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NFIB v. SEBELIUS AT 5

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Keeping up with health care reform is like running up a mountain of sand - every time you reach the top, -the terrain starts shifting. In this talk, I offer a snapshot of where we are in implementing the Patient Protection and Affordable Care Act (“ACA”) to aid in understanding the significance of *NFIB v. Sebelius*¹ at five. I will situate the ACA² within historical patterns in American health care reform. I have been asked to discuss the key points of the *NFIB* decision, after which I will share some of the research that I have performed for the past five years with co-authors to understand health care federalism within the context of implementing the ACA.³ Finally, I will talk a bit about where health care reform may be going from here and how *NFIB* has ongoing impact on implementing the ACA, even into a new presidential administration.

We have been attempting to figure out health care in the United States for more than one hundred years.⁴ Despite political rhetoric indicating the ACA is a uniquely nationalistic intrusion into historically state-based health care, a pattern exists to our efforts at health care reform, and it is more than the fact that every president who attempted to create national health care – starting with Theodore Roosevelt – has been unsuccessful. More importantly, when the federal government has acted, it is because states and markets generally have failed. In addition, Congress tends to legislate health care incrementally, even when responding to patterns of marked state or market failure, and even when a completely national program might be more constitutionally straightforward.

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¹ Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

² Patient Protection and Affordable Care Act, 42 U.S.C. §18001 (2010); see also Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (amending key provisions of the ACA).

³ See Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Health Care For?*, 70 STAN. L. REV. (forthcoming 2018), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3128270; see also Abbe R. Gluck & Nicole Huberfeld, *The New Health Care Federalism on the Ground*, 15 IND. HEALTH L. REV. 1 (2018) (discussing interviews with stakeholders in ACA implementation).

⁴ *A historical look at health care legislation*, BOSTON.COM, Mar. 21, 2010, http://archive.boston.com/news/nation/washington/articles/2010/03/21/a_historical_look_at_health_care_legislation/?page=full.

For example, FDR attempted to write national health care into the Social Security Act in the 1930s, because the Great Depression revealed that states could not afford to provide medical welfare.⁵ When Harry Truman attempted to create a national health care program after World War II, it was because the states could not afford to care for the impoverished and for the soldiers returning from the war who needed serious medical attention.⁶ In the 1950s, the federal government offered medical vendor payments to the states to help with medical costs because the states could not afford to care for their impoverished and aging populations.⁷ Likewise, when Lyndon Johnson ushered the passage of Medicare and Medicaid in 1965, it was in response to prior failed attempts to cover health care for the elderly in the United States.⁸

Every now and then, a leap rather than an increment occurs, such as with Medicare. The elderly and their families were impoverishing themselves for medical care, and it was a longstanding problem that led them to lobby Congress for a nationally uniform program.⁹ When Medicare was passed, it was not a new idea;¹⁰ rather, it was an idea whose time had come because a political taste for it arose, and Medicare remains the only true social insurance health care program in the United States (everyone aged sixty-five and over, and those who become permanently disabled,¹¹ enroll in Medicare).¹² Medicaid was the caboose to Medicare's train. But it, too, showed the same federal recognition that the states could not afford to pay for the needs of the poor and that some of the states did not want to pay as a policy matter.

My argument, in terms of the patterns briefly described here, is that federal intervention in health care in the United States tends to be incremental rather than a takeover. Part of this incrementalism is the federal desire to execute health care reforms with attention to the work that states have historically performed in the field. National legislation tends to assume that states should be in the health care game. But also, the debate as to what the

⁵ Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y L. & ETHICS 67, 87 (2015).

⁶ *69 Years Ago, a President Pitches His Idea for National Health Care*, PBS NEWS HOUR (Nov. 19, 2014), <http://www.pbs.org/newshour/updates/november-19-1945-harry-truman-calls-national-health-insurance-program>.

⁷ Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. ST. U. L. REV. 937, 947 (2010).

