighboring countries—the national government certainly internalizes more of its own costs than any given state. In a regulatory regime that experiences spillover effects, therefore, the national government might be better motivated to regulate well.

d. *Redistribution*

²⁸ See W. KIP VISCUSI, JOSEPH E. HARRINGTON, JR. & JOHN M. VERNON, *ECONOMICS OF REGULATION AND ANTITRUST* 85–88 (4th ed. 2005).

²⁹ See Frank J. Thompson, *New Federalism and Health Care Policy: States and the Old Questions*, 11 *J. HEALTH POL. POL’Y & L.* 6470 (1986); see also Dale B. Thompson, *Optimal Federalism Across Institutions: Theory and Applications From Environmental and Health Care Policies*, 40 *LOY. U. CHI. L.J.* 437, 444 (2009) (discussing how uniform federal regulation “protects states from ruinous competition”).

The final advantage of national regulation is its ability to redistribute resources from richer to poorer states. In policy regimes in which voters believe that all Americans should receive a minimum floor of public goods or services, the national government can play a role in helping the poorer states to reach that floor.

B. The Functional Federalism of Healthcare

What, then, are the factors that matter most for healthcare regulation? Although American “healthcare regulation” is far from monolithic, we propose that economies of scale, redistribution, and perhaps spillover problems are important throughout the healthcare regulatory complex. Scale, we argue, is the single most important functional factor for every regulatory question that falls under the broad umbrella of “healthcare,” and redistribution seems universally relevant because most Americans seem to believe that all citizens should receive a minimum floor of healthcare coverage.³⁰ Spillovers might also be universally important, depending on the empirical reality of the “snowball effect,”³¹ and spillovers are probably at least sometimes relevant, regardless of whether or not the snowball effect is real. Finally, uniformity is sometimes but not always important in healthcare.

It is also true, of course, that policy diversity, voice, and experimentation are often, if not always, important to healthcare. Those functional values could be protected through cooperative federalist programs that would capture benefits of scale, redistribution, and spillover prevention while relying on state implementation to accomplish diversity, voice, and experimentation. We propose, however, that healthcare regulation will work better if, instead of relying on state implementation to get diversity, voice, and experimentation, the national government simply diversifies its own policy implementation to suit local needs, invests in accurate information about local preferences, and runs its own experiments to test new policy proposals, all of which are things that the central government does in the Medicare program.³²

1. National Advantages in Healthcare

a. Scale

Healthcare regulation, like many other regulatory regimes, has become increasingly objectivist and data-driven over the last several decades. As such, the greatest need is not for voice or diversity—two important factors in subjectivist regulation, which depend on people’s preferences—but rather for scale to gather reliable data. That is, in an objectivist regulatory world, where regulatory decision-making depends on cost-benefit and welfare analyses, the single greatest need is for information. This is particularly true in healthcare, where the market failures that justify government intervention center on informational problems. Healthcare is a credence good, meaning that consumers have a hard time evaluating the quality of healthcare goods both before and after consumption, and it is a good for which there are often asymmetries of information between buyers and sellers. In a market with these particular failures,

³⁰ Several healthcare programs embody and reveal this collective belief, including the recent push for universal insurance through the ACA as well as several older public insurance programs such as Medicare, Medicaid, and SCHIP.

³¹ See Abigail R. Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 889 (2009) [hereinafter Moncrieff, *Federalization Snowballs*].

³² See *infra* Part II.A.3.

government plays a useful role in regulating quality to protect consumers and in gathering and distributing information to help smooth asymmetries. Both of these regulatory projects—both quality control and information provision—are fundamentally objectivist and data-driven projects.³³

But the information on which these projects must rely, namely information about health and medicine, is extremely costly to gather, and it is unreliable if data are gathered from small groups. For example, one individual’s bad experience with a balloon catheter (a medical device used in heart surgery)³⁴ tells us very little about the overall quality of the device, and it tells us very little about the quality of the surgeon who used it. Perhaps the device is inherently faulty and will harm other patients, but perhaps the individual catheter malfunctioned on a fluke.³⁵ Perhaps the surgeon is usually sloppy and will harm future patients, or maybe the surgeon made an uncharacteristic mistake. Or maybe the individual patient simply could not be helped.³⁶ Regulators will not be able to draw reliable conclusions about the device or the surgeon from a single datum.

Instead, in order to reach firm conclusions on which regulators can base their decisions, policymakers need to gather data from many different stories. Regulators need to know what happens when *other* surgeons use the balloon catheter to know whether the catheter suffers from a design or labeling defect. They need to know what happens when the same surgeon uses *other* devices on *other* patients to know whether the surgeon presents a safety threat. And they need to know what happens when other patients interact with the same catheter and the same surgeon to make sure that it isn’t some combination of the catheter and the surgeon that presents a danger. The more stories regulators can collect, the more reliable their conclusions will become. Furthermore, this same need for aggregated data holds for other goals of healthcare regulation, including cost control and access expansion. Across a wide range of healthcare regulations, government benefits from scale—from the authority to gather information about many people from many sources.

In addition to the regulatory need for data, scale is a significant advantage for public provision of healthcare because larger groups are more efficient at sharing risk. The American healthcare regulatory complex largely centers not on interventionist regulation—not on exercises of police power to control cost, quality, and access—but rather on public provision of health insurance. That is, a large portion of the government’s impact on healthcare markets occurs through Medicare, Medicaid, and SCHIP. In those programs, the scale advantages of risk pooling become extremely important; public insurance, like private insurance, will be cheaper per person as more people join the pool. A nationwide program like Medicare, thus, will be cheaper than a state-based program like Medicaid, even if all administrative decisions and costs are held constant between the two programs (obviously a counterfactual assumption).

b. Redistribution

³³ See generally Abigail R. Moncrieff, *The Supreme Court’s Assault on Litigation: Why (and How) it Might be Good for Health Law*, 90 B.U. L. REV. 2323 (2010) [hereinafter Moncrieff, *Assault on Litigation*].

³⁴ See *Riegel v. Medtronic, Inc.*, 552 U.S. 312, 312 (2008).

³⁵ See Moncrieff, *Assault on Litigation*, *supra* note 33, at 2365–67 (detailing a fuller explanation of information costs).

³⁶ *Id.* at 2365–66.

The other functional factor that seems important to healthcare regulation as a whole is redistribution. Although this point rests on a subjective judgment that might be controversial, there seems to be broad agreement among American voters that all citizens are entitled to a minimum baseline of adequate healthcare.³⁷ Certainly, this sentiment underlies the Emergency Medical Treatment and Active Labor Act (“EMTALA”),³⁸ which requires trauma centers, as a condition of Medicare participation, to stabilize any patient regardless of ability to pay.³⁹ And this sentiment justifies public insurance programs for the poor, including Medicaid and SCHIP, which provide baseline coverage to those who are unable to pay. If it is true that voters collectively prefer to guarantee baseline coverage for all Americans, then it makes sense to have the national government play a role in redistributing resources from richer states to poorer states in order to help the poorer states meet that baseline.

Redistribution is also particularly important for programs that need to be counter-cyclical—programs that should spend more when the economy is weaker. Most states have balanced budget requirements and therefore tend not to deficit spend during weak economies, while the federal government, which has no such requirement, can spend beyond its means during economic downturns.⁴⁰ For much of healthcare, this advantage of national control is irrelevant given that most healthcare costs are not counter-cyclical. But public insurance for the poor is. Medicaid, thus, benefits significantly from national contributions because more people will be eligible for the program during tough economic times than during strong economic times. Deficit spending might therefore be necessary for Medicaid.

c. *Spillover Prevention*

According to Professor Moncrieff’s snowball theory, the national government has created a perpetual spillover problem in healthcare by adopting national insurance programs and tax incentives by which the central government bears a substantial portion of the costs of healthcare consumption.⁴¹ Because the national government pays for about forty percent of healthcare consumption, the states externalize a significant portion of their costs when they under regulate or over regulate healthcare in a way that drives up healthcare consumption.⁴² For example, if a state enacts a policy that increases healthcare consumption by one hundred dollars, the state will pay only sixty dollars of that cost. This financial structure distorts the states’ incentives to keep consumption-related spending low. While this problem certainly exists in theory, it is not clear whether it actually influences the states’ decision-making. If it does, then only a full national takeover would fix the problem.⁴³

³⁷ See Aimee Miles, *Public Doesn’t Support Cuts to Health Care Programs*, KAISER HEALTH NEWS (Jan. 25, 2011), <http://www.kaiserhealthnews.org/Stories/2011/January/25/kff-harvard-poll.aspx> (showing that a majority of Americans support continued funding for medical entitlement programs).

