Rhetorical Federalism: The Role of State Resistance in Health Care Decisionmaking

Elizabeth Weeks Leonard
RHETORICAL FEDERALISM: THE ROLE OF STATE RESISTANCE IN HEALTH CARE DECISIONMAKING

Elizabeth Weeks Leonard*

Abstract: This Article makes the affirmative case for the widespread trend of state resistance to the recently enacted, comprehensive federal health reform law, the Patient Protection and Affordable Care Act of 2010, or ACA. A significant number of states have engaged in various forms of objection to the new federal laws, including filing lawsuits against the federal government and enacting state laws providing that ACA will not apply to residents of the state. This Article identifies reasons why those actions should not be disregarded simply as Tea Party antics or election-year gamesmanship but instead should be considered valuable to the health care decisionmaking process and federal-state relations. In making the case for rhetorical federalism, the Article examines and expands on theories of uncooperative federalism and opportunistic federalism. Key provisions of ACA implicating states are examined under the operative federalism theories.

Table of Contents:

I. Introduction
II. Health Reform Nullification Movement
III. Explanations for State Resistance to Health Reform
   A. Health Care Federalism
   B. Uncooperative Federalism
   C. Opportunistic Federalism
IV. Role of States in Federal Health Reform
   A. Medicaid Expansion
   B. High-Risk Pools
   C. Exchanges
   D. Insurance Market Regulations
   E. Individual Mandate
V. Rhetorical Federalism in Health Care Decisionmaking
VI. Conclusion

* Visiting Professor of Law, University of Georgia; Professor of Law, University of Kansas. I am grateful to Mike Wells, Mark Hall, Tim Jost, Abby Moncrieff, Abbe Gluck, Sidney Watson, Dayna Bowen Matthew, Nicole Huberfeld, Rick Levy, and Chris Drahozal; and participants at Health Law Professors Conference at the University of Texas School of Law, University of the Pacific McGeorge School of Law Faculty Workshop, University of Kansas International Seminar for Faculty, and University of Kansas School of Law Informal Workshop for comments and suggestions to improve this draft. I received excellent research assistance from Brandon Smith, Hannah Sandal, and Chelsea Barnett. Special thanks to Tara Leigh Grove for pointing me to Professor Gerken’s scholarship.
I. Introduction

The national debate over health reform did not end on March 23, 2010, when President Obama signed the comprehensive, federal Patient Protection and Affordable Care Act (Affordable Care Act, or ACA)\(^1\) into law. State resistance was brewing while the federal legislation was being debated in Congress and continues with each phase of implementation. ACA, by design, relies heavily on state fiscal and administrative capacity to realize the sweeping changes. The law also greatly increases the federal government’s involvement in health care delivery and regulation, matters that previously were left largely to states. Even after House Speaker Nancy Pelosi assembled the necessary votes for passage of the historic legislation, state objections escalated, including lawsuits challenging the constitutionality of the new law as exceeding federal enumerated powers and encroaching on states’ Tenth Amendment reserved powers. The loudest opposition aims at the new federal mandate that all individuals maintain health insurance, a requirement which imposes minimally on states but arguably infringes on individual economic and personal autonomy rights. States also have raised objections to long-standing federal-state partnerships, such as the Medicaid program. At the same time, other provisions of ACA, which strongly implicate state budgetary, administrative, and policymaking discretion, so far, have attracted little objection. ACA opponents invoke the federalism slogans and values selectively, at times expressing strong views on states rights and other times ceding considerable authority to the federal government.

State-centered dissent, such as refusing to implement new federal legislation, challenging the constitutionality of federal laws, resisting federal mandates, ignoring federal precedent, and even threatening to secede from the Union, would seem to hinder productive functioning within the federal system. In response to ACA, states mounted resistance through all of those means. In the view of many, state challenges and resistance to the new federal laws are legally null, at best, and destructive, at worst. This Article offers a counter view, suggesting that the rhetoric of federalism, even when invoked inconsistently and opportunistically, may have a salutary effect on both health care decisionmaking and federal-state relations.

The point here is not to argue the merits of particular provisions of ACA or the enforceability of various state resolutions or amendments. Rather, the Article considers the potential benefits deriving from the apparently distracting and obstructive health reform nullification trend. Following this Introduction, Part II describes the current landscape of state resistance to ACA. Part III considers plausible theories to rationalize the state nullification movement. Part IV describes key provisions of ACA that implicate states or have been targets of state objections. Part V concludes by suggesting several possible benefits of rhetorical federalism.

II. Health Reform Nullification Movement

Health care policymaking in the United States is currently focused on implementing the new federal law, ACA. In crafting the landmark legislation, lawmakers considered a wide range of proposals to address myriad shortcomings of the current
system, including rising numbers of uninsured patients, rising health care costs, lack of access to care, and inadequate quality controls. Most everyone agrees that the system needs to be fixed, but there remains sharp disagreement about the best approach. Health reform debates inevitably evoke fundamental values and priorities. One issue is whether health care is a right or entitlement that government should provide to all, or whether health care should be distributed like any other market good or service, based on private choice and ability to pay. Another challenge is the United States’ characteristic federal system, which grants both the central federal and separate state governments considerable authority over health care delivery and regulation.

During the debate that culminated in passage of ACA, those views surfaced in varying forms and degrees of intensity. Our system of representative government envisions that individual constituents will share their concerns and objections with locally elected senators and representatives, who then carry those views into the federal forum. But objection to health reform bubbled over congressional channels and welled up at the state level. A broad, bipartisan movement of state resistance emerged and continues to brew even after passage of the historic legislation. Although there are certainly individual and special interest group opponents of ACA, much of the dissent has been voiced by states, asserting both their own sovereign rights and rights of their residents.

---


During and after congressional deliberation over ACA, at least forty states considered state constitutional amendments or legislative resolutions purporting to nullify various provisions of the proposed law.\(^4\) Five states, Virginia, Idaho, Utah, Georgia, and Louisiana, enacted resolutions establishing that citizens of their respective states would not be required to comply with the new federal mandate that all individuals obtain health insurance.\(^5\) Missouri voters approved a ballot measure prohibiting the federal or state government from mandating that Missouri residents obtain health insurance or penalizing residents for directly paying their medical bills.\(^6\) Arizona, Florida, and Oklahoma will hold state constitutional ballot questions in 2010 on amendments purporting to nullify the individual insurance mandate.\(^7\) In addition to state laws, Idaho’s House and Senate passed a resolution calling for a Twenty-Eighth Amendment to the U.S. Constitution providing that Congress shall make no law requiring citizens of the United States to enroll in, participate in, or secure health insurance, or penalizing any citizen who declines to purchase health insurance.\(^8\)

Many of the state nullification resolutions and amendments are phrased in terms of individual rights, providing that citizens of the respective states will not be required to participate in any particular health plan.\(^9\) Others recognize individuals’ right to purchase


\(_5^5\) See id.

\(_6^6\) See NCSL, supra note 4.

\(_7^7\) See id. (see, e.g., Alabama, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Minnesota, South Carolina).

\(_8^8\) See NCSL, supra note 4.

\(_9^9\) See id.
health care directly from health care providers, rather than through health insurance plans. Some state resolutions and amendments object to notions of universal health care, a national health plan, or public option, proposals that are vestiges of President Clinton’s 1993 failed health reform effort and were never seriously considered in the current debates. Other resolutions focus on the states’ role in health reform implementation, prohibiting state regulators and law enforcement officials from being required to implement federal programs, or punishing individuals, employers, or providers who refuse to comply with federal mandates. Some proposals codify states’ right to opt out of federal health reforms. One California senator proposed a sweeping amendment prohibiting state enforcement of a host of provisions, including the individual mandate, employer mandate, public option, guaranteed issue, and universal health care. Five states are considering legislation objecting to the fiscal impact of ACA, in particular, Medicaid expansion. In addition to specific, health reform nullification proposals, lawmakers in forty-two states have introduced general Tenth Amendment “reinvigoration” amendments or resolutions, affirming states’ constitutionally reserved powers.

Within hours of the President’s signing ACA into law, thirteen states’ attorney generals filed federal lawsuits challenging the constitutionality of the law on states’ rights

---

10 See id. (see, e.g., Alaska, Arizona, Arkansas, Georgia, Iowa, Kansas, Kentucky, Maryland, Michigan).
11 See id. (see, e.g., Alaska, Indiana, Iowa).
12 See id. (see, e.g., Kentucky, New Hampshire, Pennsylvania, South Carolina).
13 See id. (see, e.g., Louisiana, Maryland, Virginia, Wyoming).
14 See id. (see, e.g., Arizona, Colorado, Delaware, Oklahoma, Utah).
15 See id. (citing SCA 29, introduced by Sen. Strickland).
16 See id. (listing Arizona, Illinois, Iowa, Michigan, and New Hampshire as “States Opposing Health Reform Financing and Unfunded Mandates”).
grounds. Five additional states joined the lawsuits in the subsequent weeks. By June 2010, twenty states had joined the suits. The first suit, filed by Virginia’s Attorney General, rests on Virginia’s recently enacted statute providing that no resident of the state “shall be required to obtain or maintain a policy of individual insurance coverage.” The lawsuit asserts state standing based on the direct conflict between the new state statute and ACA and alleges that the federal individual insurance mandate exceeds Congress’s power to regulate interstate commerce. A second suit, filed by Florida and several additional states, also challenges the individual mandate as well as Medicaid expansion and health insurance Exchanges as encroachments on states’ Tenth Amendment reserved powers.

In addition to legislative and judicial wrangling, states have refused assist the federal government in implementing ACA, including several provisions that specifically call for state cooperation. Georgia’s Insurance Commissioner and gubernatorial candidate took the lead in informing United States Secretary of Health and Human Services, Kathleen Sebelius, that he would not comply with the Secretary’s request

---

20 See NCSL, supra note 4.
21 Virginia Complaint, supra note 18, at 2 (quoting Virginia Code § 38.2-3430.1:1).
22 Id., at 5 – 7.
23 Florida Complaint, supra note 18, at 4 – 6.
pursuant to the new federal law to create a state high-risk insurance pool.\textsuperscript{24}

Subsequently, at least nineteen more states similarly refused to help and declined federal grants to establish high-risk pools, leaving the job to the federal government.\textsuperscript{25}

In the view of most commentators, those efforts are nothing more than political theater, mid-term election-year gamesmanship, and tea party antics. The merits of the states’ lawsuits, asserting that the individual mandate is an unprecedented, unconstitutional extension of federal commerce power, are generally dismissed as meritless.\textsuperscript{26} Resolutions suggesting that federal law would not apply within particular states’ borders are null as a matter of the Constitution’s Supremacy Clause.\textsuperscript{27} The likelihood of a federal constitutional amendment overturning ACA is exceedingly unlikely.\textsuperscript{28} There is a long history of state nullification efforts in the nation’s history,\textsuperscript{29}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{image}
\caption{Graph of data \textsuperscript{30}}
\end{figure}

\begin{table}
\centering
\begin{tabular}{|c|c|c|}
\hline
\textbf{State} & \textbf{Year} & \textbf{Status} \\
\hline
Florida & 2010 & Filed lawsuit \\
\hline
Virginia & 2010 & Filed lawsuit \\
\hline
\end{tabular}
\caption{Table of states and their status regarding ACA lawsuits}
\end{table}


\textsuperscript{28} G. ALAN TARR, \textit{UNDERSTANDING STATE CONSTITUTIONS} 23 (1998) (noting that the federal constitution has been amended less than once per decade, compared to states, which regularly amend and revise their constitutions); Daniel B. Rodriguez, \textit{State Constitutionalism and the Domain of Normative Theory}, 37 SAN DIEGO L. REV. 523, 527 (2000) (noting “key distinction between the federal and state constitutions
including recent, similar efforts by states and localities opposing the post-9/11 USA PATRIOT Act. But notions of state-level armed resistance, a health care “Tariff of Abominations,” or latter-day Orval Faubus figures, seem laughable. Nevertheless, the state resistance movement continues to gather steam. Rather than dismiss the movement as meritless, its persistence and pervasiveness warrants consideration. This Article identifies the potential value to the national health care conversation and federal-state relations of the renewed, and sometimes sincere, interest in structural federalism being voiced by health reform opponents.

III. Explanations for State Resistance to Health Reform


This Part begins by outlining the federal and state governments’ overlapping powers for health care regulation and administration and traditional values associated with a federal system of government. Then, the Part considers two plausible explanations for the state health reform nullification movement: uncooperative federalism, which considers state-based dissent as potentially valuable, and opportunistic federalism, which dismisses state-based dissent as disingenuous. Each theory begins to rationalize the array of state responses to ACA, but neither provides a fully operative explanation for the current health reform nullification movement.

The first theory, uncooperative federalism, posits that even when states obstruct or refuse to help federal authorities, the interactive process may benefit policymaking.\(^{35}\) The second theory, opportunistic federalism, suggests that opponents of substantive policies invoke federalism not because they actually care about the structural allocation of power but simply as a way to achieve some other ideological end.\(^{36}\) Closer examination of states’ responses to particular provisions of ACA in Part IV reveals the limits of and, in some cases, defies those theories. This Article offers rhetorical federalism as a more accurate depiction of the federal-state dynamic currently at work in health care decisionmaking.

A. Health Care Federalism


Health care falls squarely in the realm of shared federal and state powers, creating a ripe environment for friction. The allocation of power and responsibility between the federal and state governments is constitutionally grounded and part of the Framers’ design to facilitate centralized coordination at the federal level, on the one hand, and diffusion of power and respect for state sovereignty, on the other hand. Federal powers are enumerated in the Constitution, including the power to tax and spend, regulate interstate commerce, and provide for national security. Other than the specifically enumerated federal powers, all other governmental power is reserved to the states under the Tenth Amendment.