⁸ THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 11-15 (2d ed. 2000).

⁹ Ezekiel Emanuel, *Symposium Keynote Speech*, 15 YALE J. HEALTH POL'Y L. & ETHICS 27, 30 (2015).

¹⁰ See MARMOR, *supra* note 8, at 4-11.

¹¹ Social Security Act § 223(e), 42 U.S.C. § 423(e) (2018).

¹² Robert M. Ball, *Social Security Amendments of 1972: Summary and Legislative History*, SOC. SEC. BULLETIN (Mar. 1973), <https://www.ssa.gov/policy/docs/ssb/v36n3/v36n3p3.pdf>.

role of the federal government should be has been basically the same debate since the Supreme Court acknowledged Congress's constitutional authority to regulate insurance in 1944.¹³ It is not a question of whether Congress has authority to regulate health care, but how it will exercise that power.

One more historical example: A law called the Kerr-Mills Act was passed in 1960,¹⁴ which offered block grants to states to pay for the poor and the elderly's medical care.¹⁵ If we were to take a map of the states that participated in Kerr-Mills and transpose it onto a map of the states that were first interested in participating in the Affordable Care Act, it would be startlingly similar. Historical patterns indicate that wealthier states tend to be on the forefront of health care reform and that poorer states tend to lag behind for a variety of reasons, including budgeting or other economic reasons, class-bias reasons, and race-based reasons.¹⁶ These historical patterns – of incrementalism, of including states in reform, and of wealthy states being more participatory – help us to understand why the ACA was more of a leap forward than the usual incremental reform.

To understand this leap, we need to recall that when President Obama was elected, almost 20% of the population was uninsured,¹⁷ and there were known population gaps in insurance coverage. The United States has long relied on employer-sponsored health insurance for gaining health care coverage. Without health insurance, consistent access to medical care is difficult for most people to obtain. So, the focus has been, over time, making sure that everybody has health insurance coverage to facilitate consistent access to health care.

By the time of the 2008 presidential election, a couple of trends crystalized due to an all-time high of uninsurance. First, employers decreasingly provided health insurance, from a high of about 72% around 1980¹⁸ to about 52% of Americans being covered by employer-sponsored health insurance in 2008.¹⁹ These nation-wide percentages are just the starting place, as research shows that the less money a person earns, the less likely her employer is to offer health insurance as an employment benefit. A

¹³ *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944).

¹⁴ Social Security Amendments of 1960 (Kerr-Mills Act), Pub. L. 86-778, 74 Stat. 924 (codified as amended in scattered sections of 26 U.S.C and 42 U.S.C.).

¹⁵ Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, 27 HEALTH CARE FIN. REV. 45, 45-52 (2005).

¹⁶ See LAURA KATZ OLSON, *THE POLITICS OF MEDICAID* 13, 27 (2010).

¹⁷ Jenna Levy, *In U.S., Uninsured Rate Lowest Since 2008*, GALLUP NEWS (Apr. 7, 2014), <http://news.gallup.com/poll/168248/uninsured-rate-lowest-2008.aspx> (15.4% in Q3 of 2008).

¹⁸ Katharine R. Levit and Gary L. Olin, *Americans' Health Insurance Coverage, 1980-91*, 14 HEALTH CARE FIN. REV. 31, 31-57 (1992).

¹⁹ *Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUND., <https://www.kff.org/other/state-indicator> (last visited Oct. 1, 2017).

key demarcation was found to be 400% of the federal poverty level (FPL), because studies show that the steps from 400% to 300% to 200% to 100% of the FPL present significant decreases in the number and percentage of individuals being offered health insurance as an employment benefit or being offered health insurance that is affordable for low income workers.²⁰ For part-time workers, the chances of being offered health insurance as an employment benefit have been notably smaller and decreasing over time.