³⁸ See 42 U.S.C. § 1395dd (2006).

³⁹ 42 U.S.C. § 1395dd (2006).

⁴⁰ See generally GOVERNMENT ACCOUNTING OFFICE, BALANCED BUDGET REQUIREMENTS: STATE EXPERIENCES AND IMPLICATIONS FOR THE FEDERAL GOVERNMENT (1993), available at <http://archive.gao.gov/d44t15/148877.pdf>.

⁴¹ Moncrieff, *Federalization Snowballs*, *supra* note 31, at 848–49.

⁴² *Id.* at 861–65.

⁴³ See generally *id.* at 868–72, 881.

Even if snowballing does not actually occur, there are other, more traditional spillovers that seem to infect some healthcare regulations. For example, states might not have a full incentive to provide healthcare for the sick and the poor if their sick and poor constituents will move to more generous states. In other words, states might be able to externalize the costs of under-providing public insurance for the poor if their citizens are mobile. On the other side, states might externalize the *benefits* if they *do* provide such insurance because healed constituents might leave the state's economy after benefiting from public insurance. In short, the citizenry's mobility might cause healthcare costs and benefits to spill over from state to state. This problem might cause a traditional "race to the bottom" in public insurance for the poor in the absence of national involvement.

d. Uniformity

The most famous justification for national governance is probably the least relevant functional federalism factor in the healthcare regime. Only for employer-sponsored insurance ("ESI") does uniformity seem to be a compelling need. For ESI, employers that operate across state lines benefit from uniform regulations of health insurance—a benefit that is embodied in the Employee Retirement Income Security Act of 1974 ("ERISA")⁴⁴ and to a lesser extent in the Health Insurance Portability and Accountability Act ("HIPAA").⁴⁵ In the actual practice of medicine, however, there are few entities that operate across state lines; doctors and hospitals tend to practice in single jurisdictions. In the individual and small group markets for health insurance, only a handful of national companies sell policies in multiple states. For the most part, then, uniformity is not a compelling need in the modern healthcare market. That said, the benefits of scale would apply to private health insurance as well as public, and if the regulatory regime were uniform, more national insurance companies might emerge and might be able to sell cheaper policies on the small group and individual markets—one of the goals of the ACA's insurance exchanges.

2. State Advantages in Healthcare

a. Experimentation

The most significant benefit of state involvement in healthcare is experimentation. As noted above, the greatest need in healthcare regulation is for information, and one invaluable means of generating information is through real-world experimentation. If the states choose different policy approaches to manage the costs of, quality of, and access to healthcare, then regulators might learn which approaches work and which do not. At a minimum, regulators would learn more through the states' various attempts than they ever could from a single, uniform national policy.

There are, however, limits to the usefulness of state-based experiments. The biggest such limit is the demographic and sociological diversity among the states, which frustrates attempts to draw causal conclusions about the legal and policy approaches tried. In other words, California's experience with damages caps for medical malpractice does not tell us enough about Vermont's likely experience with the exact same caps. It is too difficult (if not impossible) to regress out the countless variables that distinguish California from Vermont, many of which might matter to the medical malpractice environment.

⁴⁴ See Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2006).

⁴⁵ See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified in various sections of titles 18, 29, 42, and 26 of the U.S.C.).

A second important limit is the insufficiency of one state's incentive to gather, keep, and distribute reliable data about its own experiences with its own policy choices. If California gathered and kept such data, it might benefit the state to some extent, but California itself could probably draw conclusions by observation, without detailed data or analysis. The benefit of such investment in useable data, thus, would accrue primarily to other states and to the central government.⁴⁶ California cannot recapture those externalized benefits, as by selling its data, and it therefore has an incomplete incentive to invest in the relevant information. This problem is essentially a spillover problem that justifies some national involvement.

b. Voice

Two aspects of modern regulation render voice less important than it used to be as an advantage of state government. First, the increasingly objectivist nature of healthcare regulation diminishes the traditional importance of voice in regulatory decision-making. Second, the increasing ease of communication makes small constituencies less necessary for capturing the benefits of voice. If voters' subjective preferences are not driving policy, then there is no need to place policy-making responsibility in the hands of a government that is particularly responsive to those preferences. Large government can do a fine job—indeed, a better job given the scale advantages identified above—of collecting the information that is relevant to objectivist regulation. Nevertheless, there are certainly some healthcare regulations that depend—or should depend—on subjective preference, including basic willingness to pay for various kinds of healthcare goods, and for those aspects of healthcare regulation, voice might be important. Furthermore, even for objectivist regulation, smaller governments might be better at the on-the-ground project of gathering data and information. But with modern communications technology, information about local needs and preferences no longer depends on physical closeness to the information source. The federal government, thus, might be able to replicate state advantages, though there is still an argument to be made that state governments have stronger electoral incentives to pay attention to local needs and preferences.

c. Diversity and Exit

As with voice, diversity and exit seem less important in a world of objectivist regulation. In such an objectivist world, local *preferences* are less important than local *needs*, and needs seem less likely than preferences to diverge on a state-by-state basis. Nonetheless, there might be divergent needs among states, and there might be aspects of healthcare regulation that ought to depend on preference. For example, perhaps state populations should be free to decide—independently of other states' preferences—how much they are willing to spend on public healthcare; that might be a legitimate variable preference. It is certainly true that the cost of healthcare varies geographically, meaning that even uniform public insurance programs will have variable financial needs. At a minimum, different states have different demographic

⁴⁶ Texas, however, keeps surprisingly meticulous records of its healthcare outcomes. See Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1998–2002*, 2 J. OF EMPIRICAL LEGAL STUD. 207 (2005); see also TEX. DEP'T OF INS., TEXAS CLOSED CLAIM REPORTING GUIDE (2009) (illustrating the process by which a closed claim is submitted to the TDI), available at <http://www.tdi.state.tx.us/company/documents/CCGuide2009.doc>; TEX. DEP'T OF INS., MEDICAL MALPRACTICE INSURANCE: OVERVIEW AND DISCUSSION (2003) (synthesizing the data from the claim reports into various charts and graphs), available at <http://www.tdi.state.tx.us/hprovider/documents/spromptpay.pdf>.

characteristics, and those characteristics might be relevant to both healthcare preferences and healthcare needs. As such—and particularly given the absence of a compelling need for uniformity in healthcare—the national government might want to allow divergences of healthcare policy across the country.

The exit-based advantages of policy diversity might also hold for healthcare regulation, though the existence of spillovers and the potential for races to the bottom undercut that point. If taxpayers are likely to leave states with generous public benefits for the poor and the sick, the competition among states for those taxpayers will result in too little public assistance relative to whatever the optimal level might be. That said, national control of healthcare certainly would decrease exit opportunities if the central government set a uniform policy nationwide.

