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Nicole Huberfeld
Boston University School of Public Health; Boston University School of Law

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Epilogue: Health Care, Federalism, and Democratic Values

Nicole Huberfeld[†][*]

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I. INTRODUCTION

Is the United States experiencing a "crisis of democracy in health care"? This symposium's central question can only begin to be addressed here. The answer depends, in part, on where we look and how we measure democracy.

Democracy is a complex ideal often said to be promoted by federalism. In health care, each level of government exercises power because federalism is a default choice in health reform efforts. This default enables state governments and the federal government to create, enforce, and adjudicate health law and policy - democratic operations at the national and the subnational levels. But on each democratic dimension – sovereignty and accountability – evidence of compression and expansion exists.

This essay briefly studies the assertion that federalism is a structure that advances the democratic values of sovereignty and accountability by considering the two key federalism-based features of Patient Protection and Affordable Care Act ("ACA") implementation. Through the lens of these reforms, we see that the question of whether democracy is in crisis is even more complex than we might expect.

II. FEDERALISM AND THE AFFORDABLE CARE ACT

American federalism is a constitutional structure defined by two layers of government, each of which performs the democratic functions present in policy choices that result in law-making, executive enforcement, and judicial power. Courts and commentators have touted federalism's importance in advancing democratic values, often naming sovereignty, accountability, and protection of liberty and equality as the key values enhanced by federalism.[1] Historically, federalism has been portrayed as distinct governments operating in their own spheres, but "dual sovereignty" federalism

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[†] Professor of Health Law, Ethics & Human Rights, Boston University School of Public Health, and Professor of Law, Boston University School of Law. Many thanks to AJLM for hosting this timely symposium. Thanks always DT and SRHT.

[1] Gregory v. Ashcroft, 501 U.S. 452, 458 (1991) ("Just as the separation and independence of the coordinate branches of the Federal Government serve to prevent the accumulation of excessive power in anyone branch, a healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front."); *see also* Bond v. United States, 564 U.S. 211 (2011). Justice Kennedy wrote:

> The federal system rests on what might at first seem a counterintuitive insight, that "freedom is enhanced by the creation of two governments, not one." Alden v. Maine, 527 U. S. 706, 758 (1999). The Framers concluded that allocation of powers between the National Government and the States enhances freedom, first by protecting the integrity of the governments themselves, and second by protecting the people, from whom all governmental powers are derived.

Id.

arguably ended when the New Deal began.[2] Throughout the twentieth century, federalism developed into an increasingly complex structure, moving from dual sovereignty to cooperative federalism (state participation in federal policies, often stimulated by federal money) to dynamic federalism, which is produced through federal money but also active negotiation, adaptation, and horizontal learning between state actors within a federal statutory scheme.[3]

The ACA was conventional in its approach to structuring health care reform to achieve universal insurance coverage because it relied on federalism, both for political expediency and for administrative ease.[4] The ACA created national public and private health insurance standards, but the law still relied on states to implement its universality norms. Specifically, the ACA invited states to participate in universal health insurance coverage through Medicaid expansion and health insurance exchanges ("exchanges").

Drawing on states' history of regulating insurance markets, the ACA offered federal money to states to create and run exchanges and assumed that state actors would carry out the ACA's goals. To the surprise of many, two-thirds of states decided to rely on the federal exchange. An even greater surprise is that most of the states using the federal exchange worked with the Department of Health and Human Services ("HHS") to ensure that it operates to suit each state's insurance market needs. While states' renunciation of state-run exchanges aggrandized federal power within state borders, simultaneously states exercised policy choice. States have become adept at asserting policy preferences in inter-governmental negotiations with HHS. Further, the negotiations that led to these hybrid federal-state exchanges created an unusual collaboration where HHS gave states cover to act as if they were not participating in ACA implementation when they were actually ensuring ACA goals were achieved.[5]

Likewise, the ACA's Medicaid expansion created a national standard for eligibility but continued the program's tradition of state implementation of federal rules. The ACA ended the historic Medicaid exclusion of childless, nonelderly poor, making all individuals earning up to 138% of the federal poverty level eligible for Medicaid. But then, in *NFIB v. Sebelius*, the Supreme Court created a greater role for state policy choice by giving states permission to opt out of Medicaid expansion.[6] The Obama administration interpreted *NFIB* to allow states to opt in or out of Medicaid expansion on their own timeline, and HHS proceeded to negotiate with states to facilitate expansion,[7] often through novel demonstration waivers.[8] The Obama administration

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[2] *See*, *e.g*., Edward S. Corwin, *The Passing of Dual Federalism*, 36 VA. L. REV. 1-24, 1 (1950); Heather K. Gerken, *Federalism 3.0*, 105 CALIF. L. REV. 1695 (2017) (describing three phases of federalism in U.S. history).