In short, a health insurance coverage crisis existed, especially for people earning less than the average income for all Americans – about \$50,000. So, the political focus was to cover people who could not buy health insurance coverage on their own or obtain it through work, which explains why the ACA’s greatest regulatory efforts were targeted to assisting lower income populations. More stable coverage existed in Medicare and in employer-sponsored insurance for the elderly and middle and upper income populations, and the ACA made only small changes to these layers of the health insurance coverage pyramid.²¹

Most of the ACA’s regulatory work is in Medicaid and in private individual or small group insurance because, historically, Medicaid has covered only the deserving poor, which in combination with weak employer sponsored coverage, left many low income Americans with no ability to gain health insurance. Focus on the deserving poor was an Elizabethan notion, an idea that no one receives assistance from the government unless they are deemed worthy of it. Historically, this has meant that Medicaid covered only people who were “poor plus”: poor plus pregnant; poor plus disabled; poor plus a child; poor plus elderly, and so on.²² The ACA changed that standard by creating a new baseline, allowing non-elderly adults earning up to 133% of the FPL to enroll in Medicaid, regardless of the status of being “deserving.”²³ This new baseline is important, because Medicaid was already partially federalized, meaning it is a federal program that invites the states to participate in nationally-established baselines with options for states to do

²⁰ *Trends in Employer-Sponsored Offer and Coverage Rates*, KAISER FAMILY FOUND., <https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014> (last visited Sept. 29, 2017).

²¹ *Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, INTERNAL REVENUE SERVICE, <https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act> (last visited Sept. 29, 2017) (Statistically, this only affected about 4% of all employers); see also John Greenberg, *Van Hollen says employer mandates affects 5% of businesses*, POLITIFACT (Sept. 18, 2013), <http://www.politifact.com/truth-o-meter/statements/2013/sep/18/chris-van-hollen/van-hollen-says-employer-mandate-affects-5-busines>.

²² See 42 U.S.C. § 1396a(a)(10)(A)(i) (2018) (identifying categories of people who are eligible for Medicaid enrollment, such as the blind, disabled, pregnant, elderly, and children).

²³ See Patient Protection and Affordable Care Act, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018).

more.²⁴ Under the ACA, a new aspect of Medicaid became nationalized -- the eligibility of nearly half of the nation's poor who had been excluded from coverage until the ACA.

The ACA also focused on middle and low-income populations through regulation of private insurance markets. Prior attempts to regulate private insurance markets occurred before – for example, the Health Insurance Portability and Accountability Act (HIPAA).²⁵ Many think of HIPAA as a privacy law, but it also assisted people who experienced job-lock to move from one workplace to the next without losing coverage, and they wouldn't be penalized for having preexisting conditions.²⁶ Until the private insurance market reforms of the ACA, these markets were so expensive that almost no one could afford individual or small group insurance. The ACA offered tax credits to people earning 100% to 400% of the FPL on a sliding scale to purchase health insurance through an exchange, which is basically a clearinghouse where consumers can purchase health insurance that meets ACA standards. In addition, the ACA makes everyone insurable by preventing pre-existing exclusions, requiring community rating, and regulating similar exclusionary practices by private insurers.

The ACA as drafted made Medicaid eligibility a national standard, envisioned as a federal baseline with an invitation to states to participate through accepting full federal funding for the newly-eligible population, and to cover more people, but not fewer. The exchanges, on the other hand, were designed to be state-run with a federal backup if states did not create their own.²⁷ Massachusetts provided the model for the exchanges, and Congress appeared to assume that other states would want to follow its lead.²⁸ But, the federalism of the ACA as drafted will remain untested due to *NFIB v. Sebelius*; we cannot determine with any certainty whether the ACA's original architecture would have worked as a model of "cooperative" federalism or whether it would have been a good model of health care reform.

NFIB was one of the most complex and most watched cases in recent Supreme Court history, and it involved three major statutory questions (challenges to the "individual mandate" to purchase insurance, the Medicaid expansion, and the ACA's severability) and five constitutional issues

²⁴ Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431 (2011).