3. Capturing and Improving on State Advantages through National Regulation

Given the virtues that the states can bring to the project of healthcare regulation—however limited they might be—our readers might wonder why we advocate complete nationalization of healthcare policy. At a minimum, our arguments so far support a role for state implementation so that states can diversify and experiment at the margins. This “cooperative federalist” model is, in fact, the one that Congress has chosen for Medicaid, for which the national government sets a host of standards but allows states flexibility in complying with those standards and even allows states to violate some such standards if granted a waiver for experimentation. The ACA expanded this particular cooperative federalist structure in its Medicaid provisions and relied on a similar federalist structure for the exchanges.⁴⁷

Importantly, though, Medicaid is not the only national healthcare program that runs experiments or that responds to local needs and preferences. Medicare does, too. It just does so without relying on state agencies for any policy design or implementation. The Medicare program frequently runs demonstration projects to experiment with new policy ideas, and its local fiscal intermediaries make diversified decisions about coverage and compensation to meet differing local needs.⁴⁸ Furthermore, Medicare can redistribute, diversify, and experiment on a more fine-tuned basis than the states because it is not governed by state boundaries; it can run single programs for constituencies that stretch across state lines just as easily as it can run programs for sub-constituencies within a given state, for state-wide constituencies, or for the national constituency. And, of course, this national program does a better job than Medicaid of capturing economies of scale, redistributing resources across state lines, avoiding spillover effects in its regulatory decisions, and achieving uniformity of standards where necessary or appropriate. In short, Medicare is a compelling model for a fully national healthcare program that captures many advantages of state governance. Furthermore, because the national government can run localized programs without the arbitrary constraints of state borders and can govern regulatory regimes with a fully internalized incentive to gather and keep detailed information, the national government certainly has a greater *capacity*—a greater theoretical ability—in the modern objectivist world to capture the benefits traditionally ascribed to state governance.

⁴⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of the U.S.C.) [hereinafter ACA].

⁴⁸ See generally CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEMONSTRATION PROJECTS AND EVALUATION REPORTS (2010).

III. THE SUCCESSES AND FAILURES OF THE ACA

This section uses the functional federalism analysis to evaluate four key parts of the ACA: the health and wellness incentives, the Medicaid expansion, the new regulations of private insurance, and the establishment of insurance exchanges. In each area, the ACA increased national control relative to the pre-ACA world. Yet because many of the new programs follow the “cooperative federalism” model, they fall short of national governance while gaining few state advantages in return. Worse still, the ACA replicated and extended the same “cooperative federalism” headaches of the past, despite the fact the 111th Congress apparently recognized these potential problems.⁴⁹ From a functional federalism standpoint, future congresses should fix these errors and further centralize healthcare regulation.

A. *Health and Wellness Incentives*

The ACA takes a decidedly national approach toward promoting wellness that, in our view, succeeds under the functional federalism framework. The wellness incentives in the ACA include menu labeling requirements, data gathering, and project grants for redistribution and experimentation.

In an effort to fight obesity and to create greater awareness for healthy diets, the ACA ushers in national menu labeling requirements for restaurants and retail food establishments with twenty or more locations.⁵⁰ These restaurants are now required to display “in a clear and conspicuous manner” the caloric content of each item as well as the suggested daily calorie intake.⁵¹ These restaurants must also have standard nutritional information about their food items available to their consumers in written form and on their premises.⁵² Because the menu-labeling requirement applies to chain restaurants, regulatory uniformity provides at least some advantage because there is no need to suffer compliance costs from variable policies across state lines. Thus, the nationalizing of menu labeling is an appropriate measure.

The ACA also seeks to improve public health by leveraging the national government’s scale to uncover the nation’s healthcare disparities through data collection and dissemination. Starting in 2012, “any federally conducted or supported health care or public program, activity, or survey” must “collect and report, to the extent practicable, (A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants, (B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated, (C) sufficient data to generate statistically reliable estimates . . . [of] subgroups for applicants, recipients, or participants,” and (D) “any other demographic data as deemed appropriate” by the Secretary of the Health and Human Services (“HHS”) regarding health disparities.⁵³ Any data collected regarding racial and ethnic minority groups must also be collected regarding underserved rural populations.⁵⁴ The data must be available to relevant

⁴⁹ For example, the ACA permits national involvement in the exchanges as a substitute if the states fail. ACA § 1321(c)(1)(B)(ii)(II), 124 Stat. at 186 (to be codified at 42 U.S.C. § 18041).

⁵⁰ ACA § 4205(b), 124 Stat. 119, 573–74 (2010) (to be codified at 21 U.S.C. § 343).

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.* sec. 4302 § 3101, 124 Stat. 119, 578–79 (to be codified at 42 U.S.C. § 300kk).

⁵⁴ *Id.* at 581.

federal administrative bodies, such as Centers for Medicaid & Medicare Services (“CMS”).⁵⁵ The Secretary must report the data through the HHS website, and she may make the data available for further research to non-governmental entities and the public.⁵⁶ These national requirements will apply to data collection under state plans and SCHIP as well.⁵⁷

This type of data collection and dissemination effort is best done at the national level to capture the greatest amount of reliable data and to minimize administrative costs. Because of the way that HHS must collect the data, this effort will shed greater light not only on national healthcare trends, but on local ones as well. Because the national government shoulders a significant portion of healthcare costs, it alone has the proper incentives to collect and to disseminate data as well as to encourage states and regulated industries to solve the demonstrated problems.

The ACA also seeks to promote wellness and prevention through targeted redistribution and experimentation. These national efforts can reach a broader population while ensuring that local needs are addressed. The law establishes the Prevention and Public Health Fund—a dedicated national funding mechanism administered by HHS that will “provide for [an] expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth” of health care costs.⁵⁸ The fund began with \$500 million in 2010 and will grow to two billion dollars by 2015.⁵⁹

In addition to the Fund, the ACA mandates the Secretary of HHS to award competitive “community transformation grants” to state and local governmental agencies and to community-based organizations that want to implement evidence-based community preventive health plans to reduce chronic disease rates and to address health disparities across the country.⁶⁰ In creating this section, Congress appears to have been focused on ensuring that experimentation will bear fruit because the law requires the Director of the Centers for Disease Control and Prevention to provide a literature review and to establish the framework for evaluating the plans as part of the grant program. The Director must also “work[] with academic institutions or other entities with expertise in outcome evaluation.”⁶¹ Grantees must meet at least annually to discuss “best

⁵⁵ *Id.* at 580.

⁵⁶ *Id.*

⁵⁷ *Id.* at 581.

⁵⁸ *Id.* § 4002(a), 124 Stat. at 541 (to be codified at 42 U.S.C. § 300u-11).

⁵⁹ *Id.* As of September 2010, HHS has awarded nearly \$100 million in grants to promote HIV/AIDS prevention and testing, to “increase epidemiology, laboratory and health information systems capacity,” and to assist other efforts such as reducing obesity and smoking. *See* Press Release, Office of Health and Human Services, HHS Awards Nearly \$100 Million in Grants for Public Health and Prevention (Sept. 24, 2010), *available at* <http://www.hhs.gov/news/press/2010pres/09/20100924a.html>. Since December 2010, however, some members of Congress have been looking to scale back funding for the Fund. *See, e.g.*, Sarah Kliff, *Doc Fix New Weapon vs. Health Reform*, POLITICO, Dec. 5, 2010, <http://www.politico.com/news/stories/1210/45976.html#ixzz17L6takUE>; David Nather, House GOP Targets Health Care Funding, POLITICO, Feb. 11, 2011, <http://www.politico.com/news/stories/0211/49385.html>.

⁶⁰ ACA sec. 10403, 124 Stat. 119, 975 (2010) (to be codified at 42 U.S.C. § 300u-13).

⁶¹ *Id.* § 4201(d)(3), 124 Stat. at 541.

practices” and “lessons learned,” and they must “develop models for the replication of successful programs and activities and the mentoring of other eligible entities.”⁶² Unlike experimentation through Medicaid waivers, these grants can rely on private organizations that are not bound by state borders, and the regulatory structure ensures that a national agency is charged with collecting results from the experiments. Depending on the degree of latitude afforded to the state agencies, this program could become another example, like Medicare demonstration projects, of useful national experimentation.