Most federal health care legislation is enacted under the spending or commerce powers. Spending Clause legislation must address matters of national concern and benefit the general welfare. Spending Clause challenges to federal health and welfare

---


38 See, e.g., Printz v. United States, 521 U.S. 898, 918 (1997) (“It is incontestable that the Constitution established a system of ‘dual sovereignty.’”); South Carolina v. Baker, 485 U.S. 505, 533 (1988) (“If there is any danger, it lies in the tyranny of small decisions—in the prospect that Congress will nibble away at state sovereignty, bit by bit, until someday essentially nothing is left but a gutted shell.”) (O’Connor, J., dissenting) (quoting Lawrence Tribe, American Constitutional Law § 5-20, at 381 (2d. ed. 1988)); see Roderick M. Hills, Jr., The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and “Dual Sovereignty” Doesn’t, 96 Mich. L. Rev. 813, 816 (1998) (“The national government has unique powers in maintaining the supremacy of federal law and an orderly federal system, yet there must be a limit to federal power and a corresponding reservoir of state power if federalism is to have any meaning at all.”).

39 See generally U.S. CONST. art I, § 8 (listing federal powers).

40 U.S. CONST. amend. X (The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively or to the people.); see Printz, 521 U.S. at 919 (noting that the states retained “a residuary and inviolable sovereignty” (quoting James Madison, The Federalist No. 39, at 245)).

legislation have been consistently rejected. The Commerce Clause generally accords broad powers to the federal government, although the Supreme Court recently has restricted Congress’s attempts to legislate social policy as not sufficiently impacting interstate commerce. Under the Supremacy Clause, as long as the federal government acts within its constitutionally enumerated powers, its laws are supreme and preempt any contrary or inconsistent state laws.

States retain vast reserved powers and broad discretion to carry out state policy objectives. Health, welfare, and safety fall squarely within states’ traditional reserved powers. States have exercised their reserved powers over health care in various forms, including licensing of health care professionals and facilities, licensing and regulation

---

44 U.S. Const. art. VI, para. 2 (“This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the contrary notwithstanding.”).
45 See Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 203 (1824) (describing state police powers as “immense mass of legislation, which embraces everything within the territory of a State, not surrendered to the general government”).
46 See United States v. Lopez, 514 U.S. 549, 564 (1995) (“In addition to criminal law enforcement and education, health care regulation is an area where states historically have been sovereign.”); Jacobson v. Massachusetts, 197 U.S. 11, 24–25 (1905) (recognizing “the authority of a State to enact quarantine laws and ‘health laws of every description;’ indeed, all laws that relate to matters completely within its territory and which do not by their necessary operation affect the people of other States”).
of health insurance companies, common law standards of care and other civil liability theories, and establishment of public health departments and agencies dedicated to protecting the health and welfare of residents.

States’ reserved powers offer unique opportunities for states to address social problems and other public policy concerns. The federal Constitution establishes a floor, requiring states to recognize at least that level of protection to individual rights. But states may exceed the federal floor and accord even greater protection. Advocates of “new federalism” would amplify that state role, “creating in every state a vigorous, independent body of state constitutional law.” More broadly, the new federalism

49 See McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1012(a) (“The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.”).
movement seeks reinvigoration of states rights and a shift in the balance of power back to state governments through judicial and legislative channels.\footnote{55} States have embraced new federalism in a number of areas, recognizing broader free speech, criminal procedure, public education, and abortion rights.\footnote{56}

State governments also allow alternative forums for citizen participation in the political process. State legislatures may be more accessible and responsive to constituents’ interests and concerns than Congress.\footnote{57} Local representatives also may embrace and express particular values and priorities of their communities, not shared by the entire nation.\footnote{58} Different territories may have different tastes and needs, especially on

\begin{quote}
\end{quote}

\begin{quote}
\end{quote}

\begin{quote}
See, e.g., Cruzan v. Director, 497 U.S. 261, 280 – 82 (1990) (recognizing that Missouri is entitled to accord stronger protection to preservation of life than federal law by requiring clear and convincing evidence to terminate life support).
\end{quote}

\begin{quote}
See Garcia v. San Antonio Metro. Transit Auth., 469 U.S. 528, 575 n.18 (1985) (Powell, J., dissenting) (“The Framers recognized that the most effective democracy occurs at local levels of government, where people with firsthand knowledge of local problems have more ready access to public officials”); Amar, supra note 53, at 1234 (“federalism operates to edify and engage the citizenry”); Chemerinsky, supra note 55, at 527 (“[T]o the extent the electorate is small, and elected representatives are thus more immediately accountable to individuals and their concerns, government is brought closer to the people, and democratic ideals are more fully realized.”); Betsy J. Grey, The New Federalism Jurisprudence and National Tort Reform, 59 WASH. & LEE L. REV. 475, 511 (2002) (noting that one value of federalism is “foster[ing] governments that are more responsive than Congress to the needs of local citizens”).
\end{quote}

\begin{quote}
\end{quote}
social policy matters. The diversity of approaches creates a “political marketplace,” allowing citizenry a choice of laws, customs, and attitudes rather than a one-size-fits-all approach to policymaking. Individuals who object to policies in one state ultimately may exercise exit rights, moving to another state.

In addition, states serve as laboratories of democracy, experimenting and crafting solutions to problems, which approaches can be borrowed by other states and the federal government. One state’s experience may counsel for or against similar policies or laws. For example, Massachusetts’s 2006 comprehensive state health reform plan was referenced by state and federal policymakers during the recent reforms.

ACA contains

Introductory Remarks, 29 HAMLINE J. PUB. L. & POL’Y vii, xiv (2007 – 2008) (“The individual states are closer to the people, and hence better equipped to reflect their plurality of values”); Robert A. Schapiro, Identity and Interpretation in State Constitutional Law, 84 VA. L. REV. 389, 403 (1998) (discussing view that state constitutional interpretation “should be guided by various indicia of state distinctiveness”).

See Alan R. Weil & James R. Tallon, Jr., The States’ Role in National Health Reform, 36 J.L. MED. & ETHICS 690, 690 (2008) (“[S]tate policies can be more closely tailored to local economic conditions and can reflect local values . . . .”).

Amar, supra note 53, at 1237 – 38; Ernest A. Young, The Rehnquist Court’s Two Federalisms, 83 TEX. L. REV. 1, 54 (2004) (the best way to please more of the people more of the time is to offer a choice of regulatory regimes”).

Gregory v. Ashcroft, 501 U.S. 452, 458 (1990) (discussing, among other federalism values “it makes government more responsive by putting the states in competition for mobile citizenry”); Richard A. Epstein, Exit Rights Under Federalism, 55 LAW & CONTEMP. PROBS. 147, 150 (1992) (“Federalism works best where it is possible to vote with your feet”); Long, supra note 53, at 101 (“Diversity among the states also permits mobile Americans to vote with their feet.”).

New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”); see Amar, supra note 53, at 1233; Chemerinsky, supra note 55, at 528–29 (“A final argument that is frequently made for protecting federalism is that states can serve as laboratories for experimentation.”); Gardner, supra note 53, at 486–87 (suggesting that the states-as-laboratories approach produces potentially valuable information about policy alternatives); Grey, supra note 57, at 512 (noting “Justice Brandeis’s famous observation about the states as laboratories for experimentation”); Long, supra note 53, at 56 (summarizing “laboratories of democracy” rationale for independent judicial interpretation of state constitutions); Rich & White, supra note 41, at 868 (“[S]tates have amply demonstrated an ability to come up with innovative new solutions and act as ‘laboratories of democracy’ in important social policy areas like health care.”).

numerous provisions pioneered by Massachusetts, including the individual mandate, employer mandate, and health insurance exchanges. Especially on controversial issues, it may be beneficial to allow public sentiment and judicial deliberation slowly to percolate up from the states through those experiments, rather than rushing a broad, federal pronouncement that may generate backlash or ill-fitting solutions.

Previous scholarship recognizes the value of dissent, especially state-level dissent, within a federal system. Dissent contributes to the marketplace of ideas, engages electoral minorities, and facilitates self-expression. The Framers envisioned friction, clashes, and “jarring” as part of the constitutional design. States may act as lobbyists and litigants, challenging federal policies and laws. Objections may be voiced by states qua states, or by states as spokespersons for individuals. Many of the same values underlying federalism – providing an accessible forum for political participation,
allowing state experimentation, diffusing power, and recognizing more robust individual rights – further support the value of state dissent.

B. Uncooperative Federalism

The first plausible theory to explain states’ resistance to federal health reform is uncooperative federalism. Uncooperative federalism operates as a novel counter-theory to the established theory of cooperative federalism. Cooperative federalism envisions the federal government and states working together as partners to address common problems or implement legislation.\(^71\) States serve as supportive allies, freely and voluntarily, albeit often with strong encouragement, implementing federal policies.\(^72\) ACA employs several cooperative federalism strategies to engage states in implementing the massive package of health care reforms, including conditional funding, conditional preemption, block grants, and contractual arrangements between states and the federal government. Under its spending power, Congress may entice states to enact laws or implement programs by conditioning grants of federal funds on states’ compliance with broad federal


\(^{72}\) See Buzbee, supra note 53, at 1550 (“[C]ooperative federalism [programs] typically involve a federal statute that regulates a risk or addresses a social need [but] do not depend solely on federal actors for their implementation and enforcement.”); Evan Caminker, The Unitary Executive and State Administration of Federal Law, 45 KAN. L. Rev. 1075, 1075 (1997) (“Congress frequently encourages states to become regulatory partners in federal programs, sometimes by threatening to preempt the existing regulations of non-participating states, and other times by rewarding participation with substantial monetary congressional invitations”); Susan Rose-Ackerman, Cooperative Federalism and Co-optation, 92 YALE L.J. 1344 (1983); Joshua D. Sarnoff, Cooperative Federalism, the Delegation of Federal Power, and the Constitution, 39 ARIZ. L. Rev. 205, 205; Frank R. Strong, Cooperative Federalism, 23 IOWA L. Rev. 459, 479–82 (1938) (introducing a symposium on “cooperative federalism”).
requirements. The federal government can offer funds with strings attached thereby effecting state-level implementation of federal programs but cannot directly regulate states or “commandeer” state regulatory authorities to implement, administer, or enforce federal programs. Medicaid is a classic example of a “cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons.”

Uncooperative federalism, a theory articulated by Jessica Bulman-Pozen and Heather Gerken, identifies the value of states’ refusals to assist and support federal policies. Bulman-Pozen and Gerken’s uncooperative federalism model departs from “dual sovereignty” or state autonomy theories of federalism, which view states as autonomous rivals to federal power and advocate broader interpretation of state powers. By contrast, Bulman-Pozen and Gerken consider the power that states wield precisely because of their subservient posture. They focus on the “power of the servant” and “the ways in which integration can serve as a distinct source of strength.”

---


74 See Dole, 483 U.S. at 206 (noting that “objectives not thought to be within Article I’s ‘enumerated legislative fields’ ... may nevertheless be attained through the use of the spending power and the conditional grant of federal funds”) (citing Butler, 297 U.S. at 65); see also Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17 (1981) (“[O]ur cases have long recognized that Congress may fix the terms on which it shall disburse federal money to the States.”).

75 Printz v. United States, 521 U.S. 898, 925 (1997) (citing cases that “made clear that the Federal Government may not compel the States to implement, by legislation or executive action, federal regulatory programs”); New York, 505 U.S. at 162 (1992) (“the Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress’ instructions”); see Caminker, supra note 72, at 1075, n.3 (1997) (discussing Court’s holding in New York).


77 Bulman-Pozen & Gerken, supra note 35, at 1256.

78 Id. at 1261 – 62, 1307.

79 Id. at 1263, 1308.

80 Id. at 1265.
Lacking adequate financial resources or regulatory reach to implement comprehensive programs, the federal government often depends on states to implement and administer federal policies.\(^81\) Because Congress cannot simply mandate or require states to administer federal programs, it must offer carrots, such as conditional funding or block grants, or sticks, such as conditional preemption or threats to take-over state implementation.\(^82\) In so doing, the federal government cedes considerable power and discretion to states by engaging them as partners. For example, under Medicaid, states must comply with broad federal requirements but otherwise are free to tailor their state plans to meet their citizens’ particular needs, still receiving federal matching dollars for every state dollar spent. Even though the federal government ultimately holds the threat of revoking federal funds or taking over state programs, financial, political, and practical realities may render that threat an empty one.\(^83\)

States’ power as servants also derives from their integration into federal program implementation.\(^84\) State regulators and policymakers have regular interaction with federal authorities in administering complex, cooperative programs. State actors may also develop subject-matter specialization within certain areas, such as environmental or health policy, which transcends federal and state lines of authority.\(^85\) A related source of power derives from the fact that states serve two masters: the federal government and their state constituents.\(^86\) Voters’ dissenting views give states the political will and capital to challenge federal policies.