²⁵ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (2018).

²⁶ See 29 U.S.C. § 1181(a).

²⁷ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(b)(1), 124 Stat. 119, 173 (2010).

²⁸ See Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 U. KAN. L. REV. 1283, 1283, 1290-91 (2007) (describing health care reform in Massachusetts, including the "Connector" – Massachusetts' health insurance exchange).

regarding congressional authority (the commerce, tax, spending, and necessary and proper powers, and the Tenth Amendment). Arguably, *NFIB* continued the Rehnquist federalism revolution, as the Rehnquist Court had pursued judicial enforcement of the line between states and the national government. In so doing, the Rehnquist Court articulated a concept of federalism rooted in old ideas about what the role of the states is or should be, a theory that the states needed to be protected from the federal government. Yet, this dual sovereignty federalism, which our research shows does not have real meaning in the modern era, contributed to the muddled constitutional and policy outcomes in *NFIB*.

The Court espoused three novel constitutional theories in *NFIB v. Sebelius*. First, Chief Justice Roberts wrote that Congress cannot regulate “inactivity” by forcing individuals to be “active” in commerce by purchasing health insurance,²⁹ a new distinction in commerce power doctrine. Second, the Court held that the Necessary and Proper Clause cannot be exercised when the Court has decided that other constitutional authority is not being used appropriately.³⁰ In other words, though it may have been “necessary” for Congress to regulate health insurance, it was not “proper” because Congress could not exercise its commerce power to require individuals to purchase insurance. (But then, the Court held that a tax penalty for failure to buy health insurance can penalize that choice not to buy health insurance through taxes – upholding Congress’s power to enact the individual mandate).³¹

Third, a plurality of the Court decided that the Medicaid expansion is “new” Medicaid, that it is too different to be part of the old 1965 program and that state funding could not be jeopardized if states desired not to participate in the ACA’s Medicaid expansion.³² The Court held that it is unconstitutionally coercive for the federal government to withhold all of a state’s Medicaid funding, and in so doing recognized a newly enforceable doctrine of coercion.³³ This wasn’t surprising, because Justice Kennedy for years had been asking why the Court was not deploying the Tenth Amendment to limit the spending power in the way that it limited the commerce power.³⁴ Yet, the Court left this novel theory unformed. Rather

²⁹ *Sebelius*, at 559.

³⁰ *Id.*

³¹ I.R.C. § 36B(b)(2)(A) (Supp. IV 2011) (The individual mandate’s penalty was revoked on December 22, 2017; see Tax Cuts and Jobs Act, Pub. L. No. 115-07, 131 Stat. 2054 (2017)).

³² *Sebelius*, at 633.

³³ *Id.* at 582-587.

³⁴ *Bond v. United States*, 564 U.S. 211, 224 (2011).

than articulate a rule for what coercion is, the Court said, essentially: “we’ll know it when we see it.”³⁵

Trying to parse coercion is tricky. Under the ACA, Congress decided to pay fully for a new health care policy that few states considered before the ACA. The Court seemed to decide that the Medicaid expansion was not related enough to what came before (“old Medicaid”), but the opinion did not overtly acknowledge a germaneness issue for the condition on Medicaid spending.³⁶ Also, the Court indicated that the amount of money Congress offers is not consequential, rather it matters how much is threatened to be taken away. But consider a simplified version of this assertion: if Congress offered Minnesota ten dollars and then said “we’re going to take it all away if you don’t fix every pothole in each of your roads,” Minnesota would say “okay,” because only ten dollars is at stake. It must matter how much Congress is offering states, not just how much or what percentage could be taken away. Also strange is that the Court protected the states in the vein of old-fashioned dual sovereignty federalism without naming the Tenth Amendment.