A similar focus on evaluation is also in place for the ACA’s authorization of HHS grants to state and local health departments and Indian tribes to carry out five-year pilot programs to improve the health of Americans from fifty-five to sixty-four years of age.⁶³ Small employers may also receive HHS grants, but the ACA does not contain statutory language requiring national agencies to evaluate results of those experiments. These small employer grants will go toward providing employees with “comprehensive workplace wellness programs,” as defined by HHS, but these grants must be “based on and consistent with evidence-based research and best practices.”⁶⁴

B. Medicaid Expansion

The ACA uses Medicaid as a primary vehicle to expand healthcare to the uninsured. Although the law has brought greater consistency to the program by nationalizing eligibility standards and increasing national funding, the ACA nevertheless perpetuates the cooperative federalist structure. States remain largely responsible for implementation or, in their view, left with problems like managing enrollment and controlling costs.⁶⁵ The only silver lining to the ACA’s failures may be that its reforms have inched the ball closer to nationalizing Medicaid.

Before the ACA, only limited categories of low-income individuals—children, pregnant women, the disabled, and seniors—were eligible for Medicaid. Because of the program’s cooperative federalist structure, states had the discretion to expand eligibility requirements, subject to federal rules. Consequently, Medicaid eligibility varied state to state, and the program was an uneven safety net dependent on state political will, policy preferences, and budgets.

The ACA replaces that patchwork with a more uniform and equitable standard. Starting in 2014, nearly all individuals under sixty-five with incomes up to 133% of the federal poverty level will be eligible for Medicaid. By streamlining eligibility requirements, the ACA opens Medicaid (and SCHIP) to about sixteen million new people, which raises the cost of administering the program.⁶⁶ To pay for this expansion, the national government significantly increased its share of Medicaid funding through the Federal Medical Assistance Percentage (“FMAP”). Specifically, to cover the care of the “newly eligible,” states will see FMAP cover

⁶² *Id.* § 4201(c)(5)(A)–(B), 124 Stat. at 541.

⁶³ *Id.* § 4202(a)(1), 124 Stat. at 566 (to be codified at 42 U.S.C. § 300u-14).

⁶⁴ *Id.* § 10408(a), 124 Stat. at 583 (to be codified at note, 42 U.S.C. § 2801).

⁶⁵ Janet Adamy, *U.S. News: GOP Governors Seek Leeway to Cut Medicaid*, WALL ST. J., Jan. 7, 2011, at A2.

⁶⁶ Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office to Nancy Pelosi, Speaker U.S. House of Representatives (Mar. 20, 2010), *available at* <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

100% of the differential from 2014 to 2016, 95% in 2017, and 90% in 2020 and thereafter.⁶⁷ This increased national contribution ensures that poorer states receive some redistributive assistance in reaching the floor of acceptable coverage. Additionally, to help poorer states bolster their minimum floor of healthcare, the ACA will also increase FMAP, “subject to various requirements, . . . for certain disaster-affected states, primary care payment rate increases, specified preventive services and immunizations, smoking cessation services for pregnant women, specified home and community-based services, and health home services for certain people with chronic conditions.”⁶⁸

Lawmakers correctly realized that this dramatic increase in Medicaid coverage would require greater national contributions to offset the states’ costs. The increase in national funding is a good thing; state budgetary constraints and shortfalls made it unlikely for states to raise their minimum level of healthcare. Unfortunately, except to cover the care of the “newly eligible,” the FMAP funding mechanism is only partial assistance. The states must still balance federal financial incentives against their own needs and will probably continue to scale back coverage to the poor during economic downturns.

Additionally, fully nationalizing the funding of Medicaid would have given the national government more power to control costs and run experiments as it does in Medicare. If Medicaid waivers have taught us anything, it is that state experimentation in this program teaches us very little.⁶⁹ The system, rather than a thoughtfully structured process to produce and replicate good policy nationwide, has become a vehicle for states to execute their individual preferences haphazardly under lax federal supervision and an instrument for the national government to push its agenda without regard to useful experimentation.⁷⁰

In other respects, the ACA exemplifies the national government’s potential for experimentation and innovation. The statute orders the Secretary of HHS to establish four different demonstration projects: (1) a project on the use of bundled payments for the provision of integrated care around hospitalization,⁷¹ (2) a project on hospital payments under a global capitation payment model,⁷² (3) a project authorizing states to allow qualified pediatric medical providers to be recognized as an accountable care organization,⁷³ and (4) a project requiring states to make payments to an institution of mental diseases for certain services for Medicaid

⁶⁷ Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1201, 124 Stat. 1029, 1051 (2010).

⁶⁸ EVELYNE P. BAUMRUCKER, CONG. RESEARCH SERV., RL32950, MEDICAID: THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) 12 (2010).

⁶⁹ See generally Frank J. Thompson & Courtney Burke, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. HEALTH POL., POL’Y & L. 971 (2007).

⁷⁰ See generally *id.* and JESSE CROSS-CALL AND JUDITH SOLOMON, CTR. ON BUDGET & POLICY PRIORITIES, RHODE ISLAND’S GLOBAL WAIVER NOT A MODEL FOR HOW STATES WOULD FARE UNDER A MEDICAID BLOCK GRANT (2011), <http://www.cbpp.org/files/3-16-11health2.pdf>.

⁷¹ ACA, Pub. L. No. 111-148, sec. 1201 § 2704, 124 Stat. 119, 323 (2010) (to be codified at note, 42 U.S.C. § 1396a).

⁷² *Id.* sec. 1201 § 2705, 124 Stat. at 324 (to be codified at note, 42 U.S.C. § 1315a).

⁷³ *Id.* sec. 1201 § 2706, 124 Stat. at 325 (to be codified at note, 42 U.S.C. § 1396a).

beneficiaries between the ages of twenty-one and sixty-five.⁷⁴ Each project has different provisions on how HHS, or other entities, is supposed to evaluate and report the resulting data.⁷⁵

The ACA's efforts regarding Medicaid benefits, however, are to some extent disappointing. The ACA does not require states to offer full Medicaid benefits to the "newly eligible."⁷⁶ Instead, the "newly eligible" will receive limited benefits packages commonly referred to as benchmark or benchmark-equivalent plans.⁷⁷ In 2005, Congress gave states the flexibility to create these benefit packages as a way to reduce federal entitlement spending.⁷⁸ Benchmark plans need only be equivalent to coverage under the Federal Employees Health Benefits Program ("FEHBP"), coverage offered to state employees, an HMO Plan that has the largest insured commercial (non-Medicaid) enrollment in the state, or any coverage approved by the Secretary of HHS as meeting the needs of the population to be covered.⁷⁹ At the same time, apparently aware of how varied these benchmark plans could be, the ACA does attempt to bring some uniformity and redistributive effect to the Medicaid benefits of the "newly eligible." It requires that benchmark plans include "essential health benefits,"⁸⁰ and they are also required to cover prescription drugs and mental health services.⁸¹

Ultimately, however, the ACA's approach to Medicaid does not harness enough of the national government's advantage in healthcare regulation. Once again, state implementation will dampen the advantages of national administration. The differences between full Medicaid benefits and benchmark plans may be difficult not only for Medicaid beneficiaries who see a change in their circumstances,⁸² but also for the states who must deal with the administrative headaches. The variance in funding—a significantly greater FMAP for the newly-eligibles than the pre-PPACA Medicaid population—may also create administrative troubles for the states in addition to the differentials in healthcare access and quality among the poor. In short, the greatest disappointment is that ACA forewent an opportunity to turn Medicaid into a fully national program like Medicare. Public insurance benefits from economies of scale, and national programs can still experiment. The Medicare model is functionally superior.

⁷⁴ *Id.* sec. 1201 § 2707, 124 Stat. at 326.

⁷⁵ *Id.* sec. 1201 § 2704-2707, 124 Stat. at 323–28.

⁷⁶ *Id.* § 2001, 124 Stat. at 271–76 (to be codified at 42 U.S.C. § 1396b). These benefits remain available only to those specified by federal law, such as dual eligibles and persons with disabilities. JOCELYN GUYER AND JULIA PARADISE, THE HENRY J. KAISER FAM. FOUND., EXPLAINING HEALTH REFORM: BENEFITS AND COST-SHARING FOR ADULT MEDICAID BENEFICIARIES 3 (2010), available at <http://www.kff.org/healthreform/upload/8092.pdf> [hereinafter EXPLAINING HEALTH REFORM].

⁷⁷ ACA § 2001, 124 Stat. at 271.