---

\(^{81}\) Id. at 1267.
\(^{82}\) See Jost, supra note 27, at 56.
\(^{83}\) Bulman-Pozen & Gerken, supra note 35, at 1269 – 70.
\(^{84}\) Id. at 1268 – 70.
\(^{85}\) Id. at 1270 (citing Roderick Hills’s “picket-fence federalism”).
\(^{86}\) Id.
Bulman-Pozen and Gerken conclude that uncooperative federalism is not necessarily destructive and may in fact be useful within a well-functioning federal system.\textsuperscript{87} Friction between the federal government and states fosters a rich dialogue, clarifies accountability, and encourages political participation.\textsuperscript{88} Doctrinal implications of the uncooperative federalism theory suggest that commandeering, traditionally viewed as unacceptably intrusive on autonomous states, perhaps should be allowed or encouraged because it fosters dissent.\textsuperscript{89} Uncooperative federalism, like state autonomy theories, prefers narrow preemption to create larger overlapping spheres of federal and state regulatory authority thereby ensuring ongoing conflict and jarring.\textsuperscript{90}

The authors are equivocal on the value of conditional spending programs like Medicaid in advancing their theory. The amount of power that states wield as servants under conditional spending schemes depends on how badly states need the federal money. If states have no real choice but to accept the federal funds, conditional spending essentially becomes commandeering, sparking various forms of desirable state resistance and dissent.\textsuperscript{91} But if states can freely decline the federal government’s offer, or bargain for additional terms, little meaningful dialogue remains. States that freely opt out of cooperative federalism programs have little reason to object, while states that bargain effectively may have their objections appeased.\textsuperscript{92}

\textsuperscript{87} \textit{Id.} at 1260, 1307.
\textsuperscript{88} \textit{Id.} at 1285 – 90.
\textsuperscript{89} \textit{Id.} at 1297 – 98.
\textsuperscript{90} \textit{Id.} at 1303 – 04.
\textsuperscript{91} \textit{Id.} at 1300.
\textsuperscript{92} \textit{Id.} at 1301.
Bulman-Pozen and Gerken offer the beginnings of a working theory and invite additional case studies and doctrinal articulation. This Article engages that invitation in the context of federal health reform, finding the theory useful but incomplete. The newly enacted federal statute relies heavily on states as servants to implement various key components over the next several years and maintain those structures and laws perpetually. As the uncooperative federalism model predicts, states have exercised their power as federal servants to object to various provisions of the new law. But they also have passively accepted provisions of the law that impose significant burdens on servant states and intrude deeply on state terrain. At the same time, states invoke the rhetoric of federalism to object to ACA provisions that implicate state responsibility hardly at all, a reaction that seems to fall outside of the uncooperative federalism theory.

C. Opportunistic Federalism

Another plausible explanation for state resistance to federal health reform is opportunistic federalism. Opportunistic federalism is not a distinctly articulated theory but a theme identified by various scholars. The idea is that opponents of particular

93 Id. at 1308 – 09.
94 See, e.g., Lynn A. Baker, Twenty-Year Legacy of South Dakota v. Dole, 52 S.D. L. REV. 468, 487 (2007) (“[O]portunistic embrace of federalism when it is convenient to attaining one’s substantive ends is quite different from a more general commitment to federalism, where one would have to take the quite-often bitter with the only-sometimes sweet.” (quote from Sanford Levinson’s response to Professor Baker’s talk)); Tim Conlan, From Cooperative to Opportunistic Federalism: Reflections on the Half-Century Anniversary of the Commission on Intergovernmental Relations, 66 PUB. ADMIN. REV. 663, 667 (2006) (“By opportunistic, I mean a system that allows – and often encourages – actors in the system to pursue their immediate interest with little regard for the institutional or collective consequences.”); Marc R. Poirier, Same-Sex Marriage, Identity Process, and the Kulturkampf: Why Federalism is Not the Main Event, 17 TEMP. POL. & CIV. RTS. L. REV. 387, 400 (2008) (There will certainly be opportunistic federalism – gamesmanship in framing arguments about what level of jurisdiction to apply to a resource, where various positions are motivated by the perception that one level of regulation – local, state, federal, or international – will as a practical matter be more favorable to a particular desired overall result than
policies may invoke federalism as the basis for their objections although, in reality, they care very little about the structural allocation of power between states and the federal government. Federalism arguments are mere proxies for substantive objections to particular laws and policies.

Opportunistic invocation of federalism to advance political positions has a long history in the United States, beginning with Southern states’ resistance to abolition and, later, desegregation. Frank Cross maintains that “federalism is consistently (and I contend inherently) employed only derivatively, as a tool to achieve some other ideological end, rather than as a principled end in and of itself.” He observes the trend among not only voters and politicians but also judges. Selective enforcement of federalism among the judiciary crosses partisan lines. Conservative justices invoke states’ rights grounds to reject habeas corpus petitions but underplay federalism implications of striking down state business regulations, voter redistricting, or affirmative action plans. Likewise, liberal justices cry federalism to strike down myriad conservative state legislation. One of the most notorious recent examples of conservative, judicial opportunistic federalism was the Rehnquist Court’s decision in Gonzales v. Raich, “holding that Congress’s Commerce Clause authority includes the power to prosecute purely local cultivation of marijuana for medical use, despite a statewide referendum another.”; Ryan, supra note 37, at 598 – 99 (describing “Americans’ historically opportunistic use of federalism” as described in other scholars’ work).

Cross, supra note 29, at 1306 (“Federalism’s role in American history as a stalking horse for racism is infamous.”); see also Devins, supra note 36, at 134 (noting “pattern of shifting constitutional positions on federalism runs throughout American history” and citing examples); Ryan, supra note 37, at 599 (“Among the most famous examples of such federalism opportunism is the role reversal between pro-slavery and abolitionist interests before and after the Civil War.”).

Cross, supra note 29, at 1307 (citing other sources, mostly commenting on Court’s selective use of federalism to achieve desired ends).

Id. at 1308 – 11

Id.

545 U.S. 1 (2005).
legalizing intrastate use and production of marijuana for approved medical purposes.”

In Gonzales, the otherwise federalist-leaning Court uncharacteristically trammeled on states’ rights to uphold federal drug control powers.

Other scholars focus on the role of courts as protectors of structural federalism against opportunistic federalism by voters, special interest groups, and politicians. 101 Neal Devins observes that

the willingness of lawmakers and interest groups to manipulate federalism in order to secure preferred substantive policies is the rule. Indeed, the historical record is so overwhelming that it is hard to believe that a majority of informed voters would suspend their personal policy preferences in order to reap the benefits of structural federalism.102

Given that federalism is undervalued in the political process, Devins calls on courts to police structural federalism, 103 urging the Supreme Court, in particular, to “racket up” its reinvigoration of federalism.104

John McGinnis and Ilya Somin agree that the political process fails to protect federalism values. But the problem, they contend, is not necessarily that voters do not value federalism but that elected representatives are not politically motivated to protect structural federalism. 105 “Elected officials invoke federalism when it comports with their substantive policy preferences, but they otherwise do not care about the federal-state

100 Ryan, supra note 37, at 600 – 01; see Raich, 545 U.S. at 19 – 21.
102 Id. at 134.
103 Id. at 137.
104 Id. at 139.
105 McGinnis & Somin, supra note 101, at 90.
McGinnis and Somin believe that if voters were knowledgeable and adequately informed about federalism values they might, in certain cases, subordinate other policy preferences in favor of preserving the structure of government. But the system breaks down because politicians, acting as agents for their voter principals, “have systemic political interests that often cause them to undermine federalism.” Voters’ “rational ignorance” of the “complex issue” of structural federalism means they will not push elected representatives to protect those values. McGinnis and Somin note:

Federalism is an abstract and complicated system compared to many underlying public policy issues like drugs and education, which are more concrete and more likely to engage the passions of citizens. Thus, when a federalism issue becomes a matter of public controversy, it almost always focuses on the specific policy question at hand than on federalism more generally.

Because neither state nor federal officials stand to gain politically by protecting federalism, courts must step in to safeguard governmental structure. The authors clarify from the outset that they are agnostic on strong state versus strong federal powers; the federalism that they seek to protect is simply the constitutional allocation of power.

Erin Ryan also describes the pervasiveness of opportunistic federalism in judicial and political contexts but ultimately concludes, for the sake of her argument, that the concern for structural federalism is earnest. She asserts that “our continued commitment

---

106 Devins, supra note 36, at 137.
108 Id. at 103.
109 Id. at 90.
110 Id. at 96.
111 Id. at 91.
112 Id. at 89.
to structural tension between local and national authority must stem from a conviction that it confers important architectural advantages” beyond federalism’s historical origins or political preferences. But Ryan cautions us not to assume that Americans necessarily or consistently place high importance on federalism, describing numerous examples of opportunistic federalism, beginning with the Louisiana Purchase. Ryan observe that federalism “is inherently content-neutral with regard to substantive political issues” and acknowledges other scholars’ observations that political preferences tend to trump governmental structure preferences. She also notes that critics of the “New Federalism revival” dismiss it as “an opportunistic political ploy attempting substantive political objectives under the unrelated guise of preserving constitutional federalism.” Despite strong evidence of opportunistic federalism, Ryan maintains, for the sake of her argument, that we do, in fact, value federalism as a policy-neutral, structural matter. She then articulates a model of balanced federalism for resolving inherent tension between federal and state authority.

The foregoing scholarship demonstrates a recognized trend of opportunistic federalism. States’ rights arguments and Tenth Amendment claims pervade the ongoing federal health reform debate. Opportunistic federalism provides a plausible explanation inasmuch as many health reform opponents objection may not be primarily about the allocation of power between states and the federal government. But opportunistic federalism is an overly blunt explanation for the current national dialogue. After considering ACA objections more carefully, it is apparent that opponents loudly, if

113 Ryan, supra note 37, at 598.
114 Id.
115 Id. (quoting, among others, Devins: “No one really cares about federalism.”).
116 Id. at 600.
117 Id.
selectively, do seem to care very deeply about protecting state authority from federal encroachment, aside from opinions on the merits of ACA or deeper ideological issues of health care rights and responsibility. Moreover, the constant invocation of federalism rhetoric in the health reform conversation suggests that federalism has greater political salience than opportunistic federalism theories suggest. Even if some of the rhetoric is empty, incoherent, or inconsistent, nuanced issues of health care policymaking and implementation are now placed “at the center of American political life.”

Opportunistic federalism theories do not fully account for the rhetorical value of federalism in the current debate.

IV. Role of States in Federal Health Reform

ACA is staggering in scope and length, addressing everything from employer responsibility to offer health insurance, prohibition on preexisting condition exclusions in health insurance plans, health care provider payment increases, public health demonstration projects, expansion of federal health care programs, extension of

---

118 See Huq, supra note 26 (suggesting that states’ lawsuits “seem to resonate with deeply felt, if sometime inchoate sentiments about the proper role of the federal government, the states, and individual liberty”).
121 HCERA§ 1003(a) – (c); ACA § 1511.
122 ACA § 1201(a)(2)(A) (amending Public Health Service Act (PHSA) § 2704).
123 See, e.g., HCERA §§ 1105(a) – (d) (Medicare market basket update), 1109(a) (Payment for qualifying hospitals), 1202(a)(1)(A), (b) (Medicaid payment to primary care physicians); ACA §§ 3401(a) (Medicare market basket updates), 3023 (Bundled payment pilot project), 3102(b)(2) (adjustments to physician fee schedule).
124 See, e.g., ACA §§ 4201(a) (community transformation grants), 4202 (a)(1) CDC grants to states or large local health departments to control chronic health conditions of pre-Medicare population), 4102(a) (grants
dependent child coverage, health information technology, break-time for nursing mothers, taxes on tanning salon customers, and restaurant nutrition labeling, to name just a few.

This Part describes ACA provisions relevant to the role of states in health reform and states’ reactions to the new laws. The discussion begins with Medicaid, a long-standing cooperative federalism program in which all states participate but to which many are now objecting. Next, it is useful to consider states’ divergent reactions to two new requests under ACA for state cooperation with federal authorities: High-risk insurance pools, which many states have resisted, and health insurance Exchanges, to which states seem amenable. Another revealing example is states’ lack of objection to a host of new federal health insurance market regulations that broadly preempt state authority and discretion. Finally, states’ loudest objections are directed at the individual health insurance mandate, a new federal requirement that has very little impact on state authority and discretion.

The survey of ACA provisions reveals that state resistance does not follow a consistent, principled line or fit a single federalism theory. States balk at voluntarily programs yet fail to exercise their exit rights. States walk both sides of the line on new requests for cooperation, at times objecting loudly to federal authorities’ requests and at times willingly assuming the role of able servants. States seem to tolerate expansive

---

125 HCERA §§ 1101(a)(1) (closing Medicare Part D “donut hole”), 1201(a)(1)(B) (federal funding for Medicaid expansion); ACA §§ 3301(b) (closing Medicare Part D “donut hole”), 2001(a)(1)(C) (Medicaid expansion), 2101(b)(1) (requires states to maintain CHIP eligibility levels).
126 ACA § 1001 (amending PHSA § 2714).
127 ACA § 1561.
128 ACA § 4207.
129 ACA § 10907(b).
130 ACA § 4205(b).
federal preemption of their traditional reserved powers yet strenuously resist federal attempts to restrict individual rights of their residents. Despite the inconsistency, it is notable that when states do object, federalism is the rallying cry. The health reform debate has given new political salience to the rhetoric, if not the substance, of federalism.

A. Medicaid Expansion

Medicaid is a long-standing, classic example of cooperative federalism that relies heavily on states to carry out federal policies.\textsuperscript{131} Although states have long participated in Medicaid, several states are now raising federalism objections to ACA’s Medicaid provisions, including new eligibility rules and additional administrative requirements. Medicaid is a conditional spending program whereby Congress offers federal dollars to states that agree to implement state Medicaid programs.\textsuperscript{132} The federal Medicaid statute outlines broad eligibility, coverage, provider enrollment, and procedural requirements. States that agree to implement programs meeting those requirements receive a percentage-on-the-dollar match from the federal government for every state dollar spent


on the approved program.\textsuperscript{133} States may also receive federal matching dollars for state spending on certain optional groups of beneficiaries and services.\textsuperscript{134} Financial contribution by both the states and the federal government is the “cornerstone of Medicaid.”\textsuperscript{135} States are incentivized to provide generous public benefits, receiving federal support for every dollar spent, while the federal government shifts a portion of the funding burden to states.\textsuperscript{136}

Medicaid is entirely voluntary; states do not have to participate and could refuse federal dollars, establishing their own state indigent health care programs or electing not to provide any medical assistance for low-income individuals. All states have accepted the conditional funding carrot and operate approved state Medicaid plans.\textsuperscript{137} The constitutionality of cooperative federalism arrangements like Medicaid is beyond serious doubt as states retain the option of simply walking away from the partnership and refusing federal dollars.\textsuperscript{138}


\textsuperscript{135} Harris v. McRae, 448 U.S. 297, 308 (1980).