Ultimately, despite finding Medicaid expansion to be unconstitutionally coercive, the Court decided not to strike down any part of the Medicaid Act or the ACA, and instead it limited the power of the Secretary of the Department of Health and Human Services (HHS) to penalize a state that chooses not to participate in the Medicaid expansion.³⁷ Empowering states to make that choice in either direction (opt in or opt out) was deeply federalism-centric. Yet, paradoxically, even though the Court rendered a mandatory feature of Medicaid optional, the statute remains the basis for an ongoing implementation relationship between the federal government and states, but with a new set of extra-statutory parameters.³⁸

The federalism of the *NFIB* decision is messy. It turned Medicaid expansion on its head, giving leverage to the states so that they could negotiate with the federal government in deciding whether to expand eligibility. Medicaid expansion was nationally-oriented as written in the ACA, but after *NFIB*, expansion became more state-oriented. The enabling statute still contains the national goal of universality, but the tools for

³⁵ That view did not work for the First Amendment, see *Jacobellis v. Ohio*, 378 U.S. 184, 198 (1964) (Stewart, J., concurring).

³⁶ *South Dakota v. Dole*, 483 U.S. 203 (1987).

³⁷ Nicole Huberfeld, Kevin Outterson & Elizabeth Weeks, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U.L. REV. 1, 6 (2013).

³⁸ *Sebelius*, at 585-589 (citing 42 U.S.C. § 1396c (2006)).

enforcing universal coverage were partially removed.³⁹ And, states were empowered to negotiate harder. Notably, section 1115 demonstration waivers, a tool states have been using to negotiate Medicaid expansion, already existed before *NFIB*.⁴⁰ Nothing is different in the statutory law; what is different is *NFIB*, a difference that also spilled over into the implementation of exchanges. States used the leverage that they gained with Medicaid to decide not to engage with the state-based exchanges in the ACA. Instead, they have exercised power for its own sake by not participating in the exchanges. As a result, the federal government had to do much more work in creating exchanges than it ever intended to do, but simultaneously the federally-run exchange states have drawn national power into their borders.

As of June 2012, many states were holding out as to whether they were going to participate in implementing the ACA, because they wanted to see what would happen in *NFIB v. Sebelius*. The reporting in the wake of the decision was dissatisfying, because, at least at the national level, it sounded like state participation was a simple in/out binary. While it is true that if a state doesn't participate in Medicaid expansion, no expansion of eligibility occurs in the state and millions of people have no health insurance, the in/out binary is not true from the perspective of dynamic federalism. States have been engaged in highly effective, ongoing negotiations with the federal government to figure out how they could expand, when they could expand, and what they could get for expanding.

In studying this set of negotiating dynamics beneath the surface, my co-authors and I found that the ACA's implementation is much more complex than any two-color map shows.⁴¹ We have seen that noticeable triggers prompted state decisions to participate in ACA implementation. Take Medicaid as an example. First, some states signed on to Medicaid expansion very early -- Minnesota was one of them⁴² -- states that had already been participating in Medicaid in a robust way, maximizing federal dollars to expand coverage to everybody that they could. Second, *NFIB* was decided, followed closely by HHS guidance indicating states could opt in or out at any time, and some governors decided to take that federal money that was sitting on the table. Third was the Arkansas section 1115 waiver -- the first Medicaid expansion waiver to permit a state to use federal Medicaid funding to place the newly eligible Medicaid population into private insurance in the

³⁹ See generally Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 2014 U. ILL. L. REV. SLIP OP. 1 (2014) (analyzing the concept of universality as a civil right for Medicaid beneficiaries).

⁴⁰ 42 U.S.C. § 1315 (2016).

⁴¹ See Gluck & Huberfeld, *supra* note 3.