⁷⁸ See generally DAVID RUBIN ET AL., CASEY FAM. PROGRAMS, THE DEFICIT REDUCTION ACT OF 2005: IMPLICATIONS FOR CHILDREN RECEIVING CHILD WELFARE SERVICES (2006), available at <http://www.healthychild.ucla.edu/Publications/TheDeficitReductionActOf2005.pdf>.

⁷⁹ 42 C.F.R. § 440.330 (2010).

⁸⁰ "Essential health benefits" refers to the package of benefits that the law also requires of plans provided through the state exchanges. See ACA § 1302, 124 Stat. at 163–68 (to be codified at 42 U.S.C. § 18022).

⁸¹ *Id.* § 2001(c)(2)(B)(ii), 124 Stat. at 277 (to be codified at 42 U.S.C. § 1396u-7).

⁸² EXPLAINING HEALTH REFORM, *supra* note 76, at 5.

C. Private Insurance Regulations

The ACA contains numerous regulations designed to overhaul the private insurance market in favor of greater coverage and consumer protections. These rules best reflect the national government’s ability to prevent “races to the bottom” and to set uniform standards to level the marketplace, foster competition, and benefit the consumer. For example, the ACA requires the Secretary of HHS, along with National Association of Insurance Commissioners (“NAIC”), to develop national standards for group health plans and health insurance issuers to use in their summaries and explanations of their plans’ benefits and coverage.⁸³ These standards must detail a uniform format, standard definitions, the required content, and they must be subject to periodic review.⁸⁴

The ACA also establishes an “essential health benefits package,” that must be available to consumers through the exchanges in 2014.⁸⁵ This provision gives the federal government the power to determine and standardize a federal floor that guarantees a minimum level of benefits. The new law contains several services that it lists as mandatory, such as ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, and pediatric services.⁸⁶ Currently, only twenty-four states mandate standardized plans in their small group markets while just twelve states have standardized plans in their individual markets.⁸⁷

The Secretary of HHS must ensure that the scope of the benefits is equivalent to “a typical employer plan,” and she must factor several enumerated criteria in determining the package (e.g., the balance of benefits and the health needs of diverse segments of the population). She must also periodically review and report to Congress whether modifying the package is needed.⁸⁸ Qualified health plans must offer at least one “silver level” plan (benefits that are actuarially equivalent to seventy percent of the full actuarial value) and at least one “gold level” plan (benefits that are actuarially equivalent to eighty percent of the full actuarial value).⁸⁹

The ACA also explicitly prohibits the practice of rescission, or post-claims underwriting.⁹⁰ State laws governing rescission, guaranteed-issue, and preexisting conditions

⁸³ ACA § 1323(b), 124 Stat. at 192–5 (to be codified at 42 U.S.C. § 18043).

⁸⁴ *Id.* § 1001, 124 Stat. at 130–38 (to be codified in scattered sections of 42 U.S.C.).

⁸⁵ *Id.* § 1302, 124 Stat. at 163–68 (to be codified at 42 U.S.C. § 18022).

⁸⁶ *Id.* § 1302(b)(1), 124 Stat. at 163–64.

⁸⁷ HEALTH POL’Y INST., GEORGETOWN UNIV., THE HENRY J. KAISER FAM. FOUND., STANDARDIZED PLANS IN THE SMALL GROUP MARKET, AS OF JAN. (2009), *available at* <http://www.statehealthfacts.org/comparereport.jsp?rep=7&cat=7>; HEALTH POL’Y INST., GEORGETOWN UNIV., THE HENRY J. KAISER FAM. FOUND., STANDARDIZED PLANS IN THE SMALL GROUP MARKET, AS OF MAR. (2009), *available at* <http://www.statehealthfacts.org/comparereport.jsp?rep=6&cat=7>.

⁸⁸ ACA § 1302(b)(2)–(4), 124 Stat. at 164–65..

⁸⁹ *Id.* §§ 1301(a)(1)(C)(ii), 1301(d)(1)(B)–(C), 124 Stat. at 162–63, 167 (to be codified at 42 U.S.C. § 18021).

⁹⁰ *Id.* § 2712, 124 Stat. at 131 (to be codified at 42 U.S.C. § 300gg-12).

varied dramatically pre-ACA.⁹¹ Prior to the ACA’s passage, only five states required any health insurer to accept every applicant, only one state required state pre-approval of rescissions, and more than half a dozen states failed to define preexisting condition entirely.⁹² Congress found that most states “were unable to answer basic questions about rescissions” occurring in their individual insurance markets.⁹³ Under this fractured regulatory environment, some insurers aggressively rescinded coverage, often linking employee bonuses to canceling coverage despite affecting innocent policyholders.⁹⁴ In fact, before the ACA’s passage, some insurance companies pointedly refused to limit rescissions only to policyholders who fraudulently obtain coverage.⁹⁵

The ACA correctly replaces the mess with a simpler standard: a bar on group health plans and issuers in individual markets from rescinding coverage except in situations of fraud or intentional misrepresentation.⁹⁶ The current law also permits states to be more protective than the new federal floor, and it requires prior notice—at least thirty calendar days—before coverage can be retroactively discontinued.⁹⁷

The ACA also establishes a national minimum medical loss ratio (“MLR”) requirement. Prior to the ACA, only “a handful of states” required a MLR of seventy-five percent from individual or small-group insurers.⁹⁸ Large group plans must now meet a MLR of eighty-five percent, while individual and small group plans must hit eighty percent.⁹⁹ States can establish a higher MLR if they choose, though the Secretary of HHS may adjust the rates “on account of the volatility of the individual market” in each state.¹⁰⁰ Insurers must submit annual reports of their costs and earned premiums to the Secretary, and those that fail to meet the relevant MLR must issue annual rebates to their policyholders on a pro rata basis.¹⁰¹ HHS has already issued an

⁹¹ See HILARY HAYCOCK ET AL., ROBERT WOOD JOHNSON FOUND., PRIMER ON POST CLAIMS UNDERWRITING AND RESCISSION PRACTICES 6–7 (2009), available at <http://www.rwjf.org/files/research/texascasesstudyaug2009.pdf>.

⁹² *Id.*

⁹³ Memorandum from the H. Comm. on Energy and Commerce Staff to the Members and Staff of the Subcomm. on Oversight and Investigations 3 (June 16, 2009), available at http://democrats.energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf.

⁹⁴ Lisa Girion, *Health Care: Roads to Reform; Insurers Refuse to Limit Policy Cancellations; Lawmakers Ask Three Executives If They’ll Stop Dropping Honest Customers. All Say No.*, L.A. TIMES, June 17, 2009, at B1.

⁹⁵ *Id.*

⁹⁶ ACA § 1001, 124 Stat. 119 (2010) (to be codified in scattered sections of the U.S.C.).

⁹⁷ ACA, 75 Fed. Reg. 37,188, 37,192 (June 28, 2010) (to be codified at 45 C.F.R. pts. 144, 146, & 147).

⁹⁸ FAMILIES USA, MEDICAL LOSS RATIOS: EVIDENCE FROM THE STATES 1 (2008), <http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf>.

⁹⁹ ACA sec. 10101 § 2708 124 Stat. at 883 (2010).