\textsuperscript{136} \textit{Strong}, supra note 72, at 479 – 82.


\textsuperscript{138} See New York v. United States, 505 U.S. 144, 167 (1992) (citing cases that exemplify use of the conditional spending power); South Dakota v. Dole, 483 U.S. 203, 203 (1987) (conditioning federal highway funds on states enacting laws limiting alcohol sales to minors and introducing limits on conditional spending power); Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17 (1981) (“[O]ur cases have long recognized that Congress may fix the terms on which it shall disburse federal money to the States.”); Helvering v. Davis, 301 U.S. 619, 645 – 46 (1937) (upholding mandatory payroll tax to support Social Security as constitutional use of congressional spending power); Steward Mach. Co. v. Davis, 301 U.S. 548, 592-93 (1937) (regarding unemployment compensation law); \textit{see also} \textit{Is Health Care Constitutional?}, N.Y. TIMES, Room for Debate Blog, March 28, 2010 (see Abbe Gluck, The Tenth Amendment Question, emphasizing that Medicaid is a voluntary program and that states are free to “drop
ACA expands Medicaid by creating a new, categorically eligible population and lowering the income threshold for certain currently eligible groups. Historically, Medicaid provided no coverage for low-income adults unless they had eligible children or were elderly or disabled. The new federal law extends Medicaid to all children, parents, and childless adults who are not entitled to Medicare and have family incomes up to 133 percent of federal poverty level (FPL).\(^{139}\) States may expand their Medicaid programs as early as April 1, 2010, and must cover newly eligible individuals by January 1, 2014.\(^{140}\) Also, beginning January 1, 2014, Medicaid income eligibility for children expands from the current 100 percent FPL to 133 percent FPL.\(^{141}\) All newly eligible individuals must be guaranteed a benchmark plan that provides essential health benefits, as defined in ACA.\(^{142}\) Medicaid currently covers sixty million Americans. By 2014, sixteen million more people will be eligible.\(^{143}\) By 2020, it is estimated that twenty-five percent of the U.S. population will be covered by Medicaid, making it the single largest payor of health care services in the country.\(^{144}\) The expansion is estimated to cost $434 billion just in federal dollars, not to mention state spending.\(^{145}\)

ACA places much of the funding onus for Medicaid expansion on the federal government. Under traditional Medicaid, the Federal Medicaid Assistance Percentage (FMAP) that states receive to match their state Medicaid spending varies based on states’...
relative poverty levels, from at least 50 percent up to 74 percent. Under the new law, the federal government will bear a larger percentage of the cost for newly eligible individuals. For the first three years, 2014 to 2016, the federal government will pay 100 percent of the cost for new eligibles in all states. Thereafter, the federal percentage phases down gradually, from 95 percent in 2017, to 90 percent in 2020 and thereafter.

States also face additional administrative requirements under ACA to coordinate Medicaid enrollment with other government and private health insurance plans. A new federal condition of participation for Medicaid requires states to establish Internet websites for patients to enroll in Medicaid and the state Children’s Health Insurance Program (CHIP). If individuals are deemed ineligible for Medicaid or CHIP, the website must screen for eligibility for premium assistance and Exchange enrollment, using the same application form. The federal government is responsible for creating the streamlined application form, but states may develop their own, alternative forms, as long as they meet federal requirements.

147 HCERA § 1201; ACA § 2001.
149 ACA § 2201(a), (b) (amending Social Security Act, 42 U.S.C. § 1943). The State Children’s Health Insurance Program (CHIP) is another cooperative federalism program, offering states federal block grants to extend state health plans to children who otherwise exceed the income eligibility requirements for Medicaid. CHIP, 42 U.S.C. §§ 1397aa – 1397jj; see Kenney & Yee, supra note 137, at 356. States also must maintain current income eligibility levels for children in CHIP through September 30, 2019, and receive a 23% increase in the federal CHIP match. ACA § 2101.
150 ACA § 2201(b)(1).
151 Id. § 1413(b)(1)(A).
152 Id. § 1413(b)(1)(B).
Expansion of the Medicaid program is one of the central complaints in the Florida lawsuit, which characterizes the legislation as “an unprecedented encroachment on the sovereignty of states.” 153 The suit acknowledges that Medicaid began as a voluntary partnership between states and the federal government in which states could freely participate or decline. But over more than four decades of Medicaid’s existence, the Plaintiff States assert, the program has become “customary and necessary for citizens throughout the United States.” 154 Accordingly, they claim that states no longer have any real choice about participating, turning the program into “a compulsory top-down federal program” that exceeds federal enumerated powers and intrudes on states’ reserved powers. 155

In addition to lawsuits, state objection to Medicaid expansion has taken other forms. Legislation pending in New Hampshire would prohibit expansion of the state Medicaid program unless the state legislature approves or the federal government funds the expansion. 156 Five other states are considering similar bills resisting additional financial burdens on states as a result of federal health care reforms. 157 In congressional debates over the United State Senate health reform bill, Senator Ben Nelson of Nebraska agreed to sign the bill only in exchange for a special provision providing one hundred percent federal funding for Medicaid expansion exclusively for his state. 158 The “Cornhusker Compromise” was struck from the final law but evidences state resistance to

153 Florida Complaint, supra note 18, at 4 – 5.
154 Id. at 5; see Rosenbaum, supra note 26, at 1954 (summarizing and critiquing arguments).
155 Florida Complaint, supra note 18, at 5.
156 See NCSL, supra note 4 (citing, e.g., New Hampshire S.B. 417, introduced by Senator Bradley).
157 Id. (listing Arizona, Illinois, Iowa, Michigan, and New Hampshire).
cooperatively funding the federal program.\textsuperscript{159} Several months after ACA’s enactment, Congress voted in emergency session to provide additional federal Medicaid funding for states, through June 2011,\textsuperscript{160} but with no promise of additional funding for Medicaid expansion under ACA.

The two plausible federalism theories fall short of explaining state resistance to Medicaid expansion. Under uncooperative federalism, we should expect strenuous, resistance and meaningful dialogue. State litigation over Medicaid expansion and other forms of resistance should lead to some positive benefit. Under opportunistic federalism, we should find that allocation of power arguments are mere proxies for deeper, substantive policy preferences. But those predictions do not seem entirely accurate.

According to uncooperative federalism, the litigant states’ allegation that they no longer have any choice about participating in Medicaid should provoke strong dissent, leading to productive dialogue. If states no longer have a real choice, the federal-state partnership becomes more coercive than cooperative,\textsuperscript{161} nudging close to the commandeering line.\textsuperscript{162} Bulman-Pozen and Gerken’s theory predicts that if “states are so starved for federal funding that they cannot afford to turn down a federal invitation to join a regulatory scheme” and are “forced to implement a program they find distasteful”

\textsuperscript{159} HCERA § 1201(1).
\textsuperscript{161} South Dakota v. Dole, 483 U.S. 203, 211 (1987) (quoting Steward Mach. Co. v. Davis, 301 U.S. 548, 590 (1937)) (recognizing that conditions on federal grants may be unconstitutional if they are so “coercive as to pass the point at which ‘pressure turns into compulsion’
\textsuperscript{162} Florida Complaint, supra note 18, at 13 (“[Florida’s Agency for Health Care Administration (AHCA)] and other Florida agencies will be rendered arms of the federal government, and AHCA employees will be conscripted and forced to administer what is now essentially a federal Medicaid program”).
that “should push them to engage in variants of uncooperative federalism.”\textsuperscript{163} At the same time, states should wield particular power because the federal government relies on them to implement federal policy.\textsuperscript{164} The federal government is highly dependent on states to maintain their participation in Medicaid as a core component of the health care safety net. Using a program that is jointly funded by federal and state governments to achieve the goal of near-universal health insurance coverage allows the federal government to defray a considerable portion of the funding burden.\textsuperscript{165}

The uncooperative federalism theory is descriptively accurate inasmuch as the federal government is highly dependent on states to administer Medicaid and, at the same time, that states are effectively forced to cooperate, even if they do not like ACA’s Medicaid changes. But uncooperative federalism’s further normative suggestion that those conditions will produce meaningful dialogue has not borne out in the Medicaid context. States seem to hold considerable power and motivation, yet they have failed to protest forcefully or productively, other than filing lawsuits on dubious grounds.\textsuperscript{166} Objecting states have not suggested any preferable alternative policy, other than demanding more federal funds.\textsuperscript{167} No state has urged repeal of Medicaid or suggested that it will now opt-out of Medicaid to protest the new coverage and administrative requirements. Indeed, the essence of the Florida lawsuit is that states simply cannot opt out. In the Medicaid context, states’ dependence on federal funds both motivates resistance and silences dissent. Their practical inability to walk away from the

\textsuperscript{163} Bulman-Pozen & Gerken, \textit{supra} note 35, at 1301.
\textsuperscript{164} \textit{Id.} at 1266.
\textsuperscript{165} Rosenbaum, \textit{supra} note 26, at 1953.
\textsuperscript{166} \textit{See} Massachusetts v. Mellon, 262 U.S. 447 (1923) (holding that states have no standing to challenge the constitutionality of a federal law).
\textsuperscript{167} \textit{See supra} note 158 – 59 (describing the “Cornhusker Compromise”).
cooperative relationship mutes their objections. As the issue stands, the federal
government is not impelled to respond to states or consider other ways of extending
health insurance coverage to low-income individuals. The servant states stand angry but
impotent.

Opportunistic federalism is inapt to the Medicaid issue because objecting states
do, in fact, seem to care very much about structural allocation of power. Concerns about
state power, autonomy, and fisc – classic federalism tensions – motivate the resistance.
The Florida lawsuit alleges that Congress exceeded its spending power and intruded on
states’ reserved powers by effectively commandeering states to expand their Medicaid
program. ACA limits states’ discretion to exclude certain groups from Medicaid
eligibility and requires them to implement new beneficiary application and consumer
information improvements. States do not object, in the main, to a government health care
program for the indigent or a cooperative federal-state approach to covering those
individuals. They instead suggest that the cooperative, voluntary nature of the program
has been fundamentally altered by ACA’s onerous, expensive new requirements. Their
concerns, then, are precisely about allocation of power within the federalist system.
States’ federalism grounds for opposing Medicaid expansion are not opportunistic but
reveal true concerns about state authority.

B. High-Risk Pools

In addition to expanding the long-standing Medicaid program, ACA seeks to
enlist states for new cooperative health insurance programs. The first new program
involves high-risk insurance pools. ACA requires the U.S. Secretary of Health and Human Services (HHS), within ninety days of the law’s enactment, to establish temporary high-risk health insurance pools. As an alternative to establishing a federal high-risk pool, the statute allows the Secretary to contract with states or nonprofit organizations to carry out the requirement. At least twenty states elected not to cooperate with the federal government in establishing high-risk insurance pools, including strong vocal objections from some state lawmakers.

The new, temporary high-risk pools are intended to operate as stop-gaps until other provisions, namely, the prohibition on pre-existing condition exclusions, guaranteed issue and renewability, and the Exchanges take effect on January 1, 2014, on which date the high-risk pools will expire. ACA requires qualified high-risk pools to provide health insurance coverage without pre-existing condition exclusions and comply with specified premium and out-of-pocket limits. United States citizens with pre-existing

168 ACA § 1101(a).
171 See infra Part IV.D (describing insurance market reforms).
172 See infra Part IV.C (describing the Exchanges).
173 ACA § 1101(a).
174 Id. § 1101(c).
conditions who have been uninsured for six months are eligible for coverage through the temporary pools. 175

Under ACA, the Secretary may establish the high-risk pools directly or through contracts with eligible entities, including states or nonprofit entities. 176 States enter contracts with the Secretary and receive federal funding for establishing and administering the pools. ACA’s requirements expressly preempt any state laws relating to qualified high-risk pools established under the statute. 177 Accordingly, states that already operate pre-ACA high-risk pools could bring their existing programs into compliance with ACA or operate two separate programs side-by-side. 178 Alternatively, if states decline to operate high-risk health insurance pools, the federal government will establish and operate the pools. Congress appropriated five billion dollars for the purpose. 179 The Secretary proposed to allocate funds to states based on the existing CHIP formula, with state allotments ranging from $8 million to $761 million. 180

Twenty-nine states and the District of Columbia responded that they would accept the federal dollars and establish state high-risk pools. 181 Twenty states refused the funding, leaving the task to the federal government. 182 States that refused expressed concern about inadequate funding and unclear guidelines, fearing that the task would

175 Id. § 1101(d).
176 Id. § 1101(b)(2)(A).
177 Id. § 1101(g)(5).
178 Sebelius News Release, supra note 169.
179 ACA § 1101(g).
181 See Haberkorn, supra note 19.
ultimately devolve to an “unfunded mandate on states.”\textsuperscript{183} The cooperative and uncooperative states fell in roughly around party lines.\textsuperscript{184} States with Democratic governors generally agreed to operate the high-risk pools, while states with Republican governors generally refused. But there were notable exceptions.\textsuperscript{185} Republican Governor Arnold Schwarzenegger chose to accept $761 million annual federal dollars rather than let the federal government run California’s high-risk pool.\textsuperscript{186} But Wyoming’s Democratic Governor Dave Fruuenthal turned down $8 million in federal dollars, expressing concern that the funds would be insufficient.\textsuperscript{187} The political rhetoric is also mixed, with some suggesting that giving states the option to operate their own pools was intended to appease Republican concerns about expansion of federal power,\textsuperscript{188} and others suggesting that the state high-risk pools are “the first step in the recently enacted federal takeover of the United States health care system.”\textsuperscript{189}

As one of the first ACA provisions to take effect, state reaction to the high-risk pools is ripe for consideration under the operative federalism theories. States that lined up as supportive allies with the Secretary’s invitation to establish state high-risk pools exemplify the cooperative federalism model. Those states will receive federal funding in

\textsuperscript{183} See Robert Pear, States Decide on Running New Pools for Insurance, N.Y. TIMES, April 29, 2010 (quoting Governor Herbert of Utah and other state governors), available at http://www.nytimes.com/2010/04/30/health/policy/30health.html; see also Haberkorn, supra note 19 (noting that “states are concerned that the $5 billion HHS has to implement the program will quickly run dry, leaving cash strapped states with another tab”); Hoppe, supra note 170 (quoting Texas Governor Rick Perry, “As we’ve seen in federal education and stimulus programs, the administration is again asking states to commit to a program without knowing the rules of engagement.”).