⁴² *How Will the Uninsured in Minnesota Fair Under the Affordable Care Act?*, KAISER FAMILY FOUND., <https://www.kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-minnesota/> (last visited Oct 8 2017).

exchange.⁴³ When other states saw successful negotiations with HHS, they wanted to get the rewards that came before plus a little more. After Arkansas, Iowa, Michigan, Pennsylvania, and New Hampshire⁴⁴ quickly followed, and they all sought additional concessions from HHS. Fourth, once the ACA became effective as of January 1, 2014, that appeared as if it would be the final deciding moment; except that, again, *NFIB* turned everything on its head. At that point, less than half of the states had opted into Medicaid expansion, and yet HHS still had the national goal of universal coverage to pursue.⁴⁵ So, negotiations continued. Fast forward to 2016, when Indiana's Medicaid waiver was approved and was the most complex and punishing of the Medicaid expansion waivers. It contains features that were not permitted in Medicaid, such as lock-out for failure to pay premiums; arguably, this new flexibility was because of *NFIB*.

This is the health policy work *NFIB* is doing after five years: it has been disruptive to the principle of universal coverage that was the goal of the ACA (except for undocumented immigrants).⁴⁶ *NFIB* disrupted universal coverage and allowed variability where none was meant to exist. The implementation of the ACA has been, and continues to be, much more complicated than it was intended to be. That more dynamic implementation is more complex than who is participating and who is not, because the states are actively learning from one another to figure out what they can get in a Medicaid waiver, and what concessions they can obtain from HHS. After this talk goes to press, the states will still be trying to figure out what they can negotiate. States have learned they can require "premium assistance" (Arkansas style enrollment);⁴⁷ enforceable premiums (a Medicaid enrollee who cannot pay can be dropped); prevent payment for non-emergency transportation; implement wellness initiatives;⁴⁸ and institute health savings accounts. What no administration permitted, including the Obama administration, was work requirements.⁴⁹ Consistently, HHS denied requests for work requirements because providing medical assistance to the poor⁵⁰ is

⁴³ Sara Rosenbaum & Benjamin D. Sommers, *Using Medicaid to Buy Private Health Insurance – The Great New Experiment?*, 369 NEW ENG. J. MED. 7, 8 (2013).

⁴⁴ ROGER A. SEVIGNY, N.H. INS. DEP'T, N.H. BULL. NO. 15-013-AB (2015).

⁴⁵ Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 14 (2016).

⁴⁶ Huberfeld, *supra* note 5, at 2.

⁴⁷ 42 U.S.C. § 1396e-1 (2014).

⁴⁸ Huberfeld, *supra* note 31, at 81.

⁴⁹ See Drew Altman, *Behind the Split Over Linking Medicaid Coverage to Work Requirements*, WALL ST. J.: WASHINGTON WIRE (May 11, 2015, 9:55 AM), <http://blogs.wsj.com/washwire/2015/05/11/behind-the-split-over-linking-medicaid-coverage-to-work-requirements> (last visited Mar. 28, 2018).

⁵⁰ *Id.*

the stated purpose of the Medicaid Act.⁵¹ This is changing under the Trump Administration, which I will discuss more in a moment.

In negotiations with each state, HHS has been pragmatic, prioritizing insurance coverage as a long-term goal and respecting individual states' preferences for participation in the ACA. The example of the exchanges further highlights that this is not a binary, in/out set of decisions, either a federally-based marketplace or a state-based marketplace. On the surface, it could appear that "blue" is the state run exchanges and "red" is the federally run exchanges, because blue states would have wanted to implement the ACA and so would have created their own exchanges. But a state like Oregon created its own exchange, which failed, and Oregon had to rely on the federal exchange. Oregon suddenly went from "blue" to "red" because it lost its state exchange, but that is clearly too simplistic, and it highlights the oversimplification of the health care federalism present in implementation of the ACA. Some states are shifting back and forth, some have created hybrids.⁵² That is pragmatic and dynamic federalism, not formalistic constitutional federalism. The negotiations and movement happening are so different from what the Court discussed in the context of federalism in *NFIB*, it's astounding. The states are not only learning from one another and using each other's model, they are effectively negotiating for themselves without judicial intervention.⁵³

Although *NFIB* thwarted the federalism design of the ACA, it has also opened the door to perceiving a modern health care federalism that is highly dynamic, negotiable, pragmatic, and horizontal (states are learning from one another). We also can see that the states are operating as republics.⁵⁴ A governor might agree with the President more than with his own legislature. The commissioner of Medicaid in a given state may identify more with the goals of HHS than with other state actors. Political alignments are important to some degree, but they are not everything. And each state is setting its own goals, contrary to judicial depictions of "the states" versus "the federal government."