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

interim final rule that details the reporting and rebate requirements as well as the enforcement mechanisms.¹⁰²

Another immediate reform of the ACA is the ability of the Secretary of HHS to review insurance premium increases. The law orders the Secretary, “in conjunction with the states,” to establish an annual review of “unreasonable” premium increases.¹⁰³ Insurers that seek “unreasonable” increases must justify their plans and must disclose their justifications prominently on their website. HHS has issued a proposed rule stating that for 2011, it will review increases of ten percent or more.¹⁰⁴ Beyond 2011, the review will either remain at ten percent or be at a state-specific threshold established by the Secretary.¹⁰⁵ Yet even with this review process, HHS cannot reject the proposed increases; insurers that unreasonably increase their premiums only need to submit a final justification.¹⁰⁶ A final determination as to whether they can go through with the increase will depend on state law.¹⁰⁷

These ACA provisions represent a significant step forward in the national regulation of insurance. Yet, upon closer examination, a less positive picture appears. Despite the establishment of national standards, much of the law depends on state implementation and enforcement. Aware of this issue, the NAIC conducted several surveys “in an attempt to determine states’ ability to enforce the federal consumer protections scheduled to become effective plan years beginning on or after September 23, 2010.”¹⁰⁸ In a letter to Secretary Kathleen Sebelius, NAIC lauded the fact that “almost half of the states have concluded that they have the ability to enforce the federal law either through explicit state laws or general powers granted to the commissioner.”¹⁰⁹ It also stressed that “almost all states can use their form approval process, investigative powers, and/or market conduct exam authority to hold licensed insurers accountable for their compliance with the federal laws.”¹¹⁰ The NAIC concluded that these efforts, “combined with coordinated enforcement by the federal regulators, should be sufficient to ensure carriers comply with the new requirements.”¹¹¹

Although the NAIC couched its survey results positively, there is still reason for concern. That “[a]lmost half of the states” can enforce these national standards *means more than half cannot*. For these states, how aggressively will they hold insurers accountable? Without a centralized effort, enforcement will be spotty and recalcitrant states may undo the newly achieved national standard. In fact, in the NAIC survey, Arizona responded, “In light of our

¹⁰² Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 74,864 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158).

¹⁰³ ACA § 1003, 124 Stat. at 139 (to be codified at 42 U.S.C. § 300gg-94).

¹⁰⁴ Rate Increase Disclosure and Review, 75 Fed. Reg. 81006, 81010 (proposed Dec. 23, 2010) (to be codified at 45 C.F.R. pt. 154).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 81015.

¹⁰⁷ *Id.* at 81016.

¹⁰⁸ Letter from Jane Cline, President, Nat’l Ass’n of Ins. Comm’n, to Kathleen Sebelius, Sec’y, U.S. Dep’t of Health and Human Serv. (August 5, 2010), http://www.healthreformgps.org/wp-content/uploads/index_health_reform_section_letter_kathleen_sebelius-1.pdf.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

state's participation in the multi-state lawsuit over the [ACA], it seems unlikely that [we] will pass legislation expressly authorizing any agency to enforce the [ACA] in the near future."¹¹² Moreover, in 2009, Arizona Governor Jan Brewer instituted an indefinite rule-making moratorium, explaining that the state had "no plans to adopt rules related to [ACA] enforcement."¹¹³

With regard to reviewing increases in health insurance premiums, inconsistent state enforcement is already emerging due to different state practices, resources, and regulatory authority.¹¹⁴ Furthermore, the HHS-proposed rule suggests that the national government will not be an independent source of aggressive enforcement. Instead, the rule places HHS in a deferential posture to the states, stating that the ACA provision "only supplement[s] and complement[s], rather than supplant[s], and do[es] not interfere with, existing State laws and processes for rate review."¹¹⁵ As long as a state has an effective rate review program, as determined by HHS, HHS will "adopt [the state's] determination and will not conduct an independent review of the state's determination."¹¹⁶

If HHS rulemakers believe all states will implement this national standard effectively, they are too optimistic. Last December, the Kaiser Family Foundation released a fifty-state survey in which they highlighted the drastically different approaches that states have toward rate review.¹¹⁷ The report made several discomfoting conclusions. Notably, most states make "little or no effort to make rate filings transparent" and "[m]any states lack the capacity and resources to conduct an adequate review."¹¹⁸

Oddly, Congress recognized that states would have difficulty implementing this provision because the ACA authorizes HHS to dole out grant money for states to strengthen their rate review programs until 2014. In August 2010, HHS issued the first of these grants, totaling \$46 million to forty-five states and the District of Columbia.¹¹⁹ Based on what these states plan to do with the money, such as increasing the transparency and the scope of the rate review process, it appears the states also recognize that they currently lack sufficient authority. The states should take this opportunity and money to better their processes for enforcement of the provision.

Not all provisions, however, have accompanying grants for states. While states may be

¹¹² NAT'L ASS'N OF INS. COMM'N, SURVEY ON STATE AUTHORITY TO ENFORCE PPACA IMMEDIATE IMPLEMENTATION PROVISIONS 2 (2010).

¹¹³ *Id.*

¹¹⁴ Lisa Lambert, *Inconsistencies Mar States' Insurance Rate Reviews*, REUTERS, Dec. 2, 2010, <http://www.reuters.com/article/2010/12/02/us-usa-states-insurance-idUSTRE6B168X20101202>.

¹¹⁵ Rate Increase Disclosure and Review; Proposed Rule, 75 Fed. Ref. 246, 81005 (Dec. 23, 2010) (to be codified at 45 CFR pt. 154).

¹¹⁶ *Id.* at 81007.

¹¹⁷ THE HENRY J. KAISER FAMILY FOUND., RATE REVIEW: SPOTLIGHT ON STATE EFFORTS TO MAKE HEALTH INSURANCE MORE AFFORDABLE 1 (2010), <http://www.kff.org/healthreform/upload/8122.pdf>.

¹¹⁸ *Id.* at 2.

¹¹⁹ *Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities*, HEALTHCARE.GOV, <http://www.healthcare.gov/news/factsheets/rateschart.html> (last visited Mar. 15, 2010).

better rate reviewers, other federal standards will go under-enforced.¹²⁰ For all its groundbreaking, the ACA should not have ceded so much to state implementation.

D. Exchanges

Finally, the ACA embraces a muddled federalism as its structure for the new, post-reform health insurance market. Instead of creating a national insurance market for consumers and insurers alike, the ACA creates state-based insurance exchanges that may distort the regulatory effects of its reforms and hamper Americans' ability to obtain coverage. The current framework may have been necessary as a matter of politics, but it is flawed as a matter of policy. Implementing state-based exchanges prioritizes cooperative federalism at the expense of fulfilling the legislation's policy goals effectively.

1. The Framework Behind the State-Based Exchanges

The ACA mandates each state to create an "American Health Benefit Exchange" to "facilitate[] the purchase of qualified health plans" by 2014.¹²¹ Each state must also create a "Small Business Health Options Program," or SHOP exchange, for employers with 100 or fewer employees to enroll their employees in qualified health plans.¹²² The two exchanges may be combined "only if [a combined exchange] has adequate resources to assist" both individuals and small employers.¹²³ All exchanges must be run by a state government agency or a state-established nonprofit entity.¹²⁴ The establishment of exchanges does not prohibit health insurance issuers from offering nor individuals and employers from enrolling in health plans outside of the exchanges.¹²⁵ Nevertheless, issuers must treat individuals inside and outside the exchange as part of a single risk pool.¹²⁶ This rule applies to small employers inside and outside of the exchange as well.¹²⁷

Each exchange must execute, among other responsibilities, a rating system for each qualified health plan it offers, a website for consumers to compare plans, and a system to inform potential enrollees of their eligibility for SCHIP, Medicare, or other state and local programs.¹²⁸ The law requires the Secretary of HHS to issue grants to states as seed money to help establish their exchanges, but this funding ends by 2015.¹²⁹ After 2015, the exchanges must be self-

¹²⁰ See Timothy S. Jost, *Implementation and Enforcement of Health Care Reform – Federal versus State Government*, NEW ENG. J. MED. (January 14, 2010), <http://www.nejm.org/doi/full/10.1056/NEJMp0911636> [hereinafter Jost, *Implementation and Enforcement of Health Care Reform*].

¹²¹ ACA, Pub. L. No. 111-148, § 1311(b)(1), 124 Stat. 119, 173 (2010) (to be codified at 42 U.S.C. § 18031).

¹²² *Id.* §§ 1311(b)(1)(B), 1304(b)(2), 124 Stat. at 173, 172 (to be codified at 42 U.S.C. §§ 18031, 18024).

¹²³ *Id.* § 1311(b)(2), 124 Stat. at 173–74.

¹²⁴ *Id.* § 1311(d)(1), 124 Stat. at 176.