\textsuperscript{184} See Haberkorn, supra note 19; Hoppe, supra note 170; Kaiser Health News, supra note 170.

\textsuperscript{185} See Pecquet, supra note 170 (listing two states with Democratic governors that will allow the Secretary to take over, and five states with Republican governors that will operate the high-risk pools themselves).

\textsuperscript{186} Pear, supra note 183 (also noting that Schwarzenegger believes, “The federal government has the right to force you into having a health care plan.”).

\textsuperscript{187} Pear, supra note 183.


\textsuperscript{189} See Pear, supra note 183 (quoting Georgia Insurance Commissioner and gubernatorial candidate, John W. Oxendine).
exchange for lending their administrative capacity and expertise to the health reform
effort. But states that refused federal dollars, thereby allowing the federal government to
operate high-risk pools in their states, defy conventional theories, especially if resisting
states are concerned about losing power to the federal government. The mostly
Republican state governors who are unwilling to cooperate in implementing high-risk
pools also generally oppose federal health reform and expansion of federal power to
regulate health care.\textsuperscript{190} Yet they decline an opportunity to retain state regulatory power,
receive federal funding, and establish their own state high-risk pools. The preference for
a national response is all the more curious considering that thirty-five states, including
several of the objecting states, already operate their own high-risk pools to address
similar concerns.\textsuperscript{191}

From an uncooperative federalism perspective, states’ recalcitrance makes some
degree of sense. States that decline to operate high-risk pools are using their power as
potential servants to decline federal dollars and refuse to lend a hand. To the extent that
the federal government depends on state cooperation to establish high-risk pools, the
Secretary may face a considerable administrative challenges establishing and operating
those programs in the twenty states that have opted out. That should create a climate in
which the federal government is compelled to listen closely to the dissenting states’
concerns and respond accordingly.\textsuperscript{192} But if the federal government is not dependent on

\textsuperscript{190} See Pear, \textit{supra} note 183, at 12 (noting that states, including Arizona, Georgia, Nevada, and Virginia,
have opted out of the high-risk pools). Virginia is leading one of the lawsuits challenging ACA as an
overreach of federal powers, and Arizona and Nevada are parties to the Florida lawsuit. \textit{See Update 3, \textit{supra} note 19.}

\textsuperscript{191} See Pear, \textit{supra} note 183, at 12 (noting that states, including Alabama, Minnesota, and Texas, have
existing high-risk pools but will allow the federal government to run the new ACA high-risk pools in their
borders). Alabama and Texas are named plaintiffs on the Florida lawsuit. \textit{See Update 3, \textit{supra} note 21.}

\textsuperscript{192} Bulman-Pozen & Gerken, \textit{supra} note 35, at 1266.
states and can just as easily operate the high-risk pools on its own or through contracts with nonprofit organizations, states’ refusals may have little impact.

The uncooperative federalism model further suggests that states may command power as a result of their integration with federal authorities.\footnote{Id. at 1268 – 69.} Health insurance regulation is deeply embedded in state governance. In particular, states have a long history, since 1976, of operating high-risk pools and the involved tasks of designating eligibility requirements, benefit packages, beneficiary cost sharing, and provider reimbursement rates.\footnote{See Tanya Schwartz, State High-Risk Pools: An Overview, Kaiser Commission on Medicaid and the Uninsured, Issue Paper no. 8041, Jan. 2010, available at http://www.kff.org/uninsured/upload/8041.pdf.} Any federal insurance high-risk pools would necessarily engage with and draw on state expertise and infrastructure.\footnote{See Jennings & Hayes, supra note 25.} Thus, states may hold considerable power deriving from their experience in the area, even if the federal government does not depend on them financially to implement the new high-risk pools.

If the uncooperative federalism theory is accurate, we should expect states’ refusal to use their power as potential servants to advance health care policymaking. But instead they seem to be using their power simply to obstruct health reform implementation at every turn. States’ refusal to establish high-risk pools states is certainly uncooperative but not particularly federalist. They stand willing to allow federal authorities to intrude considerably and continually on their borders in operating the high-risk pools. Moreover, states that have refused to participate offer no policy alternative or engage any purposeful dialogue. Those states can simply decline federal dollars and leave the Secretary to figure out how to comply with the ACA’s requirement,
offering no comment on the merits of the federal law.\textsuperscript{196} That refusal has teeth only if the federal government cannot manage to establish and maintain twenty state high-risk insurance pools. Perhaps that is precisely the hope of opponents: By refusing to cooperate and requiring the federal government to bear the full burden of establishing state exchanges, the program will buckle under its own weight.

States resisting ACA seem to be using federalism arguments selectively and, perhaps, opportunistically. Just as conservative Justices underplayed federalism concerns in striking down California’s medical marijuana law,\textsuperscript{197} states opposing ACA gloss over the deep state autonomy implications of allowing federal authorities to operate high-risk pools in their states. In the context of the high-risk insurance pools, federalism rhetoric is not animating the objections. If anything, federalism values are cast aside in pursuit of other objectives. States that refuse to cooperate surrender power and authority to the federal government, perhaps, with the goal of undermining the entire legislation, piece by piece. Opportunistic federalism begins to explain states’ responses to the high-risk insurance pools but a more complete picture develops when compared to state responses to other, similar provisions, namely health insurance Exchanges, considered next.

\textbf{C. Exchanges}

ACA also seeks to enlist state cooperation to establish new health insurance marketplaces, or Exchanges. So far, states have not voiced strong objections to the particularly onerous demands related to establishing state-operated health insurance

\textsuperscript{196} Bulman-Pozen & Gerken, \textit{supra} note 35, at 1297.

\textsuperscript{197} See \textit{supra} notes 99 – 101 and accompanying text (discussing Gonzales).
By contrast to the high-risk pools, the responsibility for which is assigned first to the federal government, which may then contract with states, responsibility for the Exchanges is assigned first to states, with the federal government as a backstop, should states fail to comply.

Health insurance Exchanges are ACA’s attempt to address historical flaws in the individual and small-group health insurance markets. Lacking the group purchasing power and insurance risk-pooling advantages of group coverage, individuals, small employers, and other groups struggle to obtain affordable private health insurance on the open market. Exchanges are intended to facilitate the availability, choice, and purchase of health insurance for those consumers. Exchanges centralize information, allowing consumers to compare plans, and facilitate use of tax credits or other subsidies to purchase health insurance. Currently, three states, including Massachusetts, as part of its comprehensive health reform in 2006, voluntarily operate state-based exchanges.

Both the House and Senate versions of the federal health reform law included Exchanges. But they differed in assigning primary responsibility for implementing and administering the Exchanges to the federal or state governments. The House Bill would have created a National Health Insurance Exchange but would have allowed states to opt

198 But see Florida Complaint, supra note 18, at 16 (alleging that “by requiring them to establish health insurance exchanges, [ACA] deprives them of their sovereignty and their right to a republican form of government”).
200 See Jost, supra note 199, at 53; Kingsdale, supra note 199; National Governors Association (NGA), Establishing a State-Level Exchange, Discussion Draft, March 15, 2010, at 1, available at http://www.nga.org/Files/pdf/1003HEALTHSUMMITEXCHANGE.PDF.
201 Jost, supra note 199, at 53; NGA, supra note 200, at 1.
202 NGA, supra note 200, at 1, 11 – 13 (describing exchanges in Massachusetts, Washington, and Utah).
in and operate state-based Exchanges if they demonstrated capacity to meet the federal requirements.\textsuperscript{204} The Senate Bill provided for state-based Exchanges, operated by state authorities or non-profit organizations.\textsuperscript{205}

The Reconciliation Bill passed by Congress and signed into law by the President took the Senate’s approach. States are required to operate Exchanges, but if they fail to do so, the federal government will step in. By January 1, 2014, each state must establish American Health Benefit Exchanges and Small Business Health Options Program Exchanges through which individuals and small businesses with up to one hundred employees can purchase qualified coverage.\textsuperscript{206} Only U.S. citizens and legal immigrants who are not incarcerated can purchase through the Exchanges.\textsuperscript{207} The Exchanges can be established by a governmental agency or nonprofit entity in each state.\textsuperscript{208} States may also form regional Exchanges or allow more than one Exchange to operate within a state, as long as each Exchange serves a distinct geographic area.\textsuperscript{209} The federal government will provide funding to states to establish Exchanges within one year of the law’s enactment, until January 1, 2015.\textsuperscript{210}

The federal government retains authority to establish the certification criteria for the state Exchanges, while states are responsible for the actual certification of plans and administration of the Exchanges. The U.S. Secretary of Health and Human Services will establish the criteria for the certification of insurance plans as “qualified health plans.”\textsuperscript{211}

\textsuperscript{204} House Tri-Committee America’s Affordable Health Choices Act of 2009 (H.R. 3200).
\textsuperscript{205} Senate Health Education Labor & Pensions (HELP) Committee Affordable Health Choices Act (S. 1679).
\textsuperscript{206} ACA §1311(b)(1).
\textsuperscript{207} Id. § 1312(f)(1)(B), (f)(3).
\textsuperscript{208} Id. § 1311(d)(1).
\textsuperscript{209} Id. § 1332(a)(1).
\textsuperscript{210} Id. §§ 1331(d), 1333(d)(5)(A).
\textsuperscript{211} Id. §§ 1311(c)(1), 1321(a)(1)(B).
States are responsible for rating each health plan offered in an exchange in accordance with federal standards and certifying health plans as “qualified health plans.”212 Plans that fail to qualify may not be offered on the Exchanges. The federal statute includes a detailed “essential health benefits package,” which must be included in plans sold in the Exchanges.213 Essential health benefits at least include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services, chronic disease management, and pediatric services including oral and vision care.214 States may require additional health benefits but must defray the costs of additional coverage through payments directly to patients or insurers.215 As an alternative to enrolling certain low-income individuals in the Exchanges, states may establish “basic health programs” for non-elderly, non-Medicaid-qualified individuals.216

ACA also requires state Exchanges to comply with various administrative requirements, defined by the Secretary, including marketing limitations, sufficient choice of providers, standardized plan information and enrollment forms, and quality improvement strategies.217 States must establish an Internet portal for providing Exchange information, including a rating system, enrollee satisfaction surveys, and other quality data.218 States must also provide a toll-free telephone hotline to respond to

212 Id. §§ 1302(b), 1331(a).
213 Id. § 1302(a), (b)(1).
214 Id. § 1302(b).
215 Id. §§ 1311(d)(3), 10104.
216 Id. § 1331(a)(1).
217 Id. § 1311(c).
218 Id. § 1311(d)(4)(C).
requests for assistance. In addition, states must establish procedures for enrolling individuals and determining eligibility for tax credits. When individuals submit an application to an Exchange, states will be required to inform them of eligibility requirements for Medicaid and CHIP, screen for eligibility, and enroll those individuals in the appropriate program, if any. States also must certify to the federal government when an individual is exempt from the individual requirement to purchase health insurance. States are authorized to contract with a non-governmental entity to carry out Exchange-related administrative responsibilities. If states fail to establish Exchanges the federal government will step in, administering them directly or by contracting with a non-profit entity in the state.

As described even briefly, it is apparent that the Exchanges impose massive financial, administrative, and enforcement burdens on states to operate the new individual and small-group health insurance marketplace and coordinate with other specific ACA components. State-operated Exchanges rely on states’ expertise and experience in regulating commercial health insurance. State-operated Exchanges also allow states some flexibility in operation and enforcement of the Exchanges and related requirements. The statute’s provision of federal funding to states ensures that Exchanges do not run awry of the anti-commandeering doctrine, at least for the first few years. But federal funding ceases in 2015. The statute contains a nominal opt-out;

---

219 Id. § 1311(d)(4)(B).
220 Id. § 1311(d)(4)(F).
221 Id. § 1311(d)(4)(H).
222 Id. § 1311(f)(3).
223 Id. § 1321(c) (requiring Secretary to determine by January 1, 2013, whether states will have Exchanges in place by January 1, 2014, deadline).
224 See Jost, supra note 199, at 56.
225 See generally ACA §§ 1321, 1332 – 34.
226 See supra note 75 and accompanying text.
states could simply refuse federal dollars, fail to establish Exchanges, and wait for the federal government to come in and do so for them. But unlike the high-risk pools, so far, no state has suggested that it will decline to cooperate.