[3] For a detailed exploration of the federalism in the implementation of the ACA and coining of the phrase dynamic federalism, s*ee generally* Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689-1803 (2018). I rely on our findings for many factual assertions including health care reform history and ACA implementation specifics in this essay. *See id.* at Parts II, III, IV & V.

[4] Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 67-88, 69 (2015); Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 2014 ILL. L. REV. SLIP OPINIONS 1-8, 3 (2014).

[5] Abbe R. Gluck & Nicole Huberfeld, *The New Health Care Federalism on the Ground*, 15 IND. HEALTH L. REV. 1 (2018).

[6] *See generally* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

[7] *The New Health Care Federalism on the Ground*, supra note 5.

[8] 42 U.S.C. § 1315 provides:

> In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter … XIX, … in a State … (1) the Secretary may waive compliance with any of the requirements of section … 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project.

drew a line at proposals for work requirements (like all prior administrations). However, in January 2017, the Trump administration issued policy guidance encouraging states to impose work requirements as a condition of Medicaid eligibility. So far, HHS has approved ten states' demonstration waiver proposals for work requirements,[9] though a federal court has struck down three of the waivers as inconsistent with the purpose of Medicaid – to "furnish medical assistance" - as this essay goes to print.[10]

III. SOVEREIGNTY AND ACCOUNTABILITY

The democratic values of sovereignty and accountability are tested by health care federalism. In broad brush strokes, the federal decision to enact major health reform, defend it in court, and implement it through administrative decisions that support the law's overarching goals, as well as state choices in rejecting, negotiating, and deciding whether and how to implement the ACA's policies, provide evidence of federal and state sovereignty. But some of these acts have been unlawful and test the bounds of executive authority at the federal level. Further, when transparency is lacking, the claim that federalism advances accountability is tested and the value of sovereign acts becomes questionable.

Sovereignty can be defined as power and control over policymaking. This includes creating, enforcing, and adjudicating laws and policies, a characteristic of both federal and state government. Even when multiple levels of government participate in a policy goal, each still exercises sovereign functions. But, power and control must operate within constitutional and statutory boundaries, otherwise the "sovereign" is no longer promoting democracy.

Accountability can be defined as responsibility for, and transparency in, policymaking.[11] The Supreme Court has expressed that state implementation of federal law should be a freely and openly made state choice, in part because voters might not be able to discern responsibility for the policy.[12] While Congress may regulate an activity directly, or influence states with money so they will regulate that activity, Congress may not "commandeer" states to implement federal law.[13] In other words, if we think about accountability broadly, it means that one level of government cannot punt responsibility for its policy to another level of government.

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42 U.S.C. § 1396-1 states that the "purpose" of Medicaid is to "furnish medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." The people eligible for Medicaid have increased since 1965, most recently through the ACA's expansion to an "eighth category" of eligibility. 42 U.S.C. § 1396a(a)(8) & (10).

[9] *A Snapshot of State Proposals to Implement Medicaid Work Requirements Nationwide*, NATIONAL ACADEMY FOR STATE HEALTH POLICY (March 20, 2019), https://nashp.org/state-proposals-for-medicaid-work-and-community-engagement-requirements/ (last visited March 25, 2019) [https://perma.cc/K53R-38HJ]. Three states' waivers have been challenged in federal court so far.

[10] Stewart v. Azar II, Civil Action No. 18-152 (JEB) (D.C. Dist. Ct., Mar. 27, 2019), at https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf; Gresham v. Azar, Civil Action No. 18-1900 (JEB) (D.C. Dist. Ct., Mar. 27, 2019), at https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58.

[11] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 678 (2012) (Scalia, Kennedy, Thomas, Alito, JJ., dissenting).

[12] New York v. United States, 505 U.S. 144, 166-69 (1992).

[13] *Id*. at 168-9. The majority wrote: "where the Federal Government compels States to regulate, the accountability of both state and federal officials is diminished. …it may be state officials who will bear the brunt of public disapproval, while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision. Accountability is thus diminished when, due to federal coercion, elected state officials cannot regulate in accordance with the views of the local electorate in matters not pre-empted by federal regulation." *Id*.

On one hand, the ACA's federalism illustrates that state sovereignty can exist within a federal law's superstructure. In the effort to achieve universal coverage after *NFIB* allowed states to opt-out of a pillar of the law's architecture, HHS had a defined policy goal (to achieve Medicaid expansion) and negotiated with states to customize their implementation of that goal.[14] States were successful in negotiating features of Medicaid expansion to suit local politics and other policy desires. The negotiations represented the effort of each sovereign to negotiate for its preferred outcome.