¹²⁵ *Id.* § 1312(d), 124 Stat. at 183–83 (to be codified at 42 U.S.C. § 18032).

¹²⁶ *Id.* § 1312(c)(1) 124 Stat. at 182.

¹²⁷ *Id.* §§ 1312(c)(2)–(3), 124 Stat. at 182.

¹²⁸ *Id.* § 1311(d)(4), 124 Stat. at 176–77 (to be codified at 42 U.S.C. § 18301).

¹²⁹ *Id.* § 1311(a), 124 Stat. at 173.

sustaining.¹³⁰ If a state fails to establish an exchange, or meet all the standards, the Secretary must “directly or through agreement with a not-for-profit entity . . . establish and operate” an exchange within the state.¹³¹

The Secretary has the power to issue regulations with respect to the establishment and operation of the state exchanges, the offering of qualified health plans, and other such related requirements.¹³² Additionally, she has the power to investigate each exchange for fraud and abuse and she must conduct annual audits of each exchange.¹³³ The Secretary’s oversight is coupled with the requirement that each exchange submit an annual accounting.¹³⁴ The Secretary also maintains the power to establish, by regulation, the criteria for certifying health plans as qualified health plans.¹³⁵ The criteria must, among other things, require minimum marketing requirements, ensure a sufficient choice of providers, and insist on certain qualify accreditation measures.¹³⁶ Furthermore, the Secretary must develop a rating system for the plans at each benefits level based on relative quality and price.¹³⁷ Nevertheless, it is ultimately each exchange that will certify the plans in a manner consistent with the Secretary’s guidelines.¹³⁸ Thus, each state may require additional benefits to be offered, but it would be responsible for the cost.¹³⁹

To ensure that consumers have options, the ACA contemplates the creation and regulation of nonprofit health insurance issuers under the Consumer Operated and Oriented Plan (“CO-OP”) Program.¹⁴⁰ The Secretary of HHS must award grants and loans toward the creation of these nonprofits in each state.¹⁴¹ If a nonprofit issuer fails to take hold in a state, the Secretary may use CO-OP appropriated funds to encourage the establishment of a nonprofit issuer or the expansion of another state’s qualified nonprofit issuer into the state.¹⁴²

On the other hand, the new law also provides tremendous flexibility for states to establish alternative programs and options within, and in place of, insurance plans offered in their exchanges. For example, subject to HHS certification, states can establish basic health programs for low-income individuals ineligible for Medicaid rather than offer plans through their own exchanges for these individuals.¹⁴³ If they abide by certain qualifications, states can create subsidiary exchanges within their states.¹⁴⁴ In 2016, upon HHS approval, two or more states can enter into interstate “health care choice compacts” that would allow qualified health plans to be

¹³⁰ *Id.* § 1311(d)(5), 124 Stat. at 177–78. The exchanges can “charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding,” to help make it sustainable. *Id.*

¹³¹ *Id.* § 1321(c)(1)(B)(ii)(II), 124 Stat. at 186 (to be codified at 42 U.S.C. § 18041).

¹³² *Id.* § 1321, 124 Stat. at 186–87.

¹³³ *Id.* § 1313, 124 Stat. at 184–85.

¹³⁴ *Id.*

¹³⁵ *Id.* § 1311(c)(1), 124 Stat. at 174 (to be codified at 42 U.S.C. § 18301).

¹³⁶ *Id.*

¹³⁷ *Id.* § 1311(c)(3), 124 Stat. at 175.

¹³⁸ *Id.* § 1311(e), 124 Stat. at 178.

¹³⁹ *Id.* § 1311(d)(3), 124 Stat. at 176.

¹⁴⁰ *Id.* § 1322, 124 Stat. at 187–192 (to be codified at 42 U.S.C. § 18042).

¹⁴¹ *Id.* § 1322(b), 124 Stat. at 187–189.

¹⁴² *Id.* § 1322(b)(2)(B), 124 Stat. at 188.

¹⁴³ *Id.* § 1331, 124 Stat. at 199–203 (to be codified at 42 U.S.C. § 18051).

¹⁴⁴ *Id.* § 1311(f), 124 Stat. at 179 (to be codified at 42 U.S.C. § 18301).

sold and bought across state lines.¹⁴⁵ And in 2017, states can apply for waivers from the federal requirements if they can show that they can “provide coverage that is at least as comprehensive [and affordable] as the coverage . . . offered through [state exchanges].”¹⁴⁶

Finally, in place of a public health insurance program, known during the health care reform debate as a “public option,” the ACA gives the Office of Personnel Management (“OPM”), a federal body that administers the health insurance plans for federal workers, the ability to sponsor nationwide health plans.¹⁴⁷ The law mandates that the Director of the OPM contract with health insurance issuers to offer at least two multi-state qualified health plans through each state exchange.¹⁴⁸ At least one of the issuers must be a non-profit entity.¹⁴⁹ Furthermore, like with the federal employees health benefit program, the Director has the power to negotiate the medical loss ratio, the profit margin, the premiums, and “other terms and conditions of coverage . . . in the interests of enrollees” with each health insurance issuer.¹⁵⁰ The plans must meet all the minimum benefits requirements established elsewhere by this bill, and States can require additional benefits if they cover the costs.¹⁵¹

2. Criticism

Despite lodging some necessary power with the Secretary of HHS, this state-centric framework contains several flaws. First, because this legislation places the initial burden on states to create the exchanges, every state’s political process will now become another politicized forum for health care opponents to delay or hinder the effort toward universal health care. In other words, rather than closing the book on political fights and moving toward implementation or execution of a national exchange, this country will be headed for more political battles, fought at the state level, over the design *and* implementation of state-based exchanges.¹⁵² Lawmakers in over half the states have already begun to fight against what they perceive to be the overreach of federal power.¹⁵³ This past year, the governors in six states fought their state attorneys general over whether to join the lawsuit challenging the individual mandate requirement.¹⁵⁴ In states where conservative activists have succeeded in blocking or slowing down state implementation

¹⁴⁵ *Id.* § 1333(a)(1), 124 Stat. at 206 (to be codified at 42 U.S.C. § 18053).

¹⁴⁶ *Id.* § 1332(b), 124 Stat. at 205 (to be codified at 42 U.S.C. § 18053).

¹⁴⁷ Shailagh Murray & Lori Montgomery, *Senate Passes Health-care Bill, Now Must Reconcile It With House*, WASH. POST, Dec. 25, 2009, at A1.

¹⁴⁸ ACA, Sec. 10104, § 1334, 124 Stat. at 902–03 (to be codified at 42 U.S.C. § 18054).

¹⁴⁹ *Id.* § 1334(a)(3), 124 Stat. at 903.

¹⁵⁰ *Id.* § 1334(a)(4), 124 Stat. at 903.

¹⁵¹ *Id.* § 1334(c)(2), 124 Stat. at 904.

¹⁵² See Jost, *Implementation and Enforcement of Health Care Reform*, *supra* note 120 (discussing the difference between the House and Senate versions of the bill).

¹⁵³ *ALEC’s Freedom of Choice in Health Care Act: How Your State Can Protect Patients’ Rights*, AMERICAN LEGISLATIVE EXCHANGE COUNCIL, <http://www.alec.org/Content/NavigationMenu/ALECInitiatives/ALECFreedomofChoiceinHealthCareAct/default.htm> (last visited Mar. 15, 2011). See Monica Davey, *Health Care Overhaul and Mandatory Coverage Stir States’ Rights Claims*, N.Y. TIMES, Sept. 29, 2009, at A25 (discussing actions being taken in certain states).