Like state-based high-risk insurance pools, state-based Exchanges represent a concession to Republican lawmakers who resisted increasing federal authority and favored retention of state control over health care reform.227 Both provisions allow states to refuse to cooperate but start from different baselines. The high-risk pools operate as a state opt-in while the Exchanges operate as a state opt-out. The statute requires the Secretary to establish high-risk pools but allows her to contract with states or non-profit entities. The Exchanges, by contrast, are statutorily assigned to states, but the Secretary retains authority to take over if states fail to comply. Otherwise, the two provisions operate similarly yet draw divergent responses.

Neither the uncooperative federalism nor the opportunistic federalism theory provides a complete explanation for the lack of resistance to state-based Exchanges. At least for now, states have not objected to the Exchanges on federalism or any other grounds. But the lack of dissent is notable, especially by contrast to the strong resistance to the high-risk pools, which rely on a similar mechanism for allocating federal and state powers. The uncooperative federalism model suggests that the “soft” opt-in – high-risk pools – would trigger milder reaction than the “hard” opt-out – Exchanges.228 If states can easily, without consequences, walk away from a federal program with which they

---

228 Bulman-Pozen & Gerken, supra note 35, at 1291.
disagree, “they may not have much incentive to devote the resources needed to mount an
effective challenge to the federal policy.” Yet, twenty states spurned the Secretary’s
invitation to establish state high-risk pools while, so far, none has expressed
unwillingness to establish an Exchange, precisely the opposite of uncooperative
federalism’s prediction.

Opportunistic federalism theories suggests that politicians and voters care little
about the structure of government but nevertheless assert federalism grounds as a strategy
for challenging substantive policies that they oppose. It may be true that structural
federalism is not the main concern of states resisting ACA. If states were truly concerned
about loss of state power to the federal government, they would seem to prefer state
implementation of both high-risk pools and Exchanges. But a significant number of
mostly right-leaning, health-reform-opposing states favor federal high-risk pools while
apparently all states, for now, prefer state-based Exchanges. Indeed, during
congressional debates, state-based Exchanges won over a national Exchange, in part,
because of concerns about expansion of federal power. If states maintain their support
for state-based Exchanges, there is nothing opportunistic about their views on federalism.
Perhaps states truly do prefer state-level insurance marketplaces, consistent with states
autonomy rhetoric and congressional floor votes. Lack of opposition to state Exchanges
may demonstrate the real salience of federalism, not just as a rhetorical device but a
substantive policy preference.

229 Id.
230 See Janet Adamy & Laura Meckler, Support Grows for U.S. Health Exchange, WALL ST. J., Jan. 13,
2010 (describing White House’s push for national health insurance exchange) available at
http://online.wsj.com/article/SB1263350725076727217.html; Peter Grier, Health Care Reform Bill 101:
What’s a Health “Exchange”? CHRISTIAN SCI. MONITOR, March 20, 2010 (noting national exchange bill
“is gone with the wind”) available at http://www.csmonitor.com/USA/Politics/2010/0320/Health-care-
reform-bill-101-What-s-a-health-exchange; Kingsdale, supra note 199.
Another plausible explanation for states’ less strident objection to the Exchanges, compared to the high-risk pools, is that the issue is not yet ripe. Federal funding is not available until one year after ACA’s enactment and the Exchanges are not required until 2014. If the uncooperative federalism and opportunistic federalism models are predictive, we should expect state resistance to the Exchanges to mount as the 2014 implementation date approaches. States should marshal their power to resist and decline to establish Exchanges. In taking that position, however, they must downplay any states’ rights and state autonomy rhetoric, much as they have in declining to establish state-based high-risk pools. If structural federalism is an earnest concern, it is incongruous that states would willingly allow the federal government to intrude on their territory in establishing high-risk pools and Exchanges yet complain about federal overreaching in the context of Medicaid expansion and the individual insurance mandate.

That incongruity is mostly consistent with the opportunistic federalism interpretation of the state nullification movement; opponents invoke federalism arguments when it is to their advantage but look past those concerns when other objectives are primary. The primary objective, in all of this, may be simply to undermine federal health reform at every turn. As a strategic matter, states may be staging objections to the provisions of ACA as they roll out, keeping steady pressure on Congress to revise or repeal the new legislation. But even inconsistent, opportunistic use of federalism suggests that notions about the proper role of state and federal governments have more traction with voters than opportunistic federalism theories suggest.

D. Insurance Market Regulations
States also have not objected to ACA’s significant reallocation of power to regulate the health insurance market from the states to the federal government. Several provisions broadly preempt states’ traditional authority over commercial health insurance companies operating in their borders. Some of the new federal health insurance regulations take effect almost immediately after ACA’s enactment, beginning with the high-risk pools in June 2010.\textsuperscript{231} Within six months of the statute’s enactment, insurers will be required to allow dependent children to remain on their parents’ policies until age 26.\textsuperscript{232} Effective January 1, 2010, the law creates a mandatory, nationwide medical-loss ratio, meaning that insurers will be required to spend eighty-five percent of revenue on patient care and no more than fifteen percent on non-medical, administrative expenditures.\textsuperscript{233}

More sweeping changes take effect on January 1, 2014. Insurers across the country will be prohibited from excluding individuals on the basis of pre-existing conditions,\textsuperscript{234} exceeding annual dollar-amount caps on patient cost-sharing,\textsuperscript{235} and rescinding coverage after individuals become ill.\textsuperscript{236} Guaranteed issue and renewability also take effect in 2014,\textsuperscript{237} meaning that insurers will be required to accept everyone who applies for coverage and cannot refuse to renew policies based on health status, utilization of services, or other factors. All new individual and small-group health insurance policies, including those offered through the Exchanges, will be required to

\textsuperscript{231} See supra Part IV.B.
\textsuperscript{232} ACA § 1001 (amending PHSA § 2714).
\textsuperscript{233} Id. § 1331(b)(3).
\textsuperscript{234} Id. § 1201 (amending PHSA § 2704).
\textsuperscript{235} Id. § 1001 (amending PHSA § 2711).
\textsuperscript{236} Id. § 1001 (amending PHSA § 2712).
\textsuperscript{237} Id. § 1201 (amending PHSA §§ 2702, 2703).
cover an essential benefits package\textsuperscript{238} and comply with one of four benefit categories (platinum, gold, silver, and bronze) as defined in the statute.\textsuperscript{239} Insurers will continue to be licensed and regulated by the states,\textsuperscript{240} but any state insurance laws will have to accord with the new federal laws.\textsuperscript{241}

In 2014, insurers will also be restricted in how they price plans. The statute establishes nationwide modified community rating and specified rating bands. Insurers may not vary premium rates except based on age (limited to a three-to-one ratio), premium rating area, family composition, and tobacco use (limited to a 1.5-to-one ratio) in the individual and small-group markets and the Exchanges.\textsuperscript{242} States are required to establish rating areas in compliance with the federal law.\textsuperscript{243} Waiting periods cannot exceed ninety days.\textsuperscript{244} The statute also limits beneficiary cost-sharing obligations. Deductibles in the individual and small-group markets are capped at $2,000 for individuals and $4,000 for families.\textsuperscript{245} New, standardized administrative and reporting requirements apply to all qualified plans.

ACA’s new federal health insurance rules apply uniformly across the country with no state opt-out. As a matter of federal supremacy, states cannot adopt requirements that conflict with or impede the purpose of the federal law.\textsuperscript{246} Beginning on the effective date of each provision, any state law that does not meet the minimum federal standard

\textsuperscript{238} Id. § 1302.
\textsuperscript{239} Id. § 1302(d).
\textsuperscript{240} Id. § 1302(a)(1)(C)(i).
\textsuperscript{241} See Jennings & Hayes, supra note 25.
\textsuperscript{242} ACA § 1201 (amending PHSA § 2701).
\textsuperscript{243} Id. (amending PHSA § 2701(a)(2)).
\textsuperscript{244} Id. § 1201 (amending PHSA § 2708).
\textsuperscript{245} Id. § 1302.
will be preempted. States retain flexibility to adopt laws that provide greater protection, above the federal minimum but cannot vary the requirements to protect health insurance consumers below that floor. 247 The insurance market reforms in the federal legislation generally have received broad support from citizens and politicians. 248 From a states'-rights perspective, however, those new federal laws significantly intrude on states’ authority and discretion to regulate private health insurers.

Insurance regulation was long considered within core state police powers to protect the health, safety, and welfare of their citizens. In 1945, Congress re-affirmed the states’ authority to regulate insurance with the McCarran-Ferguson Act, 249 which effectively reversed a U.S. Supreme Court opinion applying federal antitrust laws to the business of insurance. 250 McCarran-Ferguson allows the federal government to regulate insurance only to the extent the states have not done so. 251 Congress is actively considering legislation that would repeal the McCarran-Ferguson Act, 252 but the repeal was not included in ACA. If the antitrust exemption were repealed, the federal

247 See ACA § 1321(d) (“Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.”); Jennings & Hayes, supra note 25 (explaining that ACA “establishes new minimum federal standards for insurance policies”).


250 United States v. Southeastern Underwriters Ass’n, 322 U.S. 533 (1944); see Jost, supra note 201, at 55.

251 15 U.S.C. 1012(b) (“No Act of Congress shall be construed to invalidate, impair, or supersed any law enacted by any State for the purpose of regulating the business of insurance … unless such Act specifically relates to the business of insurance”).

government would gain substantial regulatory authority over insurers, thereby further narrowing the space for state regulation.

In earlier legislation, Congress has exercised it preemptive powers over state regulation of health insurance. Most notably, the Employee Retirement Income Security Act of 1974 (ERISA), 253 enacted under federal commerce power, broadly preempts state laws that “relate to” employee benefit plans, including most employer health plans. 254 ERISA also contains a generous “savings clause” that retains state authority over traditional insurance plans purchased by employers on behalf of their employees. 255 A separate ERISA provision preempts a host of state common law remedies for plan enrollees aggrieved or injured by health insurers’ coverage decisions and administrative errors. 256 ERISA is widely considered a major obstacle to comprehensive state health reform. 257

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) 258 also preempts state law by establishing national standards for small-group and individual health plans. HIPAA restricts insurers’ application of preexisting condition exclusions for individuals who move between employer group plans, government health care programs, or other “creditable” coverage. 259 The law also

---

254 29 U.S.C. § 1144(a) (ERISA § 514(a)).
255 29 U.S.C. § 1144(b) (ERISA § 514(b)(2)(A)); see also id. § 1132(b)(2)(B) (ERISA § 514(b)(2)(B) (deemer clause) (clarifying that “self-insured” employer health plans shall not be deemed to be the business of insurance and, therefore, remain subject to ERISA preemption)).
256 29 U.S.C. § 1132(a) (ERISA § 502(a)).
requires guaranteed issue for individuals with creditable coverage, although it does not limit the premium amounts that insurers may charge. State laws that do not meet the minimum federal requirements of HIPAA are preempted. ACA extends HIPAA protections to the individual, or non-group, market, and others with gaps in health insurance coverage or no prior “creditable” coverage.

ERISA and HIPAA notwithstanding, the federal government has largely refrained from substantively regulating the terms of health insurance plans or practices of health insurance companies, leaving those matters to state law. Some states have implemented various requirements on health insurance plans, including coverage mandates, premium-rating rules, guaranteed issue and renewability, restrictions on rescission, “any willing provider” laws, marketing restrictions, grievance and appeals rights, and various other insurance market reforms. State laws focus particular regulatory attention on the small-group and individual markets because those markets tend to impose greater obstacles to coverage than the employer and large-group market. The number and specificity of the new ACA rules targeted to those same markets represent a significant reallocation of authority from states to the federal government. With ACA, state policymaking discretion, and, accordingly, insurance plan variability, is much more limited. But states generally have not expressed dissent over that loss of power, even to new federal requirements that take effect almost immediately.

---

260 29 U.S.C. § 1182(a) & (b).

261 But see 29 U.S.C. §§ 1181, 1185, 1185a, & 1185b (listing very few federal coverage requirements under ERISA, including minimum hospital stays after childbirth, breast reconstruction after mastectomy, and mental health parity); FURROW, ET AL., supra note 134, at 752 (describing mental health parity and “drive-through delivery” laws).

New federal coverage mandates for qualified health plans, limits on insurers’ underwriting practices, state administrative requirements, consumer protection provisions, standardized and coordinated enrollment processes, information disclosure and technology infrastructure requirements, and other changes to the commercial insurance market substantially limit states’ authority to enact conflicting insurance laws within their own borders. ACA’s insurance market regulations do not seek states’ participation as servants or allies of the federal government but simply restrict their autonomy as a matter of federal preemption.

Squaring states’ apparent tolerance for federal preemption of insurance regulation with the uncooperative federalism model turns on the scope of the preemptive effect. If federal preemption is read narrowly, then the insurance market reforms fit fairly well under Bulman-Pozen and Gerken’s model. Uncooperative federalism encourages overlap and friction between spheres of state and federal authority as a means to foster productive dissent.\(^{263}\) With ACA, the federal government reclaimed considerable insurance regulatory authority. If states are allowed space to adopt different policies and approaches, outside of the specific federal requirements, that tension may lead to useful, alternative approaches and testing of new federal laws. But if federal preemption of state regulation of health insurance is read broadly, states will be pushed to the margins with little room to object, silencing any productive dialogue.\(^{264}\) Until states begin to test the scope of their residual authority to regulate health insurance under the new federal law, it is difficult to fully consider the descriptive accuracy of the uncooperative federalism model in this context.

\(^{263}\) Bulman-Pozen & Gerken, supra note 35, at 1302 – 03.