On the other hand, sometimes HHS gave states cover so that they could appear to oppose federal policy while simultaneously implementing it, evidenced by unique names that averted responsibility for implementing the ACA like "HIP 2.0" (Indiana), "Apple Health" (Washington), and "HUSKY" (Connecticut). States sought cover from the federal government so that they could negotiate and then implement the ACA quietly. This dynamic was not anticipated in the Court's accountability analysis. Such responsibility shifting – what Abbe Gluck and I call "secret boyfriend federalism" – clouds policy accountability and goes beyond the Court's contemplation of commandeering, because HHS was not forcing policy on the states; rather, the states were very actively working with HHS to facilitate the illusion that they were not complying with the ACA when in fact they were.[15] Each had the same goal, to make the ACA's rules work for the state, but each approached those goals differently – HHS had the long-term goal of getting people covered, and states wanted the money (if not the policy) that came with ACA implementation. Further, the vigorous negotiations between HHS and states opened the door to ACA implementation but chipped away at the law's norms.

The 2016 election revealed that the electorate did not understand the ACA's role in increasing health insurance coverage and improving access to care. This is demonstrated by polls showing that voters expressed misunderstanding during the 2016 election as to whether the ACA and "Obamacare" were the same law, which level of government was responsible for insurance coverage gains, and confusion over who was responsible for other popular parts of the law (*e.g.*, keeping young adults on parents' insurance plans).[16] The state-specific names were one way to hide ACA implementation from the voter's view, but that was just one facet of the responsibility shifting that occurred. The vigorous negotiations between HHS and states opened the door to state sovereign negotiation but chipped away at federal norms. States sought cover from the federal government to blur their responsibility for implementing "Obamacare", and the Obama Administration played along to entrench the universal insurance coverage policy at the heart of the ACA.

Arguably, this flexibility in implementing the ACA opened the door to the Trump administration working to administratively dismantle the law when Congress failed to repeal it. For example, HHS encouraged states to implement work requirements as a condition of eligibility, which specifically targets the Medicaid expansion population.[17] So far, work requirements have resulted in significant disenrollment of the expansion population and undercut the ACA without repealing or modifying the law

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[14] *See generally The New Health Care Federalism on the Ground*, *supra* note 5 (detailing interviews with key stakeholders in ACA implementation, who consistently described this process).

[15] *What Is Federalism in Healthcare For?*, *supra* note 3, at 1700, 1767, 1771, 1780.

[16] Ashley Kirzinger, Elise Sugarman, & Mollyann Brodie, *Kaiser Health Tracking Poll: November 2016*, KAISER FAMILY FOUNDATION (Dec. 1, 2016), https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2016/ [https://perma.cc/A7AL-S9DB].

[17] Centers for Medicare and Medicaid Services, SMD: 18-002 (Jan. 11, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

itself.[18] Likewise, refusing to defend the ACA in federal court is an executive decision that undermines the law and that defies constitutional norms regarding executive enforcement of existing laws.[19] These administrative forms of demolishing the ACA may have been facilitated by the responsibility-punting that started during the Obama years. In other words, accountability deficits have consequences, ripple effects that move beyond the administration that originates a policy.

The aftermath of the 2016 election – repeated Congressional attempts and failures to repeal the ACA – suggests that accountability deficits may not be permanent. While many voters did not know that repealing "Obamacare" would eliminate their health insurance coverage, soon after the election, many became aware of the law's structure and goals, at least aware enough to foment grassroots resistance to the 2017 "repeal and replace" efforts.[20] This grassroots movement fed ballot initiatives in 2017 and 2018 to expand Medicaid in five states (Maine, Montana, Utah, Idaho, Nebraska), four of which were successful.[21] It very likely also led to the election of ACA-sympathetic governors in states like Kansas that had not expanded Medicaid as of 2018.

Is this accountability problem intertwined with the federalism structure of American health care? Imagine that no *NFIB* litigation occurred, and the ACA were implemented as drafted. States would have implemented Medicaid expansion across the country by January 1, 2014, and while some state policy variation always occurs because of Medicaid's cooperative federalism design, it likely would have been clearer to voters that the federal government was responsible for the universal coverage rule. And the policy goal – increased coverage - would have been achieved more quickly and cheaply, because administrative negotiation and litigation over novel policies takes substantial time and money. Alternatively, imagine that health reform had cut states out of the picture (which the ACA did not, despite cries of a "federal takeover").[22] Do sovereignty and accountability disappear as well? While state sovereignty loses ground, federal sovereignty gains ground, and accountability gains too because government responsibility is clearer without layers of governance.