¹⁵⁴ Kevin Sack, *In Partisan Battle, Governors Clash With Attorneys General Over Lawsuits*, N.Y. TIMES, Mar. 18, 2010, at A25.

bills, governors and insurance commissioners are looking to implement the ACA by skirting their legislatures through executive power.¹⁵⁵ Ironically, rather than wanting to overreach, the Senate *purposely chose* a framework of state-based exchanges precisely because several key Senators believed that states should have the flexibility in creating their own plans.¹⁵⁶ Yet, because of this leeway, those fundamentally opposed to health care reform now have a prime opportunity to block reform efforts.¹⁵⁷

Second, state autonomy and flexibility may end up creating counterproductive solutions, which under the new law would simply return the problem back to the federal government.¹⁵⁸ In establishing a “hierarchy between the federal and state governments” and having the states enforce and uphold exchange responsibilities, the federal government is pushing the costs onto the states without providing them with any resources to maintain their duties except initial start-up money.¹⁵⁹ The framework passed by the House, which gave states the option to create their own exchanges only if they could show that such exchanges would be stable, is a better approach and should have been adopted instead. It would have guarded against failed state experimentation while still providing ambitious states the room to innovate. Such a framework treats the federal government and the states as partners, “not as either underlings or wholly independent sovereigns.”¹⁶⁰ While the federal government implements, enforces, and pays the national exchange through a new federal agency, states remain responsible for their traditional duties, such as insurer licensure and solvency, as well as enforcement of its own laws on behalf of consumers.¹⁶¹

Third, state-based exchanges are problematic because “[e]fforts by the states to establish open exchanges have largely failed.”¹⁶² Even among the more recent ones, Massachusetts’s exchange has seen qualified success. Nearly everyone in Massachusetts now has health insurance, but the state has not succeeded in controlling costs effectively.¹⁶³ Massachusetts’s

¹⁵⁵ Sarah Kliff, *Tea Party Finds Success Blocking Reform*, POLITICO, Mar. 30, 2011, <http://www.politico.com/news/stories/0311/52231.html>.

¹⁵⁶ Greg Hitt & Janet Adamy, *Offer to Let States Opt Out of Health Plan Gains Support*, WALL ST. J., Oct. 23, 2009, at A6.

¹⁵⁷ Sarah Kliff, *Tea Party Finds Success Blocking Reform*, *supra* note 155; Editorial, *Rehabilitating HealthCare: One Nation, Insured: Some States, Such as Arizona, Are Considering Ways to Opt Out of a National Plan. That’s Foolish*, L.A. TIMES, Nov. 16, 2009, at A20.

¹⁵⁸ ACA, § 1321 Pub. L. No. 111-148, 124 Stat. 119, 186–87 (2010) (to be codified at 42 U.S.C. § 18041).

¹⁵⁹ Jost, *Implementation and Enforcement of Health Care Reform*, *supra* note 120.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² TIMOTHY S. JOST, THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES IN HEALTH CARE REFORM: LEGAL AND POLICY ISSUES 5 (2009), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/Dec/1364_Jost_hlt_ins_exchanges.pdf [hereinafter, JOST, HEALTH INSURANCE EXCHANGES].

¹⁶³ *See, e.g.*, Kevin Sack, *Massachusetts Faces Costs of Big Health Care Plan*, N.Y. TIMES, Mar. 15, 2009, at A1; PAUL FRONSTIN & MURRAY N. ROSS, EMPLOYEE BENEFIT RESEARCH INSTITUTE, ADDRESSING HEALTH CARE MARKET REFORM THROUGH AN INSURANCE EXCHANGE: ESSENTIAL POLICY COMPONENTS, THE PUBLIC PLAN OPTION, AND OTHER ISSUES TO CONSIDER 14 (2009), http://www.ebri.org/pdf/briefspdf/EBRI_IB_6-2009_HlthExchg.pdf. This February, the

record should be understood in light of earlier “fairly significant reforms” that the state undertook before establishing the exchange.¹⁶⁴

Relatedly, cooperatives designed to help small businesses purchase insurance failed in the 1990s because they were never able to command any more than a small portion of the market, giving them little negotiation power and few options to choose from.¹⁶⁵ Moreover, insurers began to select among firms, “signing up all the small business with generally health employees and offloading the bad risks—companies with older or sicker employees—onto the exchange.”¹⁶⁶ Premiums increased, and both insurers and small businesses began to leave.¹⁶⁷

Fourth, the size of the risk pool is a significant factor. Unless an exchange offers a sufficiently sized market, issuers can, and will, take their products elsewhere. Yet, the very problem with state-based exchanges is the “risk that some smaller states may not have large enough risk pools.”¹⁶⁸ A stable exchange should not only have a minimum size of 100,000 people but it should also have at least twenty to twenty-five percent of non-Medicaid/non-Medicare populations in the coverage pool.¹⁶⁹ Before the final bill’s passage, some experts even suggested giving the Secretary the power to consolidate exchanges in order to achieve the 100,000-person threshold to counter the effects of adverse selection.¹⁷⁰ At least one former governor was quick to realize that his state will need to join neighboring ones to be an effective exchange. Former West Virginia Governor Joe Manchin has said, “The borders don’t separate where the care might be given, and I have five borders We’re going to work in conjunction with our fellow states, with our fellow governors, to make the best delivery system and the best economy that we can.”¹⁷¹

Massachusetts Governor unveiled his plan to tackle the state’s rising healthcare costs. Liz Kowalczyk and Noah Bierman, *Patrick Unveils Health Overhaul*, BOSTON GLOBE, Feb. 18, 2011.

¹⁶⁴ AMY M. LISCHKO ET AL., THE COMMONWEALTH FUND, THE MASSACHUSETTS COMMONWEALTH HEALTH INSURANCE CONNECTOR: STRUCTURE AND FUNCTIONS 11 (2009), <http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/May/Issue%20Brief.pdf>.

¹⁶⁵ MARK MERLIS, NATIONAL HEALTH POLICY FORUM, A HEALTH INSURANCE EXCHANGE: PROTOTYPES AND DESIGN ISSUES 4 (2009), http://www.nhpf.org/library/issue-briefs/IB832_HealthExchange_06-05-09.pdf.

¹⁶⁶ Cappy McGarr, Op-Ed., *A Texas-Sized Health Care Failure*, N.Y. TIMES, Oct. 6, 2009, at A31.

¹⁶⁷ *Id.*

¹⁶⁸ JOST, HEALTH INSURANCE EXCHANGES, *supra* note 162, at 27.

¹⁶⁹ ALAIN ENTHOVEN ET AL., COMMITTEE FOR ECONOMIC DEVELOPMENT, MAKING EXCHANGES WORK IN HEALTH-CARE REFORM 8 (2009), <http://www.allhealth.org/briefingmaterials/MakingExchangesWorkinHealth-CareReform-1701.pdf>.

¹⁷⁰ *Id.*

¹⁷¹ Karen Tumulty et al., *The Five Keys to Health Reform’s Success or Failure*, TIME, Mar. 25, 2010, http://www.time.com/time/specials/packages/article/0,28804,1975068_1975012_1975007,00.html.

Fifth, programs similar to the forthcoming exchanges that have succeeded are national.¹⁷² Administered by OPM, the FEHBP is “the largest single purchaser of health insurance benefits” in this country outside of Medicare and a “widely cited example of an exchange-like system.”¹⁷³ FEHBP offers federal employees and their families, who number over eight million, the option to choose from numerous health insurance plans negotiated in part by OPM.¹⁷⁴ Unfortunately, the legislation does not explicitly give exchanges the power to negotiate directly, unlike the House bill.¹⁷⁵ The many different state-based exchanges are also unlikely to secure the savings in administrative costs that a national exchange can achieve.¹⁷⁶

IV. CONCLUSION

Although the ACA accomplishes significantly greater centralization of authority for healthcare regulation, it falls far short of the full centralization that seems functionally justified. There is no doubt that the states have played an important role in healthcare regulation throughout the nation’s history, but that role is becoming increasingly irrelevant as healthcare regulation becomes increasingly technocratic—i.e., increasingly objectivist and data-driven. The ACA is a step in the right direction, but the U.S. should further centralize authority over healthcare.

¹⁷² JOST, HEALTH INSURANCE EXCHANGES, *supra* note 162, at 25.

¹⁷³ MERLIS, *supra* note 165, at 6.

¹⁷⁴ *Id.*

¹⁷⁵ JOST, HEALTH INSURANCE EXCHANGES, *supra* note 162, at 33.

¹⁷⁶ *Id.* at 31.