\(^{264}\) See Young, supra note 55, at 1385 (considering preemption from the perspective of “ensuring that states retain something meaningful to do”).
There is, however, reason to doubt the uncooperative federalism model’s prediction regarding states’ reaction to the new federal health insurance reforms. Evidence can be drawn from states’ reactions to existing federal insurance regulation under ERISA and HIPAA. ERISA has been interpreted to broadly preempt state regulation of employer health plans, including a wide swath of traditional common law tort and contract claims. That broad preemptive effect is considered to obstruct state health insurance reform and innovation. HIPAA, by contrast, does not expressly preempt state regulation or occupy the field but merely limits certain insurer practices for certain insureds. With respect to regulation of the individual insurance market, HIPAA expressly allows states to establish alternative mechanisms for extending access to insurance to individuals. All but seven states have established alternative programs, including pre-ACA high-risk insurance pools. HIPAA’s relatively narrow preemptive effect has largely been accepted without objection.

Thus, contrary to the uncooperative federalism model’s doctrinal suggestion that narrow preemption would produce more friction and dialogue whereas broad preemption would marginalize dissenting views, those examples suggest the opposite. Broad preemption under ERISA has created a more contentious dialogue between states and the federal government. By contrast, limited preemption under HIPAA has largely been met with state acceptance and cooperation.

As with the Exchanges, it is also possible that states will not object to the new federal insurance market reforms at all, despite the intrusion on traditional state sovereignty. Acknowledging their “two masters,” states may find that their state

---

266 Bulman-Pozen & Gerken, supra note 35, at 1270.
constituents favor those consumer-protective reforms, which address some of the most notorious abuses of the commercial insurance industry. At the same time, states can pass the blame onto the federal government if insurance companies incorporated in their states or other interested constituents object to the new requirements. Uncooperative federalism values accountability, yet states may be strategically hiding behind the federal preemptive cloak to both silently support new laws popular with insureds and avoid taking responsibility for laws objectionable to insurers. That analysis comports with opportunistic federalism: states raise federalism objections to advance certain goals but accept federal control when other goals are paramount.

E. Individual Mandate

The provision of ACA that has drawn the strongest, most persistent objection from states is the least intrusive on state authority. Many states vehemently protest the mandate that every individual maintain health insurance meeting certain minimum standards. The individual mandate, however, requires nothing particular of states and will be implemented and administered entirely by federal authorities.

Before and after ACA’s passage, lawmakers in over forty states passed, introduced, or advocated state constitutional amendments or legislative resolutions providing that individuals within the state shall not be required to participate in a particular health plan or prohibited from purchasing health insurance directly from health

---

267 For a “docu-tainment” depiction of complaints about the U.S. health insurance industry, see Michael Moore’s Sicko (Dog Eat Dog Films 2007).
268 Bulman-Pozen & Gerken, supra note 35, at 1289 – 91.
269 HCERA § 1002; ACA §§ 1501, 5000A.
care providers. The nullification resolutions, modeled on the American Legislative Exchange Council’s (ALEC’s) Freedom of Choice in Health Care Act, aim squarely at the requirement to maintain individual health insurance. The current state proposals are ALEC’s second-generation model laws. First-generation state nullification laws opposed a national health plan or mandatory public option, proposals which were never seriously considered with ACA.

Under ACA, beginning in 2014, U.S. citizens and legal residents must maintain minimum essential health insurance coverage. The individual mandate can be satisfied with coverage under Medicare, Medicaid, CHIP, veterans’ health care programs, or the Peace Corps volunteers health plan. Coverage under an eligible employer-sponsored plan, a plan offered in the individual market, or a grandfathered health plan will also suffice. Individuals will be required to report their coverage status on their annual federal income taxes, and failure to maintain coverage will result in monetary penalties. The penalty for the first year, 2014, is a very modest ninety-five dollars. At full implementation, the penalty is 695 dollars per year, up to a maximum of three times

270 See, e.g., Arizona Prop. 101 (2008) (“Prohibits laws that: restrict person's choice of private health care systems or private plans; interfere with person's or entity's right to pay directly for lawful medical services; impose a penalty or fine for choosing to obtain or decline health care coverage or for participating in any health care system or plan.”).
272 See Jost, supra note 27, at 870.
273 ACA §1501(b).
274 Id. §1501(f).
276 ACA §1501(c).
that amount (2,085 dollars), or 2.5 percent of household income, whichever is greater.\textsuperscript{277} The law provides exemptions based on religion, unlawful presence within the United States, incarceration,\textsuperscript{278} inability to afford coverage,\textsuperscript{279} hardship, membership in an Indian tribe, coverage for more than nine months of the year,\textsuperscript{280} and taxable income below the federal income tax filing threshold.\textsuperscript{281} 

To assist individuals in complying with the mandate, ACA provides premium assistance federal tax credits for eligible taxpayers.\textsuperscript{282} Also, individuals with incomes above one-hundred percent but below 400 percent FPL are eligible for federal subsidies for beneficiary cost-sharing under certain plans purchased through the Exchanges.\textsuperscript{283} The federal government will inform insurers that an individual is eligible for cost-sharing reductions\textsuperscript{284} and then remit periodic and timely payments to the insurer to make up the premium difference.\textsuperscript{285} 

The individual mandate relies negligibly on state participation for implementation, imposing no additional burdens other than existing obligations to coordinate Medicaid eligibility,\textsuperscript{286} establish state-based Exchanges,\textsuperscript{287} and maintain existing state licensing and regulation of insurance companies offering qualified plans.\textsuperscript{288} 

\begin{footnotesize}
\textsuperscript{277} HCERA §§ 1002(a); ACA §1501(b).
\textsuperscript{278} ACA §§ 1501(b) (amending Internal Revenue Code by adding § 5000A).
\textsuperscript{279} Id. (providing exemption for individuals whose penalty for being uninsured would exceed eight percent of individual’s annual household income).
\textsuperscript{280} Id.
\textsuperscript{281} HCERA § 1002(b)(2)(A).
\textsuperscript{282} ACA § 1401 (adding new Internal Revenue Code provision, 36B).
\textsuperscript{283} Id. § 1402(b) (sliding scale for incomes between 100 and 400 percent of federal poverty level).
\textsuperscript{284} Id. § 1402(a).
\textsuperscript{285} Id. § 1402(c)(3).
\textsuperscript{286} See supra Part IV.A.
\textsuperscript{287} See supra Part IV.C.
\textsuperscript{288} See supra Parts IV.D.
\end{footnotesize}
Enforcement, exemptions, credits, and subsidies are tied to federal individual income tax rules, enforced and administered by federal authorities. 289

The policy goal of the individual health insurance mandate is to bring more people into the insurance market, including young, healthy individuals who often elect not to purchase health insurance, thereby spreading the risks more broadly and making insurance more affordable for all. 290 Opponents invoke libertarian values and free market principles, objecting to a law that requires individuals to spend their own money on particular transactions or engage in particular conduct. 291 The insurance mandate arguably intrudes on economic freedom to decline health insurance and personal autonomy rights to arrange and pay for medical care other than through third-party insurers and without government intrusion. More particularly, opponents of the individual mandate prefer a system in which each pays for his own medical costs, rather than effectively requiring healthy people to subsidize unhealthy people through insurance risk pools. 292 In sum, the state nullification amendments and resolutions opposing the federal individual insurance mandate speak more in the language of individual than states’ rights. 293

289 ACA § 1002.
290 See id. § 1501(a)(2)(G) (“By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.”); Balkin, supra note 26, at 483; Peter Urbanowicz & Dennis G. Smith, Constitutional Implications of an “Individual Mandate” in Health Care Reform, THE FEDERALIST SOCIETY L. & PUB. POL’Y STUDIES, July 10, 2009, at 1, available at http://www.fed-soc.org/doclib/20090710_Individual_Mandates.pdf.
291 See, e.g., Michael F. Cannon, All the President’s Mandates: Compulsory Health Insurance is Government Takeover, CATO INSTITUTE BRIEFING PAPER, No. 114, Sept. 23, 2009; Urbanowicz & Smith, supra note 290, at 4 (characterizing individual mandate as unconstitutional “taking”).
293 See, e.g., Virginia Complaint, supra note 18, at 4 – 6 (arguing that individual mandate exceeds congressional power to regulate interstate commerce, operating as regulation of individuals’ non-commercial conduct); Monica Davey, Health Care Overhaul and Mandatory Coverage Stirs States’ Rights Claims, N.Y. TIMES, Sept. 29, 2009 (“All I’m trying to do is protect the individual’s right to make health care decisions” (quoting Minnesota State Representative, Tom Emmer)); Rivkin & Casey, supra note 26;
Because the federalism basis for states’ opposition to the individual mandate is tenuous at best, it is difficulty to place those objections within the uncooperative federalism model. States have no particular role, servant or otherwise, to play in implementing or enforcing the mandate. The federal law requiring individuals to maintain qualified health insurance coverage does not solicit states’ cooperation or commandeer state officials. The federal government does not depend on states to effect the new national requirement.\textsuperscript{294} The individual mandate is novel; states, therefore, are not integrated or imbedded in an existing regulatory regime, which might give them stronger voice in the policymaking conversation.\textsuperscript{295} Therefore, state resistance does not fit neatly under uncooperative federalism’s “states as servants” model.

State authorities are incidental to the new federal requirement. From that posture, it is hard to see how states could marshal any power as servants to impact federal policy. Congress can simply ignore state nullification resolutions and amendments and lawsuits challenging the individual mandate as legally without merit. There is no productive, policy-forcing dialogue between the states and federal government at work.

Opportunistic federalism offers a plausible theory for state resistance to the individual mandate but does not fully explain the pervasive trend. Opportunistic federalism posits that arguments about allocation of power between the federal government and the states are merely proxies for objections to substantive policies.\textsuperscript{296} It may well be that sponsors of state nullification amendments and resolutions would

\textsuperscript{294} See Bulman-Pozen & Gerken, supra note 35, at 1266 (suggesting that states “wield power against a federal government that depends on them to administer its programs”).

\textsuperscript{295} See id. at 1268 – 70 (observing that servants’ power may also derive from integration).

\textsuperscript{296} See supra Part III.C.
readily abandon their positions on structural federalism if the individual insurance
mandate were otherwise repealed. But even if repeal of ACA is the first-order
priority, it is nevertheless significant that objections are grounded in federalism.

States opposing the individual mandate posture themselves as advocating for
individual rights of their citizens, consistent with new federalism themes. The
purported state interest is the discretion to recognize more liberal individual economic
and personal autonomy rights for their citizens than the federal minimum, which intrudes
on Tenth Amendment reserved powers. The Virginia lawsuit asserts state standing to
bring the individual rights challenges based on its particular sovereign interest in
enforcing the recently enacted Virginia Health Care Freedom Act, against ACA’s directly
conflicting requirement. The Florida lawsuit asserts injury broadly to the states’
sovereign interests as “protectors of the freedom, public health, and welfare of their
citizens and residents.” The Complaint alleges that the individual mandate is an
unconstitutional tax that injures states’ “exclusive authority, except to the extent
permitted by the federal government by the Constitution, to make all taxing decisions
affecting their citizens.” Precisely striking a new federalism cord, the states claim the
exclusive authority, subject to federal enumerated powers, “to confer a right upon persons
in their states to make healthcare decisions without government interference.”

297 See Devins, supra note 36, at 134 (noting “the willingness of lawmakers and interest groups to
manipulate federalism in order to secure preferred substantive policies”).
298 See supra notes 52 – 56 and accompanying text (citing new federalism scholarship).
299 See Virginia Complaint, Florida Complaint, supra note 18.
300 See Plaintiff’s Memorandum in Opposition of Motion to Dismiss, Commonwealth v. Sebelius (E.D. Va.
coverage not required).
301 See Florida Complaint, supra note 18, at 18.
302 Id. at 17 – 18.
303 Id. at 18.
Opportunistic federalism dismisses new federalism as yet another example of the
disingenuous line of argument.\textsuperscript{304}

But opportunistic federalism fails to explain why states are leading the charge
against the individual mandate, especially given the states weakness of states’ legal
challenges to the individual mandate and unenforceability of state nullifications and
amendments.\textsuperscript{305} In similar cases of states challenging federal laws, the state rights
interest that accompanied the individual rights argument was more readily identifiable.
For example, the USA PATRIOT Act, clearly implicated state actors, calling for them to
perform background checks and other surveillance of suspected terrorists and also
intruded on individual privacy and liberty interests.\textsuperscript{306} Similarly, the federal Brady
Handgun Violence Prevention Act,\textsuperscript{307} was successfully challenged on anti-
commandeering grounds but was also held to impair individuals’ Second Amendment
rights.\textsuperscript{308} By contrast, there is little constitutional support for individual rights objections
and almost no basis for state objections to the individual health insurance mandate.

If opportunistic federalism is correct in suggesting that the public does not really
care about\textsuperscript{309} or understand the allocation of power between states and the federal
government,\textsuperscript{310} it is hard to explain why state-oriented challenges have been at the center

\begin{flushleft}
304 See supra note 116.
305 See supra note 26 (citing sources on both sides of that debate).
306 See Althouse, supra note 30, at 1257 – 61 (discussing federalism doctrine protections for individual
rights in context of USA PATRIOT Act); Bulman-Pozen and Gerken, supra note 35, at 1278 – 80
(describing state responses to PATRIOT Act).
308 Bulman-Pozen and Gerken, supra note 35, at 1251 – 53 (discussing United States v. Printz, 521 U.S.
309 See supra note 102 (quoting Devins).
310 See McGinnis & Somin, supra note 101, at 95 – 95 (noting, “Federalism questions are unusually
complex because they involve a wide range of policy areas and complicated intergovernmental relations”)
\end{flushleft}
of debate over the individual mandate. Libertarian, free market, individual rights arguments seem much more accessible and likely to resonate with the public. Moreover, citizens or public interest groups representing individuals affected by the mandate would have stronger, direct bases for challenging the law. The persistence of the state nullification resolutions and amendments and states’ constitutional litigation suggests that federalism is more meaningful to the public than opportunistic federalism acknowledges.