⁵¹ Nicole Huberfeld, *Can Work Be Required in Medicaid?*, 378 NEW ENG. J. OF MED. 788 (2017).

⁵² *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion*, KAISER FAMILY FOUND., <http://www.kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Mar. 28, 2018).

⁵³ See Jenna Johnson, *Maryland looks to Connecticut for health exchange answers*, WASH. POST, May 31, 2014, https://www.washingtonpost.com/local/md-politics/maryland-looks-to-connecticut-for-health-exchange-answers/2014/05/31/481a7b9c-db83-11e3-8009-71de85b9c527_story.html?utm_term=.42e528fa0d65.

⁵⁴ See Emily Le Coz, *Two states, different experiences under health care law*, USA TODAY, Dec. 1, 2013, <https://www.usatoday.com/story/news/nation/2013/12/01/health-exchange-prices/3797039/>.

There is a disconnect between the Court’s concept of federalism and what has actually been happening in the health care reform context. And, the question of how and whether formalistic federalism serves policy ends remains important. Should a person who has a heart attack in Arizona be treated differently than if she had a heart attack in New Mexico? They need the same medical care; what would the value be of state variation, sovereignty, or cooperation for a patient who needs life-saving medical attention?

To that end, keep an eye on test cases for the new administration such as Kentucky, which could be the first state to opt out of Medicaid expansion after opting in and offered the first waiver application for the Trump Administration to evaluate. President Trump’s first Secretary of HHS, who engaged with Kentucky over work requirements and other new waiver elements, seems to think that health insurance should not exist⁵⁵ and everyone should pay cash for medical care.⁵⁶ Similarly, but not as extreme, in meetings where Indiana was negotiating a waiver for expansion with HHS, then-consultant Seema Verma repeatedly used the phrase “personal responsibility” in explaining the reasoning behind her design for Indiana’s waiver application. This catch-phrase for the current Administrator of the Centers for Medicare and Medicaid Services (CMS) indicates that the agency responsible for one of the largest budgets in the federal government and for the health care of nearly one hundred million people is hostile to the ACA and to Congress’s decision to eradicate the notion of the “deserving poor.” In short, HHS is now led by administrators who have a different take on the ACA than what the law was intended to do. Further to this point, President Trump issued an executive order on the first day in office that was largely intended to be deregulatory when it comes to health insurance, whether it is private or public.⁵⁷ HHS was told to give flexibility to the states and to support a “free and open market.” It is predictable, whatever happens with legislative efforts to repeal and replace the ACA, that more section 1115 demonstration waivers will be granted in Medicaid for states that want to expand, and likely with work requirements and other new features being approved.⁵⁸

The new administration’s flexibility toward states may inspire new states to opt into the Medicaid expansion because the implementation of the

⁵⁵See Robert Pear, *Tom Price, Obamacare Critic, Is Trump’s Choice for Health Secretary*, N.Y. TIMES, Nov. 28, 2016, <https://www.nytimes.com/2016/11/28/us/politics/tom-price-secretary-health-and-human-services.html>.

⁵⁶ See generally, Empowering Patients First Act, H.R. 2300, 113th Cong. (2014).

⁵⁷ Exec. Order No. 13,765, 82 Fed. Reg. 8351 (Jan. 24, 2017).

⁵⁸ CMS approved Kentucky and Indiana waivers that include work requirements as this transcript goes to press. See Huberfeld, *supra* note 51.