Alternatively, consider the state ballot initiatives to expand Medicaid. They demonstrate direct democracy in health reform, but legislators in Utah and Idaho are trying to restrict these grassroots democratic movements through enrollment limitations such as work requirements and spending caps. Here, state sovereignty appears to be operating in conflict with democratic values. Similarly, the governor of Kentucky claims the state will opt out of Medicaid expansion entirely if his work requirements are deemed unlawful by federal courts. Again, the federalism dynamics of the ACA are turning Supreme Court doctrine on its head – not only by flipping the accountability problem, but also by allowing states to be the ones attempting to coerce the federal government. In the words of Judge Boasberg, the state is trying to hold a "gun to the head" of the

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[18] For example, Arkansas was the first state to implement work requirements and more than 18,000 were disenrolled by the end of 2018. *See* Robin Rudowitz, MaryBeth Musumeci, & Cornelia Hall, *February State Data for Medicaid Work Requirements in Arkansas*, KAISER FAM. FOUNDATION (Mar. 25, 2019), https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/ [https://perma.cc/G6WT-J6XW].

[19] Robert Pear, *Trump Officials Broaden Attack on Health Law, Arguing Courts Should Reject All of It*, N.Y. TIMES, Mar. 25, 2019, https://www.nytimes.com/2019/03/25/us/politics/obamacare-unconstitutional-trump-aca.html?action=click&module=RelatedCoverage&pgtype=Article®ion=Footer [https://perma.cc/87PX-MDNZ].

[20] *See, e.g.*, Kyle Dropp & Brendan Nyhan, *One-Third Don't Know Obamacare and Affordable Care Act Are the Same*, N.Y. TIMES, Feb. 7, 2017, https://www.nytimes.com/2017/02/07/upshot/one-third-dont-know-obamacare-and-affordable-care-act-are-the-same.html?_r=1[https://perma.cc/AN8X-9TUC].

[21] Montana's renewal of Medicaid expansion with tobacco taxes was defeated by outside tobacco money.

[22] *What Is Federalism in Healthcare For?*, *supra* note 3, at 1703 n. 39.

federal government (rather than the "gun to the head" of states, which Chief Justice Roberts perceived in the ACA's Medicaid expansion).[23]

Notably, recent studies demonstrate that Medicaid, and Medicaid expansion specifically, leads to increased voter participation through both voter registration and voting in elections.[24] Conversely, loss of Medicaid or other similar benefits decreases voter turnout.[25] The idea that financial security is a necessary feature of democratic participation is not new, but linking voter turnout to Medicaid expansion adds an important new dimension to this narrative. This suggests that Medicaid expansion advances democracy, and that people eligible for Medicaid in states that have not expanded are less likely to be able to vote. Between problems of accountability and the general trials of a life in poverty, those who would most benefit from Medicaid expansion, or easily understood access to subsidized insurance on the exchanges, are the least likely to express their policy desires through voting. These studies make the ballot initiatives of 2018 all the more remarkable in their direct democracy successes.

IV. CONCLUSION

While federalism is credited with advancing democratic values by facilitating sovereignty and accountability, the ACA's implementation details indicate that federalism's layers of governance have served to entrench the law but also to undermine it. Democratic values are difficult to measure, but they are not served by government actors pretending to reject, or ignoring, existing law. State sovereign acts are not intrinsically valuable if they defy federal law, even with federal executive blessings. Pretending to resist federal law while simultaneously implementing it is confusing to voters, expensive to implement, and indefensible from a democratic perspective. The crisis of democracy in health care deserves additional unpacking because it holds clues to a possible larger crisis in American democracy.

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[23] Stewart v. Azar II, Civil Action No. 18-152 (JEB) at 2-3, 42-43 (D.C. Dist. Ct., Mar. 27, 2019), at https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf.

[24] Jake Haselswerdt & Jamila Michener, *Disenrolled: Retrenchment and Voting in Health Policy*, 44 J. HEALTH POL. POL'Y & L. 423, 426 (2019) (summarizing studies that indicate Medicaid and Medicaid expansion increase voting); *see also* Margot Sanger-Katz, *When Medicaid Expands, More People Vote*, N.Y. TIMES, Nov. 8, 2018; Jake Haselwerdt, *Expanding Medicaid, Expanding the Electorate: The Affordable Care Act's Short-Term Impact on Political Participation*, 42 J. HEALTH POL. POL'Y & L. 667 (2017).

[25] *See id.* at 443 (concluding that loss of TennCare Medicaid benefits in Tennessee "did not mobilize people to vote. …loss of coverage appears to decrease turnout.").