The uncooperative federalism and opportunistic federalism theories do not explain why states have interjected most loudly and widely in the debate over the individual mandate, which implicates their interests the least. Moreover, the forms of resistance – weak constitutional litigation and legally null state amendments and resolutions – seem particularly impotent. The mismatch between strong state opposition to the individual mandate and minimal imposition on states under those requirements highlights the rhetorical value of federalism. Federalism themes resonate even when there are easier, more direct approaches to challenging the law. The next Part attempts to reconcile the various expressions of federalism evoked in the health reform debate.

V. Rhetorical Federalism in Health Care Decisionmaking

The persistence and pervasiveness of state resistance to the recent federal health reform legislation warrants attention. It is easy to dismiss the nullification movement as nothing more than tea-party obstructionism and partisan politics designed to undermine the hard-fought reforms. It is hard to take seriously state statutes and constitutional

and “Federalism is an abstract and complicated system compared to many underlying public policy issues like drugs and education”).

311 See, e.g., supra note 3 (citing public interest group lawsuits)
amendments proclaiming that federal laws do not operate within state borders. It seems highly unlikely that state litigants have standing much less valid substantive arguments for challenging the constitutionality of ACA’s key provisions. It is difficult to give much credence to states’ objections to federal commandeering under new Medicaid requirements when they willingly allow federal authorities to set up administrative shop inside their borders and broadly preempt state regulatory authority. Despite the inconsistencies and legally dubious arguments, rhetorical federalism plays a valuable role in public debate.

While uncooperative federalism gives states too much credit for their various forms of dissent, opportunistic federalism gives them too little credit for caring about the constitutional allocation of power. Bridging the two ideas, rhetorical federalism recognizes that even inconsistent, even disingenuous, invocation of federalism arguments may benefit both health care decisionmaking and federal-state relations. Like uncooperative federalism, rhetorical federalism finds value in states’ not simply falling in line with federal authorities. And like opportunistic federalism, rhetorical federalism acknowledges that federalism arguments have political salience aside from earnest concerns about the federal structure. By describing the health reform nullification movement as rhetorical federalism, this Article recognizes that state responses to federal health reform cannot be reduced to a unified theory. Rhetorical federalism encompasses various principles, values, and slogans, and makes space for the discordant range of highly vocal to mild objections, as well as conspicuous non-objections.
Rhetorical federalism does not purport to be a formalistic, coherent theoretical paradigm. The health reform debate reveals a mix of deep concern for state autonomy and tolerance for central direction. States rely on “federalism rhetoric to justify often disparate and inconsistent approaches.” It may be that the overarching goal of the state nullification movement is simply to undermine and ultimately repeal ACA, and not to preserve and protect state autonomy. But even that messy, politicized, and opportunistic approach to federalism informs public discussion about the challenges of health reform and the proper role of government.

Framing objections to substantive polices in terms of states’ rights, even when state interests are not implicated, as with the individual mandate, allows state policymakers to give voice to constituents’ views on the merits of the new federal law. State officials, including members of Congress, state legislators, attorneys general, and insurance commissioners, are more politically connected and may have stronger voices in the national dialogue than any individual voter. One of the values of uncooperative federalism is the ability of states to express dissenting views of their constituents from a more advantageous, insider status. At the same time, state politicians garner support from voters who oppose the law, consistent with opportunistic federalism’s observations, cooperative federalism’s two masters notion, and the federalist design

313 See id. at 204 (characterizing President Ronald Reagan’s approach).
314 Id.
315 See Bulman-Pozen & Gerken, supra note 35, at 1268 – 70; Young, supra note 29, at 1285 (noting that “[i]ndividuals are often ineffective speakers when they act alone” and that “often the most effective organizations for organizing and transmitting dissent are themselves governmental institutions”).
316 Bulman-Pozen & Gerken, supra note 35, at 1288.
318 See Bulman-Pozen & Gerken, supra note 35, at 1270 – 71.
itself.\textsuperscript{319} When one political party controls both Congress and the White House, it is especially important that state representatives and administrators express dissenting views, serving as the “fourth branch” of government.\textsuperscript{320} Regardless of Washington party control, state representatives may be more accessible and responsive to constituents’ concerns,\textsuperscript{321} allowing ideas and consensus to percolate up.\textsuperscript{322}

Federalism rhetoric may be valuable even when it has no legal merit. Even if state lawsuits fail and state constitutional amendments are unenforceable, “the constitutional ideas that animate the complaints and bubble through tea party rhetoric will be raised again to the attention of a wide public and given new credence.”\textsuperscript{323} State amendments and resolutions purporting to excuse state residents and officials from compliance with the federal individual health insurance mandate are surely unenforceable as a matter of federal supremacy.\textsuperscript{324} But even unenforced or unenforceable enactments codify state values and opinions, akin to state constitutional provisions proclaiming health as a public concern,\textsuperscript{325} anti-abortion “trigger laws”,\textsuperscript{326} or other countries’ constitutional “directive principles.”\textsuperscript{327} Similarly, state laws purporting to nullify the

\textsuperscript{319} See Young, supra note 29, at 1285 – 86 (suggesting that “transmitting the political dissent of their constituents” was consistent with the “Founders’ notion . . . that state and local governments should ‘act as intermediaries between the people and the federal government’” (quoting Wayne D. Moore)).

\textsuperscript{320} See Bulman-Pozen & Gerken, supra note 35, at 1285; Roderick M. Hills, Jr., Federalism in Constitutional Context, 22 HARY. J.L. & PUB. POL. Y 181, 182 (1998) (“In effect, state and local governments serve as a kind of ‘fourth branch’ of the federal government, even more so than so-called independent federal regulatory agencies”).

\textsuperscript{321} See supra note 57 and accompanying text.

\textsuperscript{322} See supra notes 62 – 64 and accompanying text.

\textsuperscript{323} Huq, supra note 26.

\textsuperscript{324} See Jost, supra note 27 (evaluating legality of state nullification laws).


\textsuperscript{327} See, e.g., INDIA CONST. art. 37 (“The provisions contained in this Part [IV] shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the
federal individual insurance mandate may be understood as expressions of broad public sentiment that health is a matter of individual, not government, responsibility. State laws opposing the individual mandate express widely held opinions, which may not carry the day in Congress or the courts. But even if laws such as Virginia’s are deemed legally null and preempted by ACA, they nevertheless have rhetorical value in expressing and codifying state citizens’ preferences.

Rhetorical federalism also benefits the healthcare decisionmaking process by highlighting the complexity of the new federal laws. ACA was not simply passed and put on the books but will gradually roll out over an elaborate timeline established in the statute. A new round of public debate will accompany each stage of ACA implementation, from now until 2014 and beyond. Political attention was sharply focused on health reform legislation as it is being debated. But once a bill is passed and signed into law, we typically shift our focus to the next headline. Accordingly, the general public, aside from motivated special interest groups, may be unaware and, therefore, not particularly involved with, the administrative rulemaking process and other
implementation details. State-based opposition sheds light on the usually unseen administrative processes and pragmatic challenges underlying a major piece of federal legislation.

Because ACA aims to heavily employ states as regulatory partners in implementing the comprehensive package of reforms, states will remain especially attuned to the law’s impact. Each new call for state cooperation can be expected to give rise to another round of state resistance. As uncooperative federalism suggests, the ongoing tension between states and the central government may be part of a “well-functioning federal system.” Ongoing state dissent has the potential to increase public understanding of, or at least appreciation for, the challenges that lie ahead as the ACA timeline unfolds. The public will be regularly reminded of the law’s price-tag and asked to consider the government’s ever-increasing role in health care delivery. Increased attention to the particulars of ACA implementation, particularly the cooperative federalism schemes being employed, also can address accountability problems otherwise associated with those arrangements. Public statements of states’ refusal of federal requests for cooperation may clarify lines of accountability, even if states ultimately agree to participate.

---

331 See supra Part V.C (predicting that resistance to state Exchanges, similar to state high-risk pools, will arise as the implementation date approaches); see Hills, supra note 320, at 193 – 94 (observing that “autonomous state and local politicians can be an insufferable thorn in Congress’ side”).
332 See Printz v. U.S., 521 U.S., 898, 930 (1997) (“By forcing state governments to absorb the financial burden of implementing a federal regulatory program, Members of Congress can take credit for “solving” problems without having to ask their constituents to pay for the solutions with higher federal taxes. And even when the States are not forced to absorb the costs of implementing a federal program, they are still put in the position of taking the blame for its burdensomeness and for its defects.”); New York v. U.S., 505 U.S. 144, 168 (1992) (“where the Federal Government compels States to regulate, the accountability of both state and federal officials is diminished”); Bulman-Pozen & Gerken, supra note 35, at 1260, 1296.
333 See Bulman-Pozen & Gerken, supra note 35, at 1289.
Post-enactment polling demonstrates that citizens’ understanding of the details of ACA increased in the months that followed its passage. Polls also demonstrate that public support to discrete components of ACA is stronger than for the legislation as a whole. One interpretation of those data is that the law is simply too long and complex to be well understood. But when parsed into separate provisions, respondents’ understanding of and appreciation for the law improves. Ongoing, post-enactment state resistance to each provision of ACA that rolls out may inform the public about the new law in more easily digestible bites.

Another value of rhetorical federalism is apoliticization. As opportunistic federalism observes, structure of government is an inherently content-neutral concept. Objections based on the Tenth Amendment or state autonomy grounds suggest no partisan preference or view on the underlying substantive policies. By framing objections to ACA as concern for the allocation of power within the federalist system, dissenters may more effectively capture the public’s attention without turning them off. Congressional and public debates over ACA were long, bitter, and highly charged. State

---


335 See Kaiser Health Tracking Poll, Jan. 2010, supra note 248 (tracking public reaction to specific proposals, compared to overall legislation); Trapp, supra note 248 (noting that specific provisions of health reform legislation receive positive polling results even though overall bill does not); The Polling Contradiction, NEWSWEEK, Feb. 19, 2010 (reporting that although a majority of Americans say they oppose health reform, a majority actually supports specific provisions of the legislation), available at http://www.newsweek.com/2010/02/18/the-polling-contradiction.html.


337 See Ryan, supra note 37, at 598 (“Federalism as a structural feature is inherently content-neutral with regard to substantive policy issues.”); Strong, supra note 72, at 1307 (“Today’s advocates of federalism do seek to make a nonideological case for the intrinsic virtues of federalism, independent of liberal or conservative ideological policy objections.”).
politicians may accurately sense voter fatigue with party politics and congressional inaction. Federalism offers a fresh, seemingly apolitical, basis for further challenging the enacted law with less risk of alienating voters. In addition, ACA opponents may gain credibility by rising above the fray, objecting to the new law on seemingly principled, even patriotic, \textsuperscript{338} rather than political, grounds. Even if opportunistic federalism is accurate in suggesting that opponents do not particularly care structure of government, federalism slogans provide seemingly neutral grounds for objecting to highly political issues, such as health care rights and the role of government in health care decisionmaking. Federalism rhetoric is beneficial in recapturing the public’s attention and keeping it engaged in the ongoing consideration of fundamental values and policies.

Federalism slogans enliven the ongoing debate over deep political and constitutional issues of personal autonomy and government responsibility for health care. Even when opponents adopt inconsistent positions, the health reform nullification movement, for all its distractions, persistently impresses those issues on the electorate. “There is no need for a single coherent problematic to dominate; a movement might successfully force a conflicting set of issues onto the center of the nation’s political consciousness.”\textsuperscript{339} The state nullification movement demands that we consider, and reconsider, our deeply held views on health care rights and responsibility, the role of government, and state identity.

VI. Conclusion

\textsuperscript{338} See Edward L. Rubin & Malcolm Feeley, Federalism: Some Notes on a National Neurosis, 41 UCLA L. Rev. 903, 906 (1994) (“We Americans love federalism…. It conjures up images of Fourth of July parades down Main Street, drugstore soda fountains, and family farms with tire swings in the front yard.”).

\textsuperscript{339} Ackerman, supra, note 119, at 1519.
This Article considers the rhetorical value of federalism in health care decisionmaking. Worst-case scenario, federalism objections are pure politics, simply a way for health reform opponents to persistently undermine the hard-fought legislation. Best-case scenario, the state nullification movement presages a constitutional moment for both health reform and federalism. We are in the very early stages of ACA implementation; thus, any assessment of the impact of the ongoing nullification movement is necessarily predictive. With that caveat in mind, this Article demonstrates the better, if not best-case, scenario.

Rhetorical federalism draws on previously articulated federalism theories, recognizing, like uncooperative federalism, that dissent can be productive, and, like opportunistic federalism, that state objections may operate as pretextual objections to the merits rather than content-neutral structural concerns. Federalism values are not easily defined and are the subject of widely varying opinions. Likewise, sweeping health reform legislation like ACA relies on a host of loosely coordinated approaches and strategies, each particular provision of which invites different reactions. The debate over health reform, not surprisingly, places issues of individual rights and the role of government in health care at the center of politics. The national conversation has also has the perhaps unexpected effect placing the ancillary issue of allocation of power between the central federal government and the sovereign states squarely before the electorate.

340 See 2 BRUCE ACKERMAN, WE THE PEOPLE: TRANSFORMATIONS 4 – 5, 17 – 26, 410 (1998) (defining, identifying, and discussing “constitutional moments” as moments when the Constitution was, in effect, transformed through popular mandate, during periods such as the Reconstruction and New Deal); Bruce A. Ackerman, The Storrs Lectures: Discovering the Constitution, 93 YALE L.J. 1013, 1022 – 24 (1984) (describing “rare periods of heightened political consciousness” during which constitutional, rather than normal, politics prevail as “constitutional moments”).
Even when federalism arguments are made disingenuously or opportunistically, that rhetoric should not be dismissed as